

Exploring the development of PCNs

Survey of PCN
clinical directors 2020-2021



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Introduction

Since April 2019, local GP practices have been working together to create, develop and successfully run PCNs (Primary Care Networks). GP practices who form part of these networks have gone through a number of changes in their ways of working to deliver the requirements of the network contract direct enhanced service (DES).

While most of those practices benefited from already well-established working relationships, others started to work more collaboratively with their neighbour practices for the first time as they formed PCNs, often delivering new services for their local population and recruiting new staff to reinforce their primary care teams.

The BMA launched [the first edition of its PCN clinical directors survey last year](#)¹, as it wanted to hear directly from these new clinical leaders about the challenges and opportunities around the creation of PCNs. In this second annual survey², the BMA asked clinical directors about the challenges of delivering new services, operating under the testing circumstances of a global public health crisis and about the future of PCNs.

The results show that a year and a half after the creation of PCNs, clinical directors remain confident about what the networks can achieve over the next few years, provided appropriate financial and staffing resources are made available and they are given more time to deliver the requirements of the PCN DES.

PCNs have been able to play a key role in the primary care response to the COVID-19 pandemic, developing innovative ways of delivering services, providing extra support to vulnerable patients and ensuring continuity of care. They have also provided invaluable support for one another at this time of rapid change. But while the pandemic has helped to reinforce relationships with local partners, it has also disrupted these networks' development across the country, adding pressure and additional workload for practices.

As a result, clinical directors are calling for a reconsideration of the scale and timing of the expectations placed on them as well as more autonomy and flexibility to provide the best targeted response to their local population health needs.

Networks continue to aspire to provide leadership in primary care and to be part of the solution to the long-standing issues facing general practice. This is a pivotal time for PCNs, not least with the [proposed changes to local and regional NHS organisational structures](#)³, and it is of utmost importance that they are given appropriate resources (funding, premises, etc), support in terms of GP and non-GP workforce and time to recover from the pandemic to continue flourishing and reach their potential.

PCN clinical directors survey 2020 – key findings

- A significant number of clinical directors are confident that by the end of the DES in 2023/24 PCNs will have contributed to:
 - Providing better support for patients in care homes (66%)
 - Increasing the wider GP workforce (59%)
 - Improving the quality of prescribing (57%)
 - Delivering new services (49%)
 - Collaborative working between general practice and community care (49%)
- 44% of clinical directors think that provision of adequate funding is the most important condition for the success of PCNs. The second most highly ranked option was the availability of the GP workforce (20%), followed by the need for adequate premises (17%).
- Nearly seven in every 10 respondents (67%) of PCN clinical directors believe that, at the moment, the total income that their network receives is insufficient to deliver the services as required by the DES.
- The results of the survey also revealed that both PCN clinical directors and member practices are still facing a high level of workload which they are managing with increased difficulty, and which is also having an impact on workforce morale across their network.
 - 59% of clinical directors class their workload as manageable with difficulty while 27% have indicated that their workload was not at all manageable.
 - Almost two thirds (62%) say that the workload of practices in their network is unmanageable (relatively unchanged from 63% last year).
 - Almost half of the respondents (47%) class the morale of the workforce in their member practices as poor, while (42%) consider it to be neither poor nor good.
- The creation and recruitment of additional roles to the primary care team was the aspect of the formation of a PCN that had the most positive impact on workload management (51%), followed closely (48%) by collaboration between practices within the network. In addition, 85% of clinical directors also describe the relationship between the member practices as strong.
- Clinical directors were also asked to evaluate the impact of the creation of a PCN on the ability of their member practices to respond to the challenges of the pandemic:
 - **44% of clinical directors said PCNs had a positive impact to help manage workload during the pandemic.** Only 10% thought it had a negative impact. A third thought it had no impact.
 - **49% of clinical directors also said PCNs had a positive impact on the ability of their member practices to deliver services during the pandemic thanks to opportunity to share workload across the networks and set up COVID-19 hubs.**
- The majority of PCNs (62%) have now recruited at least one social prescriber, clinical pharmacist and first contact physiotherapist. Looking at the reasons why they have decided not to recruit other roles, such as physician associates, nursing associates, care coordinators, health and wellbeing coaches, occupational therapists, dieticians or podiatrists, suggests these roles may not provide the right fit compared to others (see also below) and ensuring sufficient funding is available to hire suitable individuals:
 - No clear benefit to PCNs and member practices to be gained from the role (58%)
 - Inability to hire suitable individuals (48%)
 - Disruptions linked to the pandemic made it difficult to find suitable candidates (38%)
 - Reimbursement insufficient to make the role viable (38%)
 - Reimbursement insufficient for the grade of healthcare worker required (32%).

- Most clinical directors (64%) told us they intend to still be in their role in 12 months' time despite the high level of workload. (In 2019, 62% of PCNs had told us that were intending to remain in their role in the next 12 months.) However, 22% said they were unsure, with 14% saying they don't plan to stay in the role mainly because of workload pressures. (In 2019 11% had told us they were planning to leave the role, and 27% had not formed an opinion).
- PCNs continue to work closely with LMCs (local medical committees), with 64% of clinical directors describing their relationship with their LMC as strong. (Last year, 58% of clinical directors described their relationship with their LMC as strong).
- A majority of clinical directors (52%) also describe their relationship with their local CCG as strong (55% had described their relationship with their CCG as strong last year). It seems however, that more support is needed to develop stronger working relationships with only a minority of clinical directors saying that their relationship with Local Hospital Trusts (19%), Local Mental Health Trusts (14%), Local Authorities (13%) and Integrated Care (12%) systems is strong.

