Primary care networks: what will they mean for provider trusts?

The director of policy and strategy at NHS Providers, Miriam Deakin said:

"The announcement of primary care networks (PCNs) in the long term plan (LTP) marks a significant shift for the health and care sector – and for trusts. The expectations placed on PCNs are considerable and range from acting to "finally dissolve the historic divide between primary and community health services", to addressing challenges in general practice, to acting as the building blocks on which integrated care systems (ICSs) will function successfully."

While there is recognition in NHS England/Improvement that PCNs are not the answer to everything, and can't be given too much to do too quickly, it is clear that the approximate 1,260 PCNs across the country are expected to become the principal mechanism to achieve changes in how neighbourhood-level health and care will be delivered across the country.

There are clear opportunities and challenges ahead for providers as PCNs develop. First and foremost, trust leaders see the opportunity for a population based approach to healthcare based on a shared local understanding of the needs of the population, and of the collective resource at play. Hopes for better integrated local services for local populations, including through more integrated multi-disciplinary teams, rightly run high.

Trusts are also well positioned to offer skilled support services to PCNs which they may be too small to provide themselves economically. These could include HR, data analysis and even access to legal advice. This may be an ad hoc support or a formal contract. The offer of back office support can be a transactional agreement, or a means to start to build a relationship between PCNs and the trust with a more meaningful partnership in mind, or to make best use of available estate to support integrated care (by offering PCNs access to trust sites for example, or co-locating services).

While our members welcome opportunities to work collaboratively with primary care via PCNs and other routes, they are mindful of some of the challenges to be overcome in ensuring the success of PCNs.

Many trusts are concerned that work they have done on building relationships and reshaping services around local groups of GPs has to be revised to fit into pre determined PCN footprints. This could represent extra work for trusts, and primary care partners who have actually made the most progress towards new integrated models of delivery. It is also worth highlighting that effective collaboration between secondary and primary care is not confined to the PCN model. A number of trusts already have productive partnerships with primary care, either via a structural solution (in which a trust acquires local GP practices), or through a trust's engagement with a local federation or super practice. Ensuring that the national policy drive to roll out PCNs does not deter other innovative, local solutions to integrate care will be key.

Although the introduction of PCNs does incentivise primary care colleagues to organise at greater scale, the sheer number of PCNs which each trust has to relate to is also a challenge in itself. This will be particularly difficult for trusts covering large geographical areas such as those providing mental health services, community trusts and the ambulance sector. This whole new approach will rely on building new and trusting relationships which may take considerable time to establish.

As PCNs look to develop new models of care and recruit staff, trusts are also keen to ensure they do not end up competing for staff. One area where this could happen is with paramedics, where ambulance trusts are already seeing paramedics in high demand from other parts of the NHS. There may be opportunities to mitigate this by developing innovative career pathways across PCNs, developing a more flexible multi disciplinary approach, or by allowing staff to 'passport' between local organisations.

Finally, it's worth noting that PCNs will face their own challenges. The clinical director role will be crucial but is likely to be filled by practising GPs with limited time to spare. As PCNs will cover small populations, there will also be a limited pool of GPs they can call on to become actively engaged. Much will depend on the capacity and capability of PCNs to engage with provider trusts, and on the quality of local relationships.

The community network (led by NHS Providers and NHS Confederation) recently published a briefing on the relationships between trusts and PCNs: 'PCNs: A Quiet Revolution'.