PCN Development Support – Guidance and Prospectus

09/08/2019 (Final Version 2)

NHS England and NHS Improvement

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Introduction

Purpose

Implementing the NHS Long Term Plan requires the development of effective Primary Care Networks (PCNs). To help all PCNs mature and thrive, every STP and ICS needs to put in place high quality support.

In practice, responsibility for ensuring effective support falls to primary care leads in STPs/ICSs, working hand-in-glove with PCN Clinical Directors, and critically their wider community partners: community providers, the voluntary sector, and local government. This document is written for them.

Nationally, we have provided new dedicated PCN support funding, £43.5 million was released to ICSs and STPs in June to support PCNs develop in 2019/20. We also committed to ongoing support in subsequent years. This extra money is a floor not a ceiling. Many CCGs have already been providing extensive local support over and above their share of the national funding, and we encourage all systems to consider doing the same.

The national funding should be used for two purposes: (a) PCN development and (b) a specific Clinical Director development programme in each STP/ICS. The funds are intended to help PCNs make early progress against their objectives – for example supporting much closer practical collaboration between PCNs and their community partners, including preparatory activity for the forthcoming national service specifications.

How should this document be used?

The first part is guidance that sets out parameters that all STPs and ICSs should work within, and a process which we expect many STPs and ICSs will want to use to develop support programmes. The second part sets out key components that should be used as the basis of any support offer. Systems will want to build upon the key components, adding specific details and requirements to meet local need. Different PCNs and different parts of the country are at different stages of development, and as a result, development support needs will vary.

How has it been developed?

The document has been developed in consultation with a wide range of people, including front line staff, CCG, STP and ICS primary care teams, development experts, NHS and local government representative and professional bodies, and voluntary organisations. The content has been shared and tested to ensure that it reflects the views of interested groups, and crucially has been developed alongside those that will be using the development support to ensure that it meets their needs.

Ambitions and expectations

What are our ambitions for PCNs over the next 5 years?

Your development support offer should match the scale of our collective ambitions for PCNs. PCNs were established on the 1 July 2019. Looking ahead and towards 2023/24, we aspire to PCNs having done five things:

- First, **stabilised general practice**, including the GP partnership model
- Second, **helped solve the capacity gap** and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff as well as serving to help increase GP and nurse numbers
- Third, become a **proven platform for further local NHS investment**
- Fourth**, dissolved the divide between primary and community care**, with PCNs looking out to community partners not just in to fellow practices
- And fifth, systematically delivered new services to implement the Long Term Plan, including the seven new service specifications, and **achieved clear, positive and quantified impacts** for people, patients and the wider NHS.

What is expected of PCNs by March 2020?

With the support outlined in this prospectus, by March 2020 we would like to help all PCNs to:

- **Understand their own journey**: know where they are aiming to get to over the next five years, use a diagnostic process to establish development need, using a maturity matrix or similar tool, and put a development plan in place
- Be functioning increasingly well as a **single team**
- Be part of a '**network of PCNs**' that helps shape the STP/ICS plan to implement the Long Term Plan
- Formed clear and agreed **multi-disciplinary teams** with community provider partners
- Building on existing relationships, form **links with local people and communities** to understand how to work most effectively for their benefit
- Have made **100% use of their funding entitlement for additional roles** in line with national guidance
- Have started work on at least one **service improvement project** of some kind, linked to Long Term Plan goals
- Have started thinking about their **future estate needs**, jointly with community partners
- Be ready to deliver **new national service specifications** from April 2020

Benefits

We have heard from people working in and with PCNs that good development support should help PCNs to:

- **Make a real difference for staff**, including:
  - more sustainable and satisfying roles for staff, and development of multi-professional teams;
  - reduced pressure on GPs by drawing on the skills of the wider team where these are the best fit, and enabling a more balanced workload
- **Build from what people know about communities and their wider population**, and understand and **build on existing neighbourhood working and community assets**
- **Reflect the priorities of local people**, including for example better urgent care access and digital services
- Provide more proactive, coordinated care and **improved outcomes** for patients and the wider population, better health and reductions in health inequalities;
- Focus **on prevention and anticipatory care** and maximise the difference we can make by encouraging different professional teams, independent contractors and organisations to work together;
- Promote and **support people to care for themselves** wherever appropriate;
- **Provide care as close to home as possible**, with networks and services based on natural geographies and population need rather than organisational boundaries;
- **Put in place joined up NHS care (for both physical and mental health) across primary care and other providers of NHS community care**, and remove the historic separation of these parts of the NHS;
- **Improve the link between primary care networks and secondary care/place-based care** with more clinically-appropriate secondary care in primary care settings;
- **Put in place joined up care with social care and the voluntary and community sector**, working with partners to plan and deliver personalised care and support;
- **Help systems to plan and discharge resources more effectively**, with primary care providers involved in decisions about how resources are used

Behaviours and leadership styles are critical. Your development support will need to focus on building open, honest and collaborative relationships, and helping Clinical Directors achieve results through energetic and inclusive leadership.

Sustainable and transformational change

How will we deliver sustainable and transformational change?

Experience from Sustainability and Transformation Partnerships (STPs) and Integrated Care systems (ICSs) around the country has taught us that PCN development support is most effective when it has three characteristics which are closely aligned to elements of the NHS Change Model (described in more detail in the appendix).