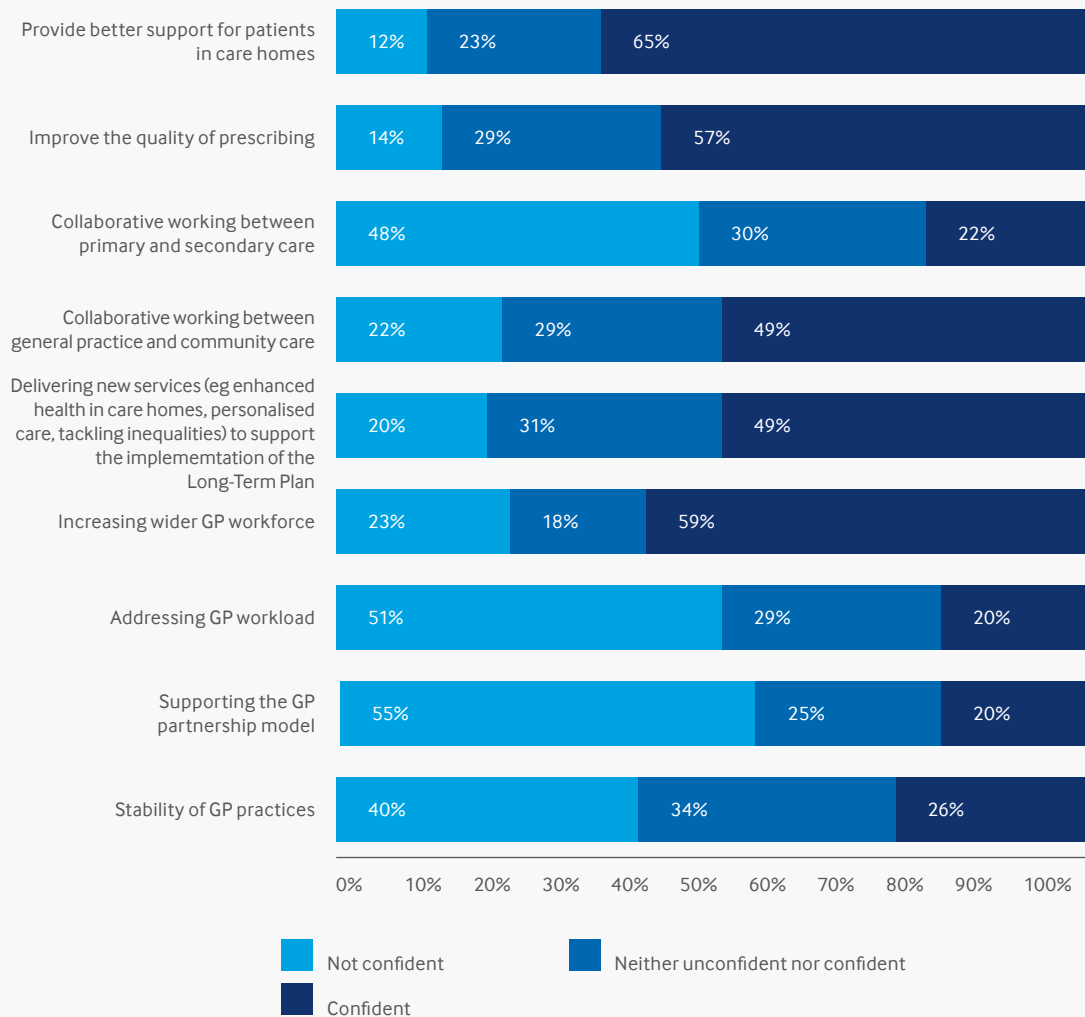
Clinical directors are confident that PCNs can achieve the majority of their aims, but more funding and support is needed.

We asked clinical directors about their confidence in the future success of PCNs and about the key factors that would contribute to that success.

In 2019, overall levels of confidence in PCNs were quite low with only 12% of clinical directors agreeing that PCNs would contribute to supporting the GP partnership model, 8% saying they thought PCNs could help to address the gap in the GP workforce and 22% indicating that PCNs could help to improve collaborative working between primary and secondary care. The 2020 results appear to be somewhat more positive. While there is still relatively low confidence among clinical directors that PCNs will contribute to addressing GP workload (20%) or supporting the GP partnership model (20%), this confidence continues to grow and move in the right direction.

In addition a high proportion of clinical directors think that by 2023/24 PCNs will have helped with the provision of better support for patients in care homes (65%), an increase of the wider GP workforce (59%), higher quality of prescribing (57%), the delivery of new services (49%) and better collaboration between general practice and community care (49%).

