PULSE Intelligence
Taking care of your business

Setting up your primary care network

Dr David Coleman
GP partner in Doncaster

> The Primary Care Network (PCN) is very much the cornerstone of the new five-year GP contract, published on 31 January 2019. The networks will be mainly funded through a new, 'very large' directed enhanced service (DES), commissioned through CCGs, termed the Network Contract DES. Although not compulsory for practices to join, NHS England says PCNs will be 'the essential building block of every ICS (Integrated Care System)'.

This article aims to cut through the jargon and make sense of the facts as they currently stand. The BMA has published a primary care network handbook, and it is critical to understand that the clock is ticking and your practice will need to act sooner rather than later.

What does a PCN look like?

The new contract document, quoting an unlinked NHS England Internal Analysis, states that 88% of practices have already joined or lead a network. However, this appears to refer to practices being involved in any type of collaborative organisation – clusters, federations, neighbourhoods, localities, even 'super-practices' – and these structures won't necessarily satisfy the criteria for PCNs.

For example, my practice is part of a Doncaster-wide federation of 40 GP practices with over 200,000 registered patients. This is clearly too large to be classified as a network in its own right.

How big should our network be?

So far NHS England has stated the target patient population size for each PCN is between 30,000 and 50,000. BMA guidance says networks will typically be this size. The suggestion is that this number is the 'sweet-spot' for working at scale while retaining a human element. In reality, practices in rural areas may run into logistical problems trying to reach even the lower threshold of 30,000. So called 'super-practices' on the other hand, may well exceed the upper limit, but there may be little rationale in dividing them up. Common sense should apply in these situations and I would advise close liaison with the CCG regarding what will be deemed acceptable.

How do we choose our co-practices?

Networks need to be geographically coherent; member practices should be close in location rather than simply close in ethos, although there will be complexity for those with distant branch surgeries. The groupings should ideally align with other geographical boundaries, such as local authority or CCG lines, but this isn't strictly a deal breaker. Again, close dialogue with the CCG will hopefully add clarification.

BMA guidance states that 'networks should form a single coherent area, without any gaps in coverage within the Network's outer boundaries'. Their FAQ documents go on to mention 'rules around size and geographical contiguity', but then states 'we have agreed that PCNs can overlap one another… if there are no geographical gaps then there should be some flexibility'.

It remains unclear who this might apply to in the real world and 'geographically coherent' is sufficiently vague a term to cover all eventualities. For example, it would seem to make sense for a practice of 50,000 patients with two close, if not quite neighbouring, branch surgeries to comprise a single network. If making the network boundary contiguous meant including two other practices of 20,000 patients each, a human scale would have been sacrificed to satisfy geographical requirements. Common sense should apply and a geographical gap be permitted provided a) it makes sense and b) the practice in the gap is part of its own geographically coherent network. The CCG and LMC should be able to arbitrate in cases like this.

It is worth noting that all practices must have the right to join a network; attempts to exclude practices considered 'undesirable' are likely to fail, and will only inflame tensions going forward. The CCG is commissioning the PCNs and will reserve the right to make marginal adjustments to memberships and boundaries as they see fit. They will not want to have to oversee and unpick a two-tier system down the line. This is likely why the networks and boundaries are set to be approved all at once — NHS England information stresses that 'all the Network Contracts within a single CCG will be confirmed at the same time', adding that this will 'ensure that both: (a) every constituent practice of a CCG, and (b) 100% of its geographical area, are included with Primary Care Networks'.

What if we don't join up?

Patients from practices that decline to engage in the networks will still be allocated to a network, but the funding for them will pass to the parent network instead. The contract document suggests that this scenario is unlikely, but there may still be practices that feel the financial rewards of networking are outweighed by the bureaucratic burden involved. There may also be historical personality clashes and rivalries that deter some from collaborating with local neighbours.

Appointing a Clinical Director

The task of shaping, supporting and delivering the network's services will fall on the shoulders of its Clinical Director. There will be funding of 0.25 WTE GP salary for this role, so the Clinical Director will need to devote the equivalent of around two sessions each week to this, for a 50,000 patient network.

An ideal Clinical Director would be a respected GP who can unite the network to work together with one vision. A candidate may emerge organically, otherwise a vote could be held. The local LMC could oversee such a process, collecting votes and announcing the chosen Clinical Director. A network board could determine the standard length of term, so that the member practices can opt to change direction in the future if desired.

What will the network do?