Characteristic	Description
Owned and driven by teams	• Ensuring collective ownership of the change that needs to take place • Developing a culture which is based on collaboration, integration and involves early partnership working across professions and organisations
Focused on improving care for local people	• Working on specific projects, aligned with local strategies, to change the way care is provided – as a means both to improve care and develop collaborative working • Focused on population health needs
Backed by a clear sense of purpose	• Understanding where the PCN is trying to get to and why • Understanding how this fits with wider system and partner organisations' goals, and the range of assets and partners available to help get there

Available resources

NHS

Additional funding has been allocated to ICS/STPs for in-year delivery of PCN development support. The funding is over and above that set out in the GP contract agreement. It is for Clinical Director and PCN development support only and must be used for this purpose and no other. The funding has been made available from national transformation funds – we would encourage each local system to supplement this with additional funding wherever possible. It is a floor not a ceiling.

Funding should be used for development support for PCNs and broader professional teams, including staff from wider organisations and independent contractors who provide care in a community setting. It must not be used to pay for or supplement anything which is already covered in the GP contract or the day to day running of PCNs, or to pay for activities already funded by CCGs/systems.

The funding is intended to be recurrent for five years dependent on need and effective use, with funding confirmed on an annual basis. Over time how funding is deployed may alter. Systems should use the funding to deliver support according to the following parameters:

1. A universal offer, with all PCNs and every CD receiving support matched to their needs.
2. Support designed alongside and agreed with PCNs and CDs, promoting collaboration and shared understanding between wider PCN members including community services providers, other NHS organisations, local government, social care, the voluntary sector, and local people and communities, at the neighbourhood and place level of the system, and with LMCs engaged in the process.
3. Alignment with commitments set out in the NHS Long Term Plan and the Network Contract Direct Enhanced Service (DES), and supporting delivery of system strategies.
4. Alignment with the approach laid out in this prospectus, including (a) based on a self-assessment of development in each PCN (b) making use of the development domains for PCN development support (c) ensuring all key components are covered in the CD development offer.
5. Adequate resourcing and sponsorship in place at ICS and place level, with a director-level lead in every STP/ICS, known to PCN CDs.
6. System plans for PCN development being agreed with NHS England and NHS Improvement regional teams, with level of regional involvement varying dependent on STP/ICS maturity.

Funding should be used for:

- ✓ Freeing up clinical time
- ✓ Local transformation resource
- ✓ Support from 'NHS family' bodies e.g. the Leadership Academy, CSUs, federations, at scale primary care providers, NHS Trusts, and from local authorities and the voluntary, community and social enterprise sector
- ✓ Commissioning support from providers and partners via the HSSF or through other procurement mechanisms

Funding should not be used for:

- × Anything that is already covered in the contract
- × Anything that is already funded by the CCG or another system partner
- × Non-transformation costs
- × Work that isn't related to PCNs

Systems should also ensure that a culture of identifying best practice, developing case studies, evaluating effectiveness, sharing learning and networking is created.

Two areas of development support

Each system will need to put in place development support in two linked areas. Proposed approaches for these two areas are covered in turn on the following slides. The PCN development funding allocated to systems in June includes funding for both PCN and CD development, with around 10% of the funds intended for CD-specific development.

PCN development support

Clinical Director development support

Proposed process for PCN development support

This diagram sets out the suggested process to put in place PCN development support.

1 Who are we?

As of 1 July 2019, PCNs have established membership, appointed clinical directors and completed Network Contract DES registration requirements. Wider PCN members and partner organisations identified.

2 Where are we now and what do we want to achieve?

ICSs/STPs, places and CCGs facilitate conversations with PCN teams to help them build relationships, a sense of identity and purpose, and identify areas of initial focus. PCNs and systems use a self-assessment tool to support this process, identifying where they are at on a journey of development. Each PCN identifies a specific service improvement priority to focus on as a means for closer collaboration. Wider PCN members, including for example community services providers, mental health, voluntary sector, local authorities, local communities and others, included in conversations.

3 What help do we need?

ICSs/STPs, places, CCGs, PCN CDs and other systems partners agree specific development support needs for 2019/20. The PCN Development Support Prospectus is used to identify potential areas for development with consideration of 2020/21 service specifications, the wider system strategy and support already in place.

4 Who can help us?

Systems deploy PCN development support funding to implement agreed development support programme, supporting PCNs and partners to come together individually and as a collective. Systems ensure existing support offers are used, including through regional networks, before additional support is put in place, making use of internal NHS support as well as external expertise.

5 We're on our way

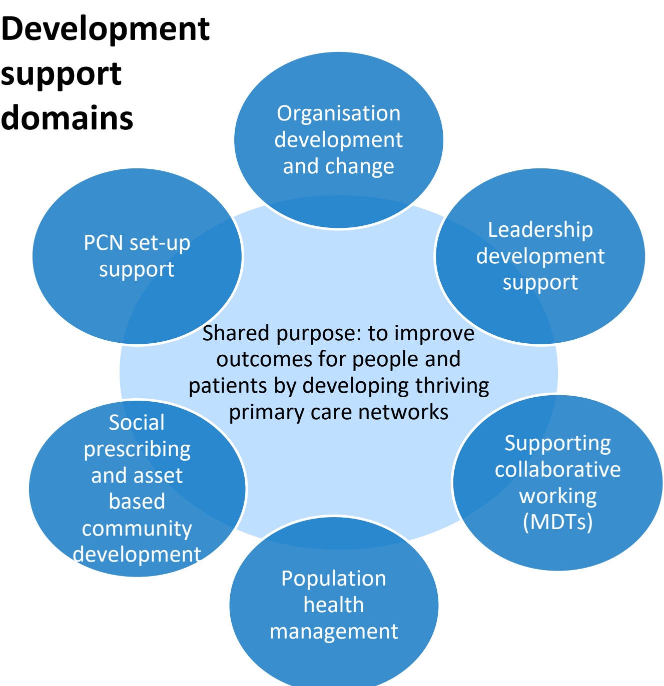
Support is delivered, enabling PCNs to move along development journey.