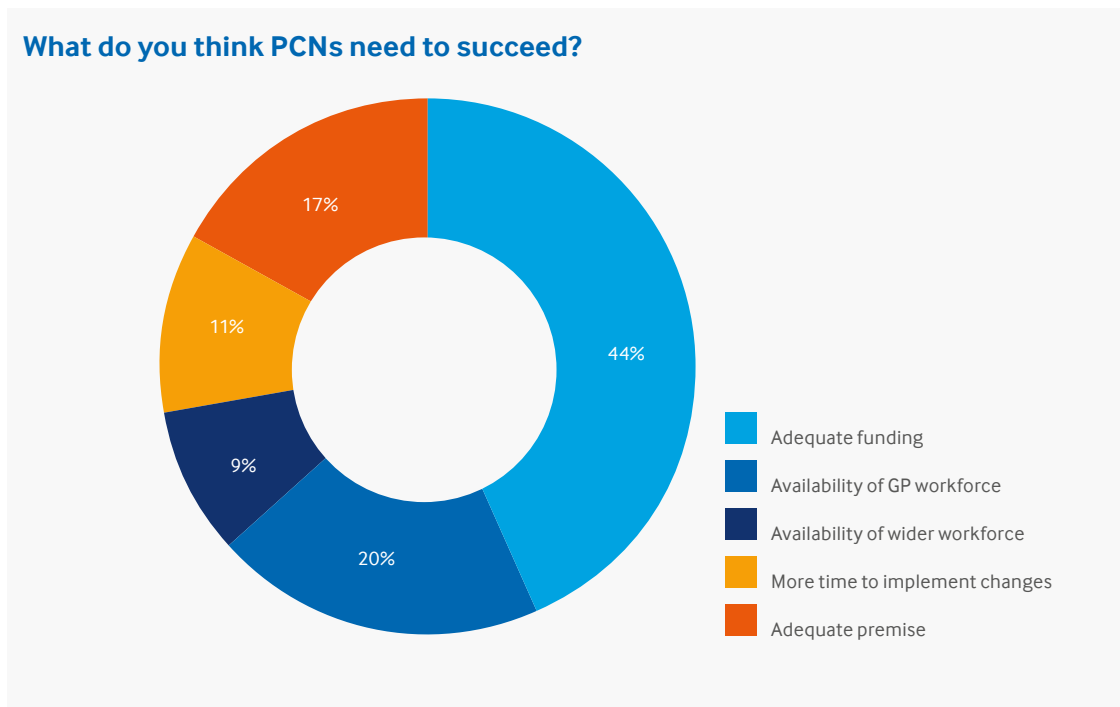
Please indicate how confident you are that the PCN DES agreement will have achieved each of these aims, as set out in the DES, by 2023/24.



While it is somewhat encouraging to see that clinical directors say they are confident that PCNs will achieve some important commitments of the network contract DES, their success will be further underpinned by appropriate funding, the recruitment of more staff including GPs, the access to better premises and further support to integrate the additional roles.

What do PCNs need to succeed?

We also asked clinical directors to tell us what support PCNs needed to continue to develop and succeed in the long run. We asked them to choose the options they feel would most contribute to the future success of their network.



Insufficient funding and a lack of GPs continue to be major constraints to the success of PCNs. 44% of clinical directors think that provision of adequate funding is the most important condition for the success of PCNs.

The second most highly ranked option was the availability of the GP workforce (20%) which they say will contribute to improve service delivery and the support to the wider primary care team, followed by the need for adequate premises (17%). Seven out of 10 respondents told us their member practices were having difficulties to find appropriate space in their premises to accommodate the additional roles.

The fourth priority that clinical directors identified was more time to implement changes as required by the network contract DES in primary care and general practice. This is followed by the need to increase the availability of the wider workforce.

In 2019 the three top priorities which had been highlighted by clinical directors to ensure their network's success were the provision of adequate funding, the availability of GP workforce and the availability of the wider workforce in this order.

We also received written feedback which reflected those priorities and also new ones around management training and administrative support:

“Way more funding is needed for management. Co-ordinating clinical work is time-consuming and complex, let alone the work involved setting up relationships with other parties who have no contractual requirement to do so. To think that this management support is possible on 50p per patient is totally unrealistic”

“Clinical leadership and autonomy to do what matters to our PCN, not being bombarded with multiple contracts and performance management”

“Support with integrating and training the new roles into practices. Linking them up with others in the city. Management for all of these new roles”

“PCNs need time to develop secure links with each of its member practices. We are not the answer to every problem in the NHS. Our management support funding is pitifully inadequate for the time it involves. As the Additional Roles Reimbursement Scheme (ARRS) workforce grows we will be employing a whole team of additional staff who will require managing eg payroll, HR, contracts etc. The PCN manager role should be either reimbursed under ARRS or its funding should be increased to match the reality of the situation. Clinical Directors working 2-3 sessions a week will no longer be able to cope with the workload involved in such a small amount of time and need to accept that they will have to further reduce clinical sessions as the job grows.”

“ARRS roles need support and management. This needs to be factored into funding and into GP workforce to support roles. PCN currently running on a shoestring and a one man band with the clinical directors taking all the burden and getting pulled by all different systems. We need to have sustainable funding for our management structure, support and organisation development. Need clarity on legal status, nominated payee which can scupper all the excellent work we have done”

Clinical directors think that the level of funding to deliver the commitments of the PCN DES is currently inadequate.

Funding for PCNs is mainly provided through the PCN DES which will be worth up to £1.8 billion by 2023/24. This funding is available to networks for operational support and up to £891 million is earmarked to recruit additional primary care staff through the ARRS.

From April 2020, funding and responsibility for providing the extended-hours access services transferred to PCNs whilst it was intended that a similar transfer of funding and responsibility for the local extended access evening and weekend service would also transfer to PCNs in April 2021. This has now been delayed until 2022. PCNs also receive payments from the [Investment and Impact Fund](#), which is a financial incentive scheme similar to the [Quality and Outcomes Framework](#) that rewards networks for performance in delivering high quality care. Some PCNs also receive additional locally determined support from their CCG.