The PCN will be 'dedicated joint investment and delivery vehicle'. Funding will flow into the network, which will employ staff and deliver services. A Network Agreement, which all constituent members must sign, will detail how the PCN intends to operate, what workforce it will require, and the roles and responsibilities of the member practices. NHS England and the GPC are producing a national template for this, to 'reduce avoidable legal and transaction costs'.

In some cases a designated practice within the network may handle the employment responsibilities, while in others an established federation may do so. In theory a new provider group could be set up to perform this role — indeed, I can see nothing in the literature to suggest this wouldn't be possible — although it is worth noting that this would add a layer of complexity regarding issues like NHS pensions and will require its own administrative workforce to oversee. Given the tight time frame, such an approach would seem nigh on impossible.

If a practice is the focal point for employment and funding to pass through, this should be an acceptable solution to all members. As this involves a degree of additional work for this primary practice, it could be argued that the practice should receive remuneration for the role. Some practices may smell opportunity here, while others may well see hassle and potential threats.

An established federation or other neutral provider group potentially removes any 'us and them' dynamic, but they would need to hold an NHS contract in order for employed staff to be on the NHS pension scheme.

A hospital/community trust would be another option; they have a larger infrastructure, but perhaps the structural size is too large to fulfil the concept of a human scale.

What funding do we know about so far?

The Network Contract DES accounts for £1.8bn of the £2.8bn funding promised to general practice over the next five years, so it will be important for practices to get the most out of them.

This will cover the majority of the costs of employing additional staff, including pharmacists and paramedics as well as a lead GP as a part-time Clinical Director (around £34,000 (ie, 0.25 whole-time equivalent of a GP) for a PCN with 50,000 patients. On top of this, PCNs will receive a recurrent Network Administration Payment to the tune of £1.50 per patient.

Practices also receive £1.70 per patient – around £14,000 a year for the average practice – just by joining a network, through the 'practice participation' additional service. This will go directly to the member practices — the only funding to do so — while the other Network DES's other constituent funding streams, such as extended access, additional roles reimbursement, clinical lead reimbursement and services will flow into the PCN directly.

If your practice currently participates in the current Extended Hours DES it is worth noting that this funding will be transferred to the PCNs. However, this will be at a slightly lower rate of £1.45 per patient compared to a current rate of £1.90; this is due to a rebalancing of the funds, as only 70% of practices participate in this DES currently and network coverage will be 100% of practices, even if practices decline to participate directly (all patients must be covered by a network).

In the next financial year, it is expected that the money currently allocated to GP Forward View Improving Access (£6 per patient), will also be injected into the PCN funding streams to support delivery of the same kind of proactive care work through the PCN.

What is the timeline?

In a word, tight; for the perpetually squeezed GP, there is an uncomfortable degree of time pressure.

The new contract document states that all PCNs need to submit registration information to their CCG by 15 May 2019. Practices who are struggling to negotiate in this time frame may wish to seek external support from their LMC to help broker an agreement. CCGs will then confirm network coverage and approve variation to GMS, PMS and APMS contracts by 31 May 2019.

So we have been given a maximum of 2.5 months to talk to our neighbours, consult existing federations, the LMC, and the CCG for advice, and agonise over decisions that may affect the future viability of our businesses.

Bear in mind the concept of choice may be an illusion; your CCG may already have some ideas about what the plan for networks should be. Of course, the process is intended to be GP-led, but the contract document does seem to suggest there is scope for 'marginal adjustment' to PCN membership and boundaries. To what extent these adjustments will be made in different CCGs remains to be seen. It seems inevitable, given the lack of clarity and the short time frame, not to mention differing approaches taken by CCGs to other issues in the past, that this will be interpreted differently across the country. I would therefore find out what the local vision is before convening meetings, because you may wish to consider this before trying to coordinate the impossible.

Final thoughts

GPs are tired and structural change is exhausting enough in itself. All practices will be looking at the new contract from slightly different perspectives and will all need to consider their own circumstances, the situation in their immediate locality, and the wider community picture.

A stable GP community reduces the threat of sudden list size surges triggered by practice closures. It's critical to explore the pros and cons of networking, and to discuss what challenges and opportunities PCNs might bring in the coming years. Be mindful of the weight attached to PCNs in the contract; they are its cornerstone, and whatever your take on the concept, they won't be going anywhere anytime soon.

Article last reviewed: 26 April 2019

Guide URL:
http://preview.pulse-intelligence.co.uk/guide/setting-up-your-primary-care-network/

PULSE Intelligence
Taking care of your business

Cogora

© Cogora 2019