6 Is the support helping us achieve our goals?

Systems and CCGs support PCNs to review progress against PCN priorities and self-assessment. Areas for additional support identified. Learning and best practice shared.

Tools are available to support this process, including the PCN maturity matrix and associated self-assessment tool, and descriptions of the six PCN development domains. Please see the appendix of this document for further info. It should be noted that development funding can be deployed to support steps 2 and 3 of the above process as well as later steps.

PCN development support domains



In 2019/20 we expect PCNs will prioritise specific service improvements that will build a common sense of purpose, focussed around the needs of local people and communities. Working in partnership on the agreed priorities will enable trusted relationships and ways of working to develop.

This Prospectus sets out a co-produced, consensus view of the six development support domains that PCNs will want to access as they do this. Descriptions of each of the six domains are included in the appendix. The development domains are the agreed essential elements that systems will want to use as the basis of any support offer. Systems may want to build upon these and make them more specific according to local needs. The domains do not have to be used in their entirety or sequentially, but we expect appropriate core components will be reflected in corresponding development support offers. For example, PCNs may want to access organisational development support initially to help create plan how their development journey, but initial support may not cover all the core components in that domain.

PCN development support should be considered alongside specific support for PCN CD development, which is outlined on the following slides.

Supporting the development of PCN Clinical Directors

Supporting the development of PCN Clinical Directors so that they can create thriving PCNs is a significant priority. Given the importance of these new roles this prospectus sets out the key components of a leadership and development support programme for this professional group. Considerable funding (£3,000-4,000 per CD) has been allocated to systems for this purpose so that they can ensure there is a comprehensive offer available for all. The following slide sets out 'how to get started' on a programme that focusses on development of the individual, leadership of PCNs, and leadership within an ICS.

Role and responsibility:

PCN Clinical Directors will provide leadership for networks' strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of network services. Together, CDs will play a critical role in shaping and supporting their ICS, helping to ensure full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. The role of each CD will vary according to the particular characteristics of their PCN, but key responsibilities are likely to include: providing strategic and clinical leadership for the network and supporting implementation of agreed services changes; fostering collaboration and developing relationships across the PCN; working closely with other network Clinical Directors, clinical leaders of other health and social care providers, local commissioners and Local Medical Committees (LMCs); and representing the PCN within the wider ICS. A fuller description is available in the Network Contract DES documentation.

CDs will need to be skilled in fostering goodwill and co-operation to achieve the PCN's objectives. The CD role will be a practising clinician from within the PCN member practices and may be undertaken by professionals including: general practitioners, pharmacists, nurses and allied health professionals.

It is crucial that we support CDs, all of whom are new to their roles, to lead PCNs in this way.

> *"The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental."* West et al, 2015

Proposed process for Clinical Director support

As of 1 July 2019, PCN Clinical Directors have been appointed. Supporting CDs in this new role is critical. Therefore each system will need to provide a comprehensive leadership development programme to its CDs, focusing on personal development, establishing & leading a PCN, and leadership within an ICS.

By going through the development cycle, CDs should receive support to develop the following skills, alongside others:

- Change management – leading complex change processes to deliver quantified impacts
- Use of data and information to aid clinical decision making
- Managing finances and budgets
- Establishing and developing a team
- Influencing and engaging staff and stakeholders to get the best out of self, team, place, neighbourhood and system
- Learning how to recognise, engage and utilise the voice of local citizens
- Building the workforce – operational management and organisational development
- Understanding newer primary care roles and how they can best be deployed

They should also develop an understanding of:

- The CD role, and what it means in practice
- Presenting the vision: how do I tell the story to different stakeholder groups?
- The system they are part of, its strategy, and how to engage with it
- Trust as a foundation of strong relationships: establishing and nurturing trust
- Establishing relationships: understanding key relationships; seeking to understand the worlds of partners;
- Getting to know local communities: understanding their needs, issues, what makes them tick, and how to identify community assets

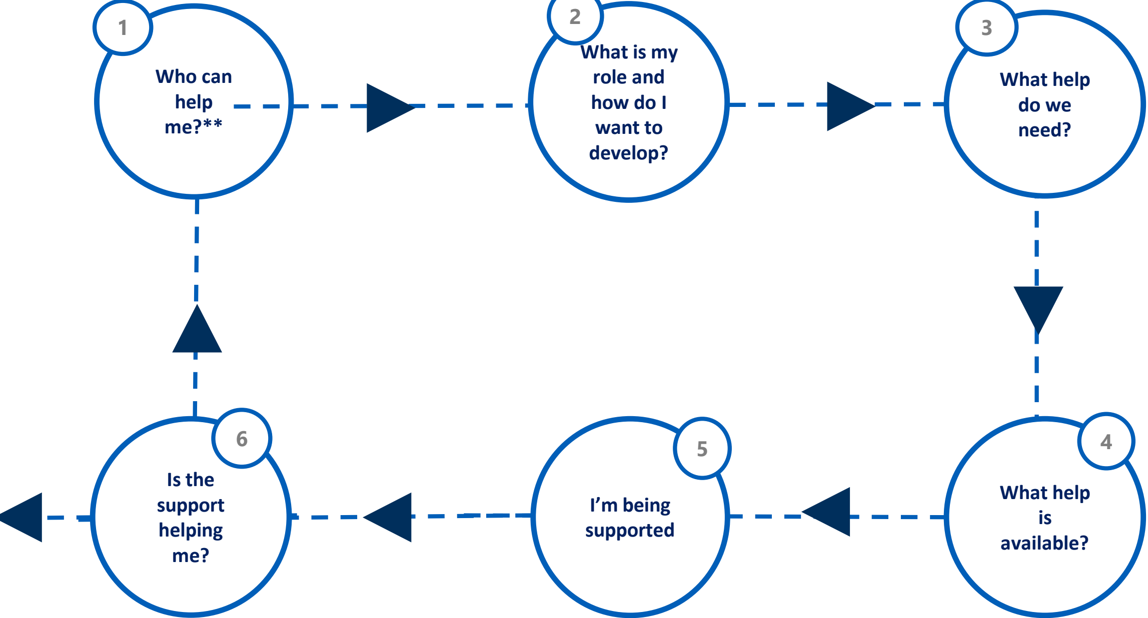
CDs should also develop an understanding of their own leadership style, values, beliefs, and behaviours, and how they can apply these to the CD role, as specified under 2 above.