The key funding streams that PCNs receive in 2020/21 are as follows:

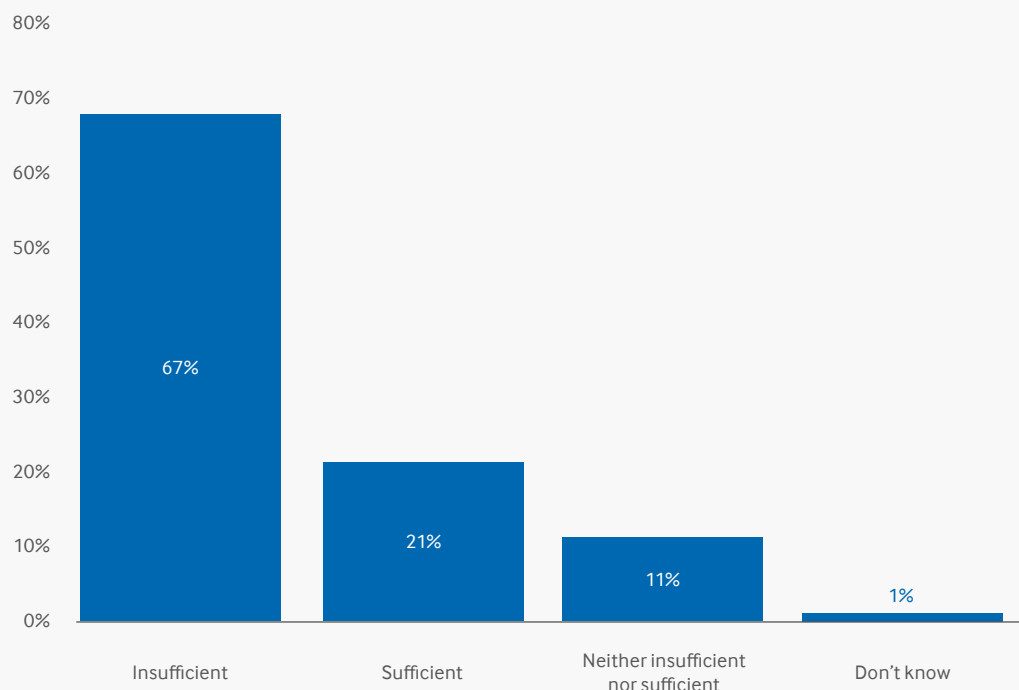
- **Core PCN funding:** payments of around £1.50 per registered patient to support the PCN as an organisation.
- **Clinical director contribution**
- **Additional Roles Reimbursement Scheme payments:** reimbursement of the salary for the new roles being recruited into general practice along with certain other costs such as

employer pension and national insurance contributions. This will increase from £430 million in 2020/21 to £746 million in 2021/22 in total, which corresponds to £597,000 for an “average” PCN according to NHSE.

- **Care home premium:** payments of £120 per care home bed to help cover the additional cost of providing services to patients in care homes.
- **PCN support payment:** a proportion of the investment and impact fund was used to further support the PCN during the COVID pandemic in 2020/21.
- **Extended hours access payments:** payments of £1.45 per registered patient for providing extended hours services
- **Investment and Impact Fund⁴** (£24.25 million in 2020/21, rising to at least £150 million in 2021/22, £225 million in 2022/23 and £300 million in 2023/24)
- **Network Participation Payment:** a payment of £1.76 per weighted patient paid directly to practices core funding to recognise an individual practice’s commitment to being part of a PCN.

Nearly seven in every 10 (67%) of PCN clinical directors believe that at the moment the total income that their network receives is insufficient to deliver the services as required by the DES and 52% think that in particular the level of funding available for the IT equipment used by the additional roles is insufficient. 42% indicated that the network member practices had to make personal investment in IT equipment to accommodate the new roles.

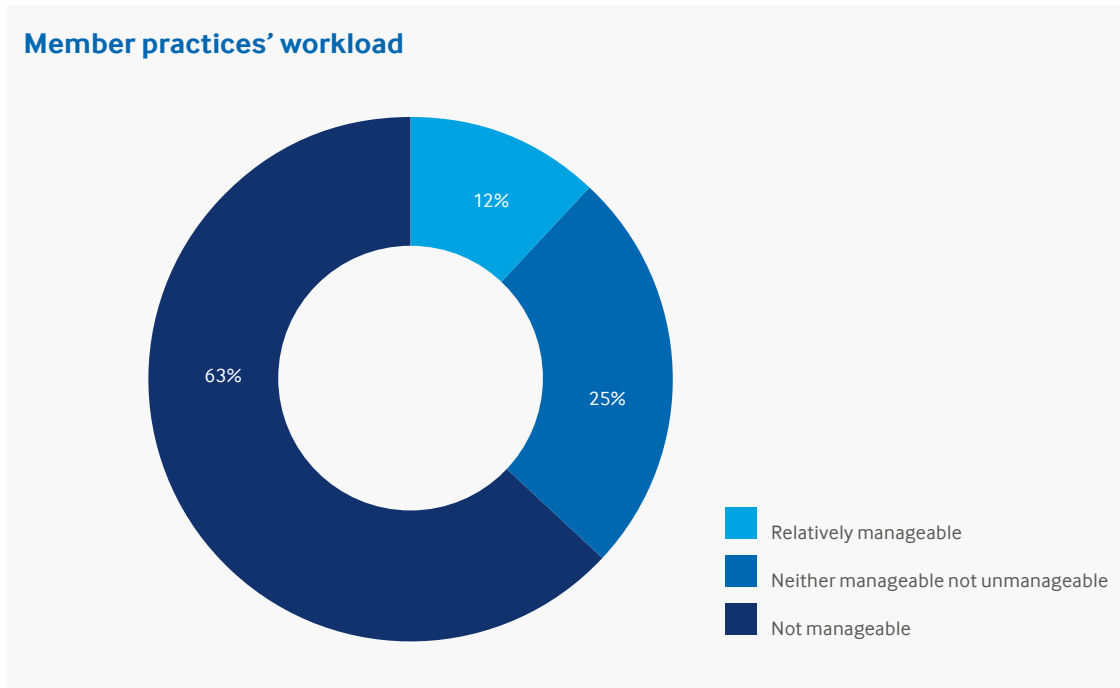
How would you rate the total income for your network, to support the work the PCN is expected to deliver?