ICSs/STPs, places and CCGs contact PCN CDs and provide them contacts for a named PCN/CD development lead

CDs come together with system primary care leads to identify individual and collective development needs, considering:

- What is my role and what do I need to do?
- What strengths do I bring to this role & what are my development needs?
- Understanding myself – My values, beliefs and behaviours – how does this impact on my leadership behaviour?
- Models of leadership
- How to develop a strong community of CDs

CDs develop tailored development plans and identify individual and collective support requirements, ensuring topic areas laid out on next slide are covered.



Systems deploy CD development support funding to implement agreed CD leadership programme based on the above, making use of support available from within the system, wider NHS and public sector, and external expertise where necessary

Support is delivered, enabling CDs to develop their leadership skills and support one another as a group.

With support from systems PCN CDs review progress against priorities. Areas for additional support identified, revised development plan produced and learning and best practice shared.

**A list of contacts in each system is included in the appendices. Buddying arrangements are also being considered, please e-mail: england.PCN@nhs.net for further information.

It should be noted that development funding can be deployed to support steps 2 and 3 of the above process as well as later steps.

Roles and responsibilities in PCN development

PCN Clinical Director	**Responsible for leading their network, Clinical Directors will:** • Provide overall leadership to their network • Be responsible for providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality and improvement and performance across many practices
STP/ICSs (through their constituent CCGs)	**Responsible for PCN development, systems (and where appropriate, places) will:** • Have a lead (named director level) for PCN development, and proactively make PCN CDs aware of appropriate contact points • Partner with PCNs to support them to identify level of development and support needs, forming an aggregate view across the system • Identify and deploy funding and associated support to meet PCNs' collective development needs, making use of system, wider NHS and external expertise and holding suppliers to account for delivery • Understand PCN progress and impact of support, and gather and share learning for subsequent years • Deliver the primary care requirements set out in the LTP
Regions	**Accountable for system delivery, regions will:** • Work with their ICS/STPs to ensure PCNs are supported to progress and that all support offers put in place meet the guidance set out in this prospectus • Support system primary care leads to develop effective system PCN development plans, sharing learning and approaches between systems • Understand system plans for PCN development, and agree specifications for how funding is deployed • Understand how development support is progressing • Be able to review a summary of the outputs of development support, and impact on PCN progress
National	**Accountable for enabling overall delivery, the national team will:** • Support co-creation of an iterative PCN Development Prospectus • Develop tools including PCN maturity matrix • Mobilise PCN development set-up support • Support clinical directors, system primary care leads and regions to convene and form communities at the national level • Engage with stakeholders to ensure the right support offers are in place • Capture learning and share best practice • Ensure progress and delivery impacts can be measured

Key milestones for mobilising PCN development support in 2019-20

This diagram sets out the suggested timeline for putting in place PCN development support. To make best use of available resources, it is important that systems move quickly to identify how it should be deployed. It is recognised, however, that systems have different starting points, and that the process of self-assessment is in itself important in bringing teams together. This timeline is considered as a guide to support systems rather than a requirement.

Appendices

1. Development support domains
2. PCN maturity matrix

The development support domains

The diagram below summarises what PCNs want from support partners based on the engagement carried out. This has provided helpful context in developing the initial domains defined for 2019/20. The domains and their content will be updated in 2020 to reflect national service specifications and other deliverables within the PCN contract.

What PCNs want from their support partners

DO

- More listening than talking
- Give power to local teams, making the process locally owned and led
- Build on our existing local strengths and expertise
- Start with our local vision and values (the "why") before the "what and the "how"
- Value our time
- Give us practical learning that makes a difference for real people
- See the big picture of PCN development in its wider system context
- Work inter-dependently with other development partners and share with others
- Expect that most development support will come from the local health and care system and from peer learning
- Respect what people want for their development
- Help networks develop in mature and sustainable ways

DON'T

- Give us your off the shelf package or courses
- Assume one size fits all
- Jump in with products
- Create dependency
- Reinvent the wheel (when other PCNs already have the answers)
- Overburden PCNs with bureaucracy

Source: PCN development support design day, 2nd April 2019

The Domains

Shared purpose: to improve outcomes for people and patients by developing thriving primary care networks

- Organisation development and change
- Leadership development support
- Supporting collaborative working (MDTs)
- Population health management
- Social prescribing and asset based community development
- PCN set-up support

To note: reflecting their importance to PCN development, a number of the support domains and the PCN maturity matrix cover areas that may, from April 2020, be part of PCN service specifications. Systems and PCNs should therefore consider draft and final service specifications, once these are published, to further inform and adapt support requirements. The support domains outlined here should not be taken as an indication of what is likely to be in service specifications, beyond the detail already laid out in the contract documentation.

PCN ‘set up’ support

Impact and expected outcomes

There is significant variation in primary care network maturity. Some PCNs are progressing at pace and some remain at the very early or ‘setting up’ stages of development. This means that for some areas, the foundations of PCN development need to be put into place before they can begin to progress through the levels identified in the PCN maturity matrix.

PCN set up support would be expected to:

- Help those in the very early stages of development to progress.
- Recognise variation and timescales for PCN set up and development .
- Address an immediate need for development support.