Additionally, at the annual [LMC England conference on 30th November 2020⁵](#), LMC representatives voted in favour of a motion describing the PCN core funding as “woefully inadequate to fund all the schemes it has been allocated to cover and additional workforce it is anticipated to employ and manage” and demanding that this payment “be renegotiated for 2021 / 2022, to accurately reflect the workload that it is supposed to support” and “uplifted annually to reflect the expanding workforce and responsibility, as a minimum in line with core GMS contract uplifts”.

Clinical directors also think that the workload of their member practices is unmanageable even if PCNs have helped to reduce pressure during the pandemic.

Almost two thirds (63%) of clinical directors say that the workload of practices in their network is unmanageable.



This figure has remained stable since 2019. A year ago, clinical directors were asked the same question and 63% indicated that the workload of practices in their network was unmanageable.

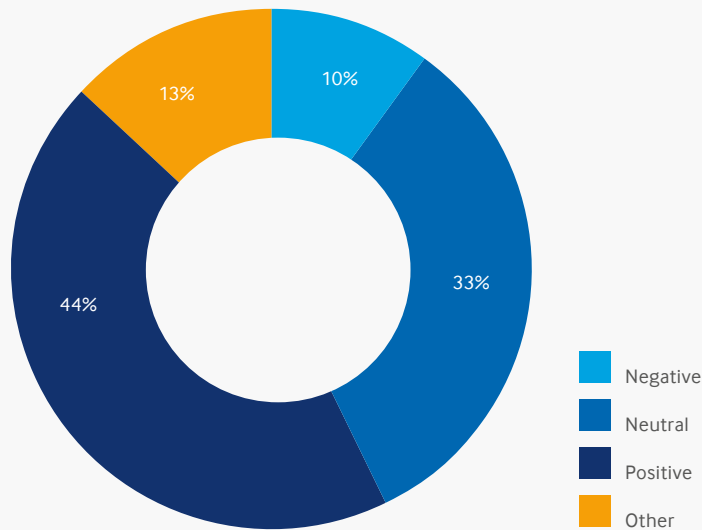
PCNs appear to have played a positive role in helping practices to deliver services during the pandemic

While the COVID-19 pandemic undeniably presented a number of unprecedented challenges, PCNs rapidly adapted to develop innovative ways of delivering safe and high quality care to patients in their community. The results of the 2020 survey show that PCNs played a positive role in helping practices to respond to these difficulties.

The majority (56%) of clinical directors told us that prior to the pandemic, the formation of PCNs had had very little effect, positive or negative, on the ability of their member practices to reduce their workload. Only 30% thought it had a positive effect and 12% thought it had a negative impact.

44% of clinical leaders told us that the ability of practices to manage workload during the pandemic had been strengthened thanks to the establishment of PCNs. Only 10% of respondents thought PCN had a negative impact.

Impact of PCNs on member practices' workload during pandemic



In addition, a high proportion of clinical directors (48%) say that the formation of PCNs has had a positive impact on the ability of their member practices to deliver services during the pandemic. A strong majority (73%) of those clinical directors who indicated that the formation of PCNs had a positive impact on service delivery during the pandemic, reconfigured their services. One could assume that this form of service delivery reconfiguration was facilitated by the fact that practices were used to working at scale and sharing resources and spreading workforce across the network.

Some clinical directors provided further examples as to how PCNs have helped member practices to respond to the challenges of the pandemic. Some of the written feedback suggested that the pandemic accelerated the development of PCNs and reinforced collaborative working between member practices.

"PCN created a strong collective voice to negotiate with the CCG on their responsibilities for delivering testing / home oximetry and other aspects of the covid response. The pandemic accelerated the development of GP PCN escalation plan and emphasised the need for increased support for GP reliance services over the winter"

"We set up a 'hot site' for seeing Covid patients alongside neighbouring PCNs. PCN meetings were conducted weekly as a method of supporting each other and keeping up to date with the masses of information. This shows the positive impact of being able to respond to challenges through the PCN"

"better communication at regular meetings of the board facilitated decision making re grouping into buddy groups and the setting up of temporary cold sites and the sending of clinicians to the hot site. Also allowed us to be one voice when dealing with the federation hot site although getting agreement between us is hard work it did pay off in the end"

"The PCN enabled practices to safely see hot patients in a designated site. Having the network agreement in place reduced the red tape involved. Practices have built on their relationships, being 'forced' together has improved those relationships further."

“By working as a PCN we shared solutions to IT problems, some practices having a greater degree of IT skill than others. Additional staff employed under ARRS also helped to support the isolated and vulnerable during the periods of lockdown”.

“Allowed Practices to come together for shared learning of Covid-19 and the changes to service delivery required. Keeping up to date with NHSE guidance. Sharing PPE supplies. Formation of a PCN Hot Hub. Generally supporting each other via WhatsApp group and Teams meetings.”