What good looks like

Key components of good PCN development support would be expected to include:

- **Policy and context**
    - Understanding the current system and why it needs to change.
    - What will be different – what are the clear intended impacts?
- **Expected ways of working**
    - Building relationships and working with the wider community.
    - Identifying support through networks and shared expertise.
    - Building on success and learning from what works.
- **Facilitating transformational change**
    - Building capacity, capability and resilience.
    - Building a culture of trusted and valued relationships across systems which includes the wider community
    - Creating a shared purpose, aligned belief, systems and values with a common challenge, vision and goals.
    - Creating operational rigour
    - Quality improvement
    - Achieving quantified impacts
    - Accountability.
- **Where do we start?**
    - Assessment of current state and areas for development.
    - Testing and measuring incremental change. Learning from experience and being prepared that your first idea may not be the best or right solution.
    - Making a start – identifying a project linked to Long Term Plan goals and the ambitions and expectations for PCNs

Accessing PCN set up support

Elements of this domain are being provided by the NHS England Sustainable Improvement team, further information can be found at england.pcn@nhs.net

Organisational development and change

"Organisation development applies behavioural science to organisational and system issues to align their strategy with their capability. It enhances the effectiveness of systems by providing interventions that build people's collective capacity and capability to achieve shared goals. ***(Do OD & LLA OD network agreed definition 2018)***

How will we deliver sustainable and transformational change?

Nationally, the NHS Long Term Plan was based on clear evidence and changes that people told us needed to happen. It provides an incredibly powerful starting point for local action, and informed the creation of new GP contract, PCNs and the new national service specifications. It would be deeply inefficient – as well as contrary to a *National* Health Service – if every system invented their own answers to common problems. Wherever it makes sense, PCNs will be adopting or adapting standard methods for example on medication management or care homes support

At the same time**, experience tells us that change in health and care settings is most effective when teams drive and own the changes that need to take place.** This ensures that the changes fits with their context, their patients and their communities. Transformational and Sustainable change is often supported by the change model illustrated at Figure 1.

The NHS Change Model is built around creating a 'shared purpose', aligned belief, systems and values with a common challenge, vision or goal. It has eight components that should be considered when planning and implementing change. Much more than a prescribed methodology; its intention is to support the generation of ideas, provoke thoughts and provide a tool which can be used in different situations. In this case by those who are leading or contributing to the development of PCNs.

By using a tool which encourages people to question "why change needs to happen" it guides and drives decision making and action planning and ultimately encapsulates peoples' cognitive, emotional and spiritual commitment to a common cause.

This 'bottom-up' approach is critical to the organic development and sustainability of PCNs, alongside the 'top-down' national work to establish common metrics, standard operating models in PCN services specifications, the PCN dashboard, and contracts. Your development programme will need to synthesise both perspectives.

Organisational development and change

Impact and expected outcomes

Organisational development and change management support are closely aligned. In the context of PCN development support, organisational development should focus on PCN development and consequent maturity through the PCN maturity matrix; and as evidenced in the forthcoming PCN dashboard and change management on supporting individual changes. Cumulative individual changes contribute to overall organisational change.

Organisational development support would be expected to:

- Provide a framework that ensures all aspects of PCN development can be considered and aligned: set up, strategy, culture, ways of working, skills, and staffing all brought together by having a common purpose and shared values.
- Bring PCN staff together around a shared vision or purpose, supporting effective collaboration, building capacity and capability that enables new ways of working, and delivery of specific service improvements for local people.
- Recognise the importance of collaboration across a 'patient-focused' or 'person-focused' whole system of care rather than care within single organisations.
- Address the need for collaboration across NHS organisations, local government departments, private and third sector organisations and local communities to find new and different ways of working together to build a health and care system.

Change is fundamental to the success of PCNs. It is about altering the way in which care and support is currently provided and making it distinctly different. In the context of PCN development this will mean having to push the boundaries of what is currently thought to be possible, challenging the status quo and leading the way to encouraging and motivating individuals into new ways of working.

Change as PCNs develop and mature through the PCN maturity matrix is likely to be on several levels. Change will be particularly recognisable as individuals begin to work more collaboratively with each other and across organisational boundaries, as traditional models of leadership break down and as PCNs establish cultures which are developed through sustainable partnerships built on collaboration, trust and mutual respect.

Change management support would be expected to:

- Address and support the cultural shift required to develop and build open, honest and collaborative relationships, recognising the value that everyone within the PCN brings regardless of profession, so reducing the existing power differentials and creating safe environments for people to speak and generate fresh ideas
- Encourage ownership and responsibility so that individuals within PCNs know what they need to do and where to get support from to change patterns of working and bring about fresh ways of thinking, new cultures and fresh and innovative ideas.
- Recognise the importance of collaboration across a 'patient-focused' or 'person-focused' whole system of care rather than care within single organisations.
- Provide and develop technical expertise to implement specific service changes in the most effective and efficient way
- Build momentum and enthusiasm through achieving early results – quick wins that become part of the PCN story
- Achieve results - demonstrate how the PCN can implement service changes to improve care and outcomes, as clearly shown through the forthcoming PCN dashboard.

Organisational development and change

What good looks like

Key components of good organisational development support would be expected to include **highly practical and specific help** on:

- **Building flourishing teams**
  - Multi-disciplinary team (MDT) development focused on joint work across practices and with community partners.
  - Team development
  - What will be different?
- **Developing good, healthy and positive environments to work in**
  - Building environments and creating cultures which are driven by continuous development and support.
- **Setting up to succeed**
  - Development of system-wide learning culture.
  - Enabling and encouraging sharing of good practice.
  - Encouraging progression through organisational and personal growth.
  - Enabling a culture of continuous improvement.
- **Working collaboratively**
  - Developing trusted relationships with STPs, ICSs and the wider community.
  - Developing trusted relationships with local people and their communities.