In addition, PCNs continue to face difficulties in recruiting additional staff

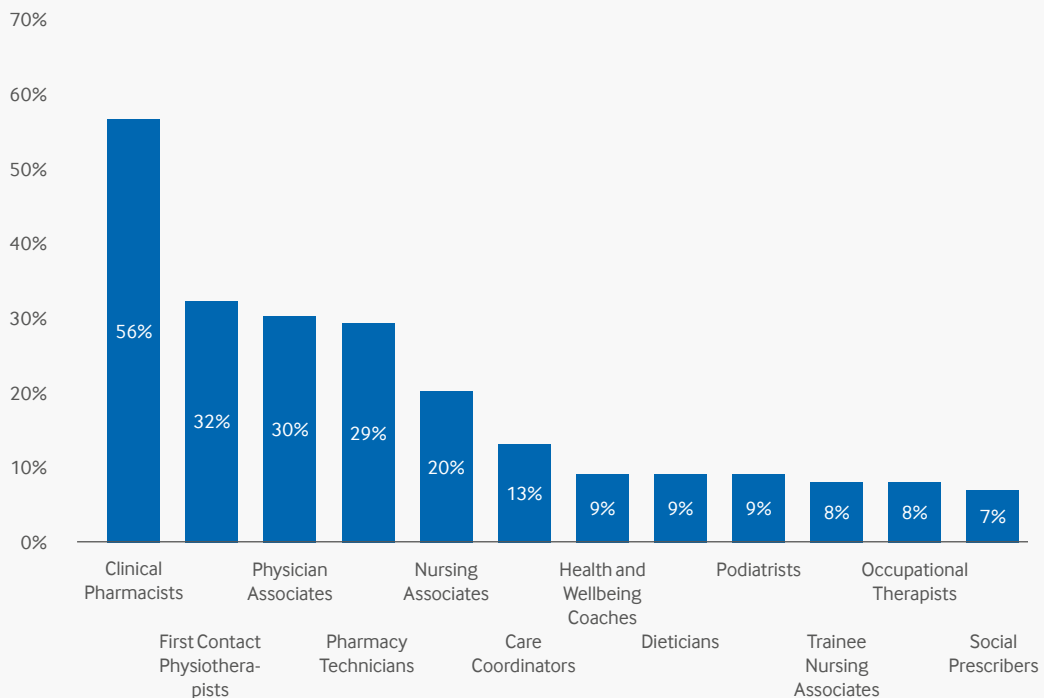
The latest version of the [Network Contract DES⁶](#) indicates that PCNs can receive full reimbursement and salary on-costs for 12 additional roles including pharmacists, social prescribing link workers and nursing associates. A number of new roles such as paramedics and mental health practitioners are planned to be introduced to the ARRS in 2021/22. The majority of PCNs have recruited at least one social prescriber, clinical pharmacist and first contact physiotherapist.

Looking at the reasons why they have decided not to recruit other roles, such as Physician Associates, Nursing Associates, Care Coordinators, Health and wellbeing coaches, Occupational Therapists, Dieticians or Podiatrists suggests these roles may not provide the right fit compared to others (see also below) and ensuring sufficient funding is available to hire suitable individuals:

- No clear benefit to PCN and member practices to be gained from the role (58%)
- Inability to hire suitable individuals (48%)
- Disruptions linked to the pandemic made it difficult to find suitable candidates (38%)
- Reimbursement insufficient to make the role viable (38%)
- Reimbursement insufficient for the grade of healthcare worker required. (32%)

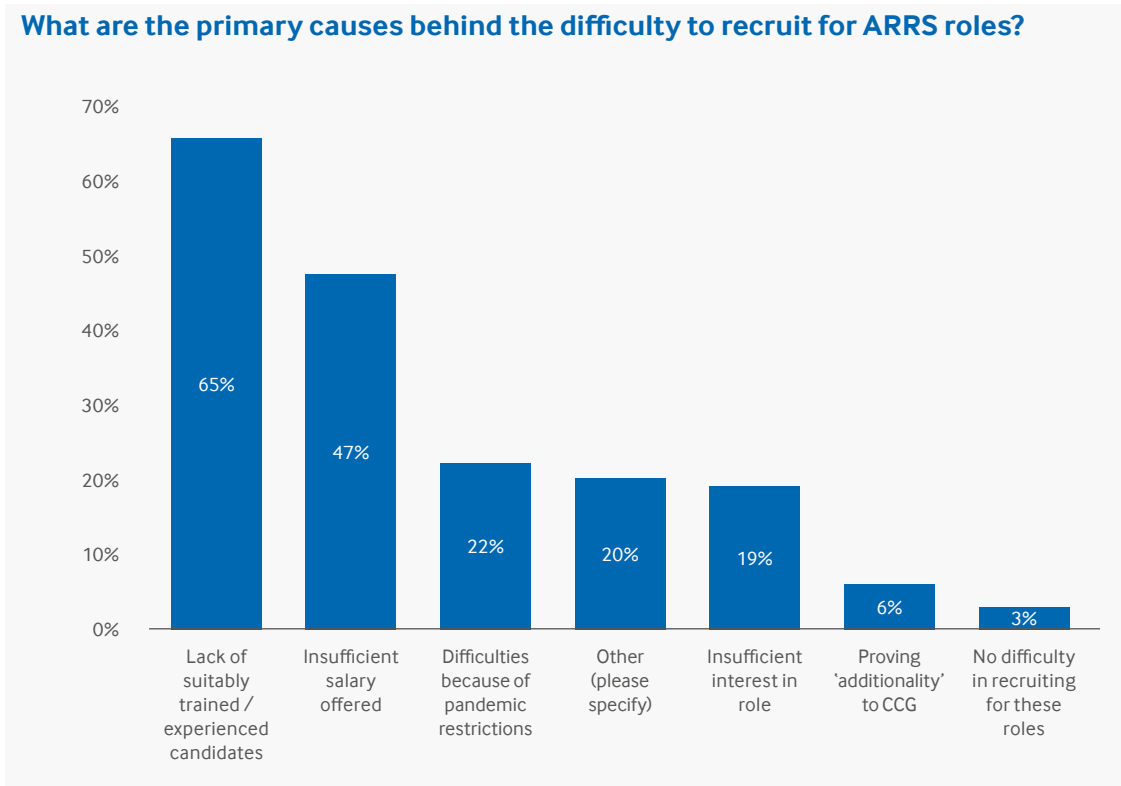
A majority of PCN clinical directors (55%) have told us that clinical pharmacists represent the group of healthcare workers which are proving the most difficult to recruit, followed by physician associates (30%) and first contact physiotherapists (30%).