Key components of good change management support would be expected to include:

- **Overview of the change process in the context of**
  - System wide change.
  - Organisational change.
  - Building capacity and capability to make change happen as a practitioner, as a carer and as a patient/citizen.
- **Building a sense of purpose and motivation to change**
  - Shared purpose.
  - Improving practice including expected quantified benefits
  - Achieving quick wins to build confidence and momentum
- **Building knowledge and skill in leading change**
  - Creating behaviours to embed new ways of working.
  - Recognising barriers.
  - Learning through improvement techniques such as lean methodology and quality improvement techniques.
  - Supporting individuals and connecting others to build support for change.
  - Identifying the enablers.
  - Provide and develop technical expertise to enable implementation of service changes in the most effective and efficient way Focusing on getting operational processes right
  - Measuring and achieving intended impacts.

Leadership development support

Impact and expected outcomes
To ensure there is a comprehensive and connected approach to development support, the leadership domain takes into account the work already underway to provide leadership development to ICSs and STPs and to PCN Clinical Directors.

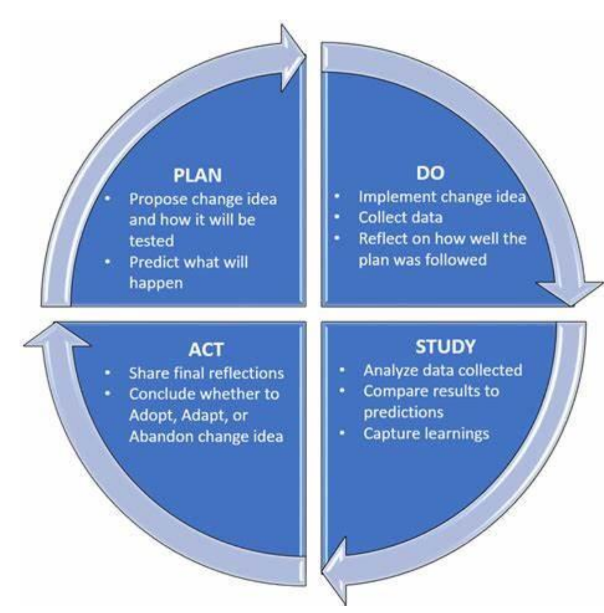
Leadership development support is relevant at all levels in the overall structure of a PCN and regardless of their maturity. The right leadership will support ongoing maturity and will guide and encourage individuals, teams and the entire PCN towards the accomplishment of their shared purpose.

Leadership development support would be expected to:

- Distinguish between the different leadership styles and the impact each has when supporting collaboration, a cycle of continuous improvement and an understanding of the skills required to work across organisational cultures and boundaries to make change happen.
- Emphasise the fact that **all** PCN members are leaders and the value this brings when seeking to bring about transformational change and the way care and support is accessed and provided.
- Stress the difference between clinical and non-clinical leadership and highlight the opportunities and positive difference this brings when working across organisational boundaries and an integrated health and care system.

What good looks like
Key components of good leadership development support would be expected to include:

- **Leadership in a changing and complex environment**
  - Managing change.
  - Cross system leadership.
  - Managing conflict in the context of a changing environment.
- **Leadership styles**
  - Behavioural
  - Situational
- **Developing clinical and non-clinical leadership skills**
- **Leading a compassionate community**
  - Shared purpose.
  - Improving practice.
  - Key to success and learning from others.
- **Leadership through the use of quality improvement tools and techniques**
  - Lean methodology and process re-design
  - Plan, Do, Study, Act
  - Capacity and demand analysis and impact modelling
  - Reducing avoidable consultations tool



Supporting collaborative working

NHS

Impact and expected outcomes

PCNs will only succeed if they look out to partners – not just other providers, but patients, their carers and the wider community. PCNs are about creating a joint model of more personalised care, delivered by multi-disciplinary teams. This requires collaboration, sharing resources and better care coordination. It makes the most of the opportunity that different professions and expertise (clinical and non-clinical) can offer.

Support to encourage better collaboration would be expected to:

- Support teams to understand scale the of the opportunity to improve through further collaboration
- Highlight the importance of case finding and case management through multidisciplinary working – an integral part of anticipatory care.
- Highlight the impact and opportunity of an integrated workforce.
- Emphasise the value of personalised care and prevention, including shared decision making and supported self-management (based on people's levels of knowledge, skills and confidence) and health promotion. This domain directly supports preparation for the forthcoming Personalised Care national service specification.

What good looks like

Key components of good support to encourage better collaboration would be expected to include:

- **Relationship between collaborative working**
    - Population health management, including case finding and risk stratification
    - Personalised care and support planning.
- **Understanding the value of existing, new and emerging clinical and non clinical roles that make up a strong MDT**
    - Opportunity and impact.
    - Involvement of local people and communities as partners including patients, carers, families and residents.
- **Competencies and skills of a strong MDT**
    - Professional and operational responsibility, as well as the responsibilities of patients.
    - Governance and accountability.
    - Effectively balancing the voices of clinical and non-clinical members of the MDT.
- **Six components of the Comprehensive Model for Personalised Care, as set out in Universal Personalised Care**
    - Shared decision making.
    - Personalised care and support planning.
    - Social prescribing and community-based support
    - Supported self-management, especially for people living with long term conditions - specifically through Patient Activation Measurement (PAM) and tailored support delivered through health coaching, supported self-management education, or peer support
    - Choice of provider, including for those choosing an elective care pathway.
    - Personal health budgets and integrated personal budgets
- **Opportunities to learn together**
    - Self directed learning and facilitated learning.
    - Group training hubs.
    - Ad hoc access to peer support/buddying.