ARRS role which are proving difficult to recruit



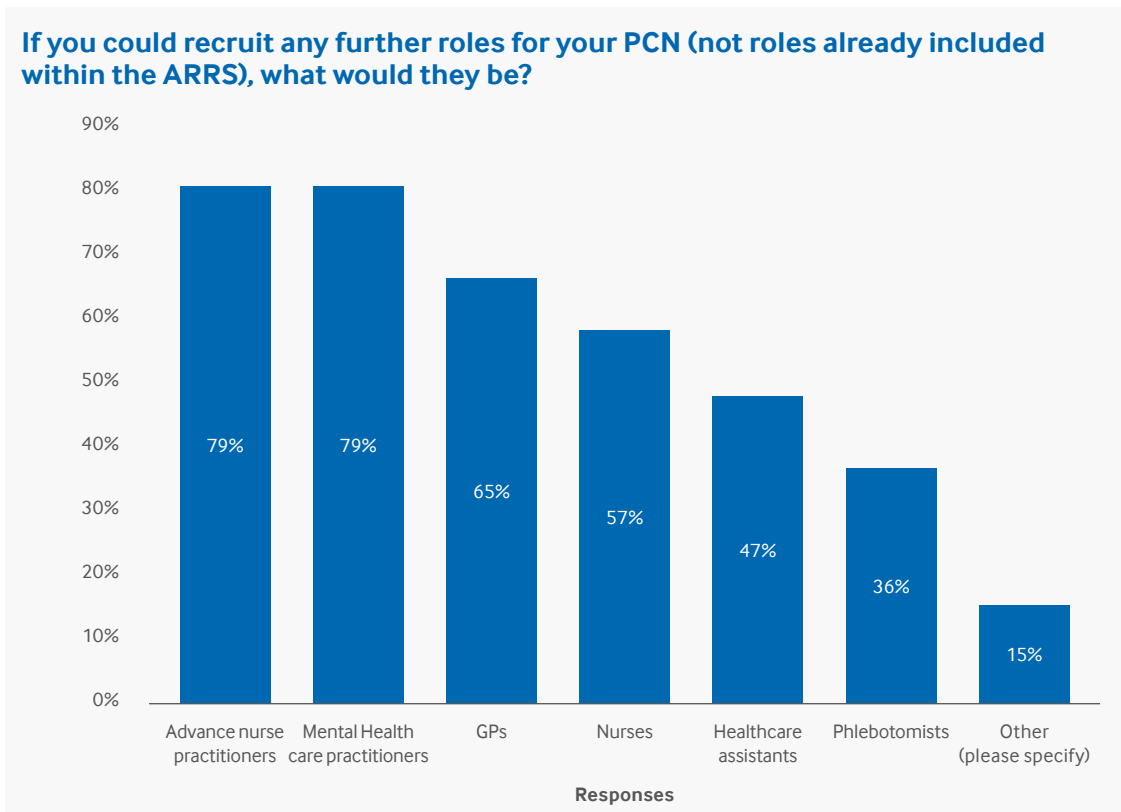
The two main reasons given for the difficulty in recruitment to ARRS roles overall were the lack of suitably trained/ experienced candidates (65%) and the insufficient salary offered (47%).

What are the primary causes behind the difficulty to recruit for ARRS roles?



A high majority of PCN clinical directors have indicated that their network would be interested in recruiting advanced nurse practitioners (80%), mental health care practitioners (79%) as well as GPs (64%), nurses (57%) and healthcare assistants (47%).

If you could recruit any further roles for your PCN (not roles already included within the ARRS), what would they be?



PCNs are asking for more freedom and flexibility around the use of the ARRS funding

The funding that PCNs receive through the scheme should be used to cover only new staff rather than already existing roles in the network and practices. Networks can decide how many of each ARRS role they want to employ, but clinical directors say member practices need more flexibility to use in the spending of the ARRS funding to better respond to their local population needs.

This was particularly reflected in the written responses we received to the question on what PCNs need to further succeed.

“Proportionate funding according to need. Less bureaucracy and flexibility in spending the ARRS funding to suit the needs of the practice population.”

“Top priorities would be more autonomy over how we spend allocated funds, and more flexibility on ARRS roles recruitment”

“The ability to set our own agenda for our local needs, better funding for certain aspects of DES eg care homes, more flexibility in the ARRS scheme.”

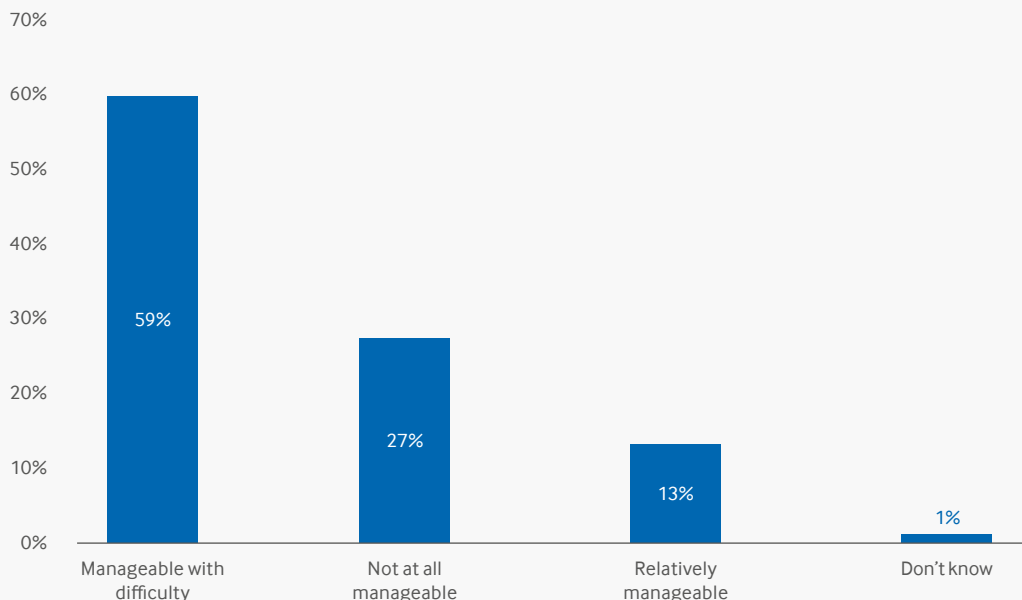
Clinical directors report unmanageable levels of workload, low levels of morale among their workforce and insufficient funding

Clinical directors’ workload continues to be heavy, with those in smaller and medium sized PCNs finding it the most difficult

In our 2020 survey we again asked clinical directors a series of questions around the level of their own workload and the level of workload and morale in their member practices.

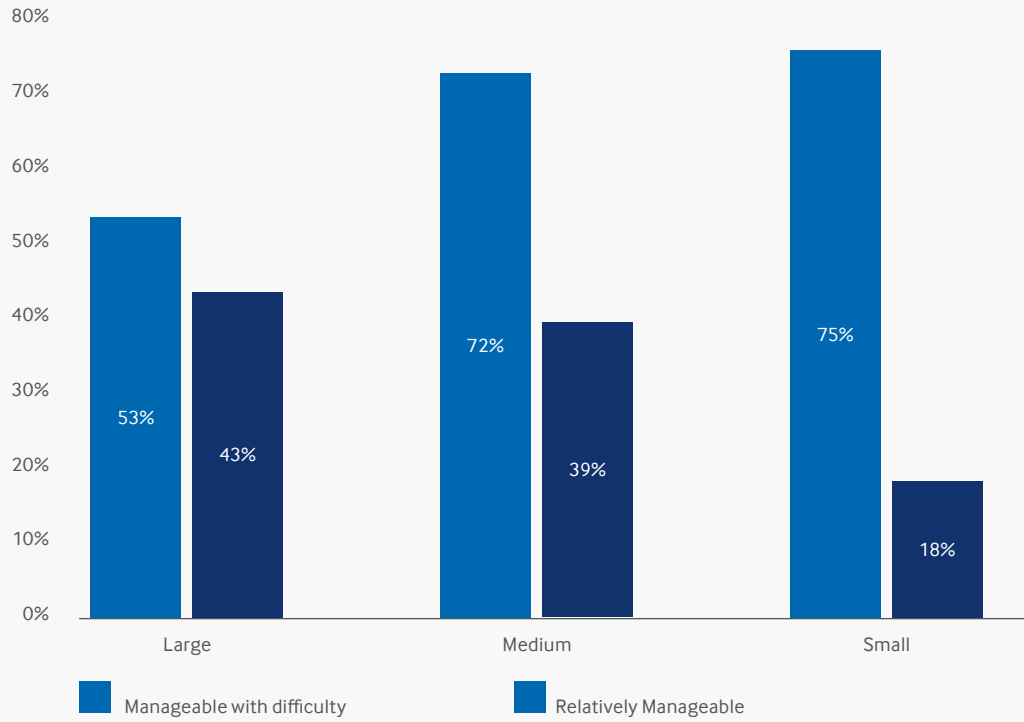
The 2020 results show that an increasing proportion of clinical directors are having difficulties in managing their workload, with over eight in every 10 respondents saying that the combined workload from their clinical director and substantive roles was either not manageable at all or manageable only with difficulty. In 2019 nearly five out 10 respondents revealed that their clinical director workload was not at all manageable or manageable with difficulty.

How manageable is the volume of work required in your role as clinical director, alongside the workload from your substantive role?



The results show that clinical directors have difficulties in managing their workload particularly in small PCNs (those with fewer than 40,000 registered patients), where nearly eight in every 10 respondent (75%) said they found their workload difficult to manage, and medium sized PCNs (those with 40,000 or more, but fewer than 55,000 registered patients), where just over seven in 10 respondents reported difficulties in managing their workload (72%).

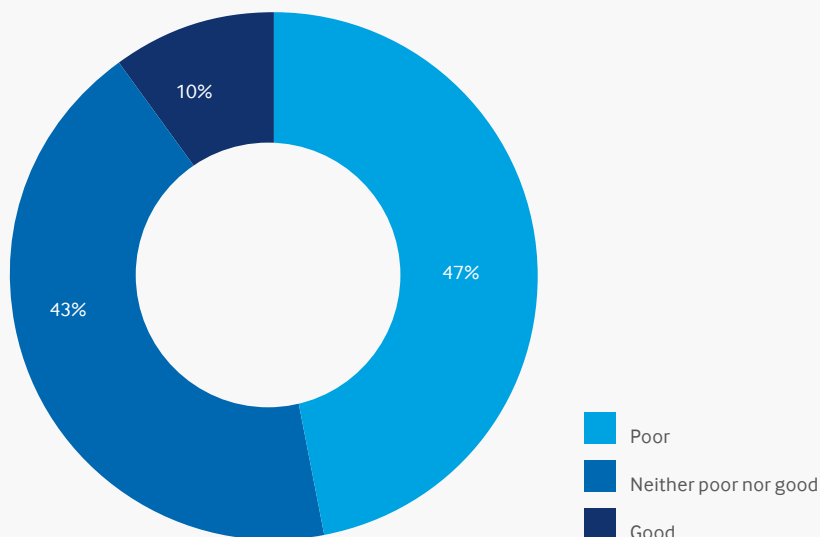
How manageable is the volume of work required in your role as clinical director, alongside the workload from your substantive role?



Two other challenges clinical directors face are low levels of morale and funding