Population health management support

Impact and expected outcomes

Population health management (PHM) is a data-driven approach to improving the care provided to a PCN population. By using data systematically, PHM can support networks to understand and anticipate the needs of their population, so that services act as early as possible to keep people well. Primary care clinicians who work in this way describe a change so that their job isn't about reactively providing appointments to patients on a registered list, but proactively caring for the people and communities they serve. **This domain directly supports preparation for the Anticipatory Care national service specification.**

Population health management support would be expected to:

- Support a better understanding of the opportunity to use data in decision-making and proactive care and support.
- Identify opportunities to link primary care data with other datasets across health, care and wider health determinants working closely with Public Health colleagues.
- Bring data intelligence together with insight from frontline staff and the local community, supporting PCNs to understand their local population's health needs – including health inequalities and unwarranted variation – and target support where it is most needed.
- Support PCNs to work with partners across health, care and the voluntary sector to develop interventions tailored to individual need.
- Promote the opportunity for prevention, including through tackling the root causes of ill health in the network's population.
- Support a cultural shift in the way PCNs provide services – moving from a focus on managing sickness to keeping people well.
- Provide data and evidence which allows commissioners to make decisions based on evidenced need rather than assumption and supports an opportunity to identify and address health inequalities on a much broader basis.

What good looks like

This domain would work well alongside the domain which focuses on personalisation, collaborative working and MDTs. **Key components** of good population health management support would include:

- **Background to PHM**
  - The PHM cycle and core PHM capabilities; relevance to PCNs and relationship with personalisation, collaborative working, MDTs.
  - Introduction to segmentation, stratification and identifying interventions likely to have the most impact ("impactability").
- **Data and information governance (IG)**
  - Identifying available datasets and working with the wider STP/ICS to link data for the purposes of PHM, including support to put in place robust IG arrangements to ensure that data flows between organisations are both effective and lawful.
- **Creating intelligence**
  - Understanding PCN populations through analysis of quantitative and qualitative data, including unwarranted variation.
  - Application of risk stratification and advanced analytical techniques to target support most effectively.
  - Bringing clinicians and analysts together to ask questions of the data and use these insights to improve care and outcomes.
- **Delivering benefit for and with people and communities**
  - Rapid learning cycles to design, test and implement new integrated models of care.
  - Working across health, social care, the voluntary and community sector, and local authority to map and join up resources.
  - Working as a PCN to design and implement interventions to improve the health outcomes of a targeted cohort.
  - Improvement tools and techniques to rapidly evaluate success and refine interventions.

Social prescribing and community development

Impact and expected outcomes
Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners..

Social prescribing can help to strengthen community resilience and personal resilience, and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which impact on wellbeing.

Social prescribing link workers will have a key role in supporting delivery of the Comprehensive Model of Personalised Care and will work under supervision of the GMS Contract holder as part of the PCN team. This domain forms part of the preparation for the forthcoming Personalised Care national service specification.

Social prescribing and community development would be expected to:

- Enhance an understanding of social prescribing and it's impact on individuals and the community overall
- Emphasise the importance and impact of patient and practitioner partnerships.
- Develop a community wide understanding of the value and fundamentals of building strengths-based community partnerships and the role PCN social prescribing link workers play in enabling this.

What good looks like
Key components of good social prescribing and community-based support would be expected to include:

- **Understanding the role of PCN social prescribing link workers**
    - Both individually and their role as part of an effective MDT;
    - Connecting people with community-based support;
    - Measuring quality and impact on health and wellbeing (through use of the social prescribing common outcomes framework).
- **Understanding community development**
    - Mapping, connecting and building partnerships of trust with community assets;
    - Relationships and engagement with the VCSE and its significance to PCN development to build a shared vision;
    - Building local community capacity and creating social value;
    - Volunteers and volunteering as an integral element of PCNs;.
    - Optimise access to and use of all capacity within the local system including local communities.
    - Governance.

PCN maturity matrix

What is the 2019/20 PCN maturity matrix?

- The PCN Maturity Matrix outlines core components that underpin the successful development of networks.
- It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for neighbourhoods.
- The matrix that accompanies this Prospectus is an evolution of an earlier matrix that will be familiar to many ICSs and STPs. The updated version reflects feedback received from systems on the previous versions.
- A number of systems have developed their own maturity matrices and/or built upon earlier drafts of this matrix to meet local needs.

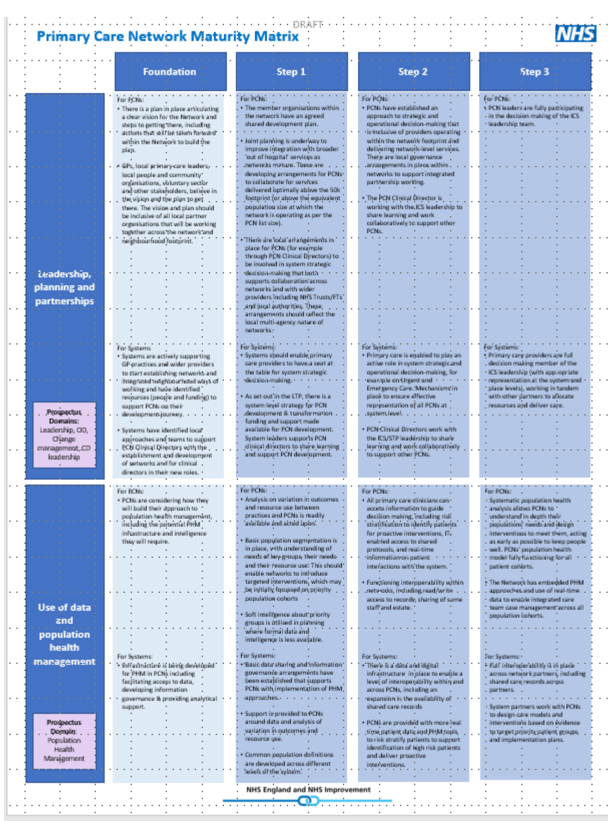
Purpose of the maturity matrix

The matrix can be **developed and tailored to meet local circumstances** and is designed to support system and network leaders, working in collaboration with their commissioners and other local leaders within neighbourhoods, to work together to:

- Identify where PCNs are now in their journey of development – and how PCNs can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.
- Develop plans for further development – that help networks to continue to expand integrated care and approaches to population health.
- Identify support needs – using the PCN Development Support Prospectus as a guide for framing support plans and coming together to form links with their new team.

A development journey for PCNs

- PCNs are at varied stages of development. Many PCNs will already be collaborating with partners across sectors on transformation schemes and initiatives. **It is important the momentum of these existing ways of working is retained and built on** where that is already adding value for patients, staff and the wider population.
- The matrix is designed to complement *Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan*, setting out the wider development journey in how networks can grow their capabilities to support local priorities and deliver LTP commitments
- The matrix will help STPs and ICSs to work with providers within networks to enable those journeys.
- As for the 2019/20 support domains, the PCN maturity matrix covers areas that may, from April 2020, be part of PCN service specifications. Systems and PCNs should therefore consider draft and final service specifications, once these are published, to further inform and adapt support requirements. The support domains outlined here should not be taken as an indication of what is likely to be in service specifications, beyond the detail already laid out in the contract documentation. The domains and matrix will continue to evolve beyond 2019/20.



N.B. This is a screenshot for illustrative purposes.
Links to the full matrix are on the next slide.

PCN maturity matrix

A basis for discussions

- The matrix should be used **pragmatically and flexibly**, with networks and their partners viewing PCN development as a multi-year journey, and one that can **build on progress that has already been made** in improving and transformation care and services for patients and populations.
- Experience from ICSs shows that the matrix can be used most effectively where general practices within a network come together with their CCGs and other local providers (for example this could include community services, local authorities and other primary care providers) for a shared discussion on current progress, future plans for integrated care and system support for PCN development. The output of these discussions can often be a shared development plan for how the network could evolve.
- The PCN Development Support Prospectus and the funding available to systems for PCN development can be utilised to support these local development discussions.

Using the matrix and diagnostic tool

- Learning from ICSs and STPs is that local development discussions framed round the matrix have been beneficial for providers within networks and for commissioners. Use of the matrix is recommended for networks and their systems to help identify on-going and future support needs, and to target deployment of transformational funding. What is important is that PCNs are active participants in development discussions, and these generate useful outputs when considering and planning for the support required using this Prospectus.

- The Primary Care Network Maturity Matrix, including full suggested instructions for use, is available as a Powerpoint presentation by e-mailing: england.pcn@nhs.net and will be available to download from the FutureNHS platform in Mid August.

- A simple excel diagnostic tool has been developed to put the matrix into action and help systems and PCNs to discuss local PCN maturity, target support and inform any local development plans. The excel tool is available by e-mailing: england.pcn@nhs.net and will be available to download from the FutureNHS platform in Mid August.

Further references

In supporting PCNs to identify their development journey using the matrix, systems may also find it helpful to consider how they may already have undertaken any reviews using the ICS maturity matrix and the PHM matrix. It is for local determination how the outputs from these various reviews (where held and relevant) can help inform together the overall picture of the transformations required for primary care within systems.

- The ICS maturity matrix can be downloaded here: https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
- The PHM maturity matrix can be downloaded here: https://future.nhs.uk/connect.ti/populationhealth/view?objectId=50226789

Where to find further information

- Contact your PCN system lead (on slide 30)
- Contact your regional primary care team or the national PCN team at england.PCN@nhs.net
- You can join our FutureNHS site which includes a highly active discussion forum and a range of PCN resources – you can request access to the site by emailing england.PCN@nhs.net
- A WhatsApp discussion group has been established for PCN leaders. To gain access to the group, please email england.pcn@nhs.net
- Webinars and events are helping to share best practice and advice. Full details at www.england.nhs.uk/pcn
- Frequently asked questions (FAQs) and other materials are available to help explain what a primary care network is. You can also watch a short animation giving further details about primary care networks at www.england.nhs.uk/pcn
- Listen to our latest #primarycarenetworks podcast online at www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/primary-care-network-podcasts
- Join our monthly Twitter chat with Dr Nikki Kanani, Acting Director of Primary Care, using #primarycarenetworks to join in the conversation.
- Regional contacts to help you engage with councils, social care, public health and pre-existing health and social care integration work:
  - https://www.local.gov.uk/our-support/lga-principal-advisers
  - https://www.adass.org.uk/
  - https://navca.org.uk/
  - https://www.adph.org.uk/adph-networks/
  - https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/care-and-health-improvement-programme
  - https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/regional-contacts/

For more information on the GP Contract and Network DES

Investment and evolution: a five-year framework for GP contract reform to implement *The NHS Long Term Plan* is available at https://www.england.nhs.uk/2019/01/five-year-deal-to-expand-gp-services-and-kick-start-nhs-long-term-plan-implementation/

The following contracting documents can all be located on the NHS England and NHS Improvement GP Contracts page or if you have any specific queries you can email the team directly at: england.gpcontracts@nhs.net

- Network Contract Directed Enhanced Service (DES) Specification 2019/20
- Network Contract Directed Enhanced Service (DES) Guidance 2019/20
- Network Contract Directed Enhanced Service (DES) Registration Form
- The Network Contract DES and VAT Information Note
- Mandatory Network Agreement
- Network Agreement Schedules

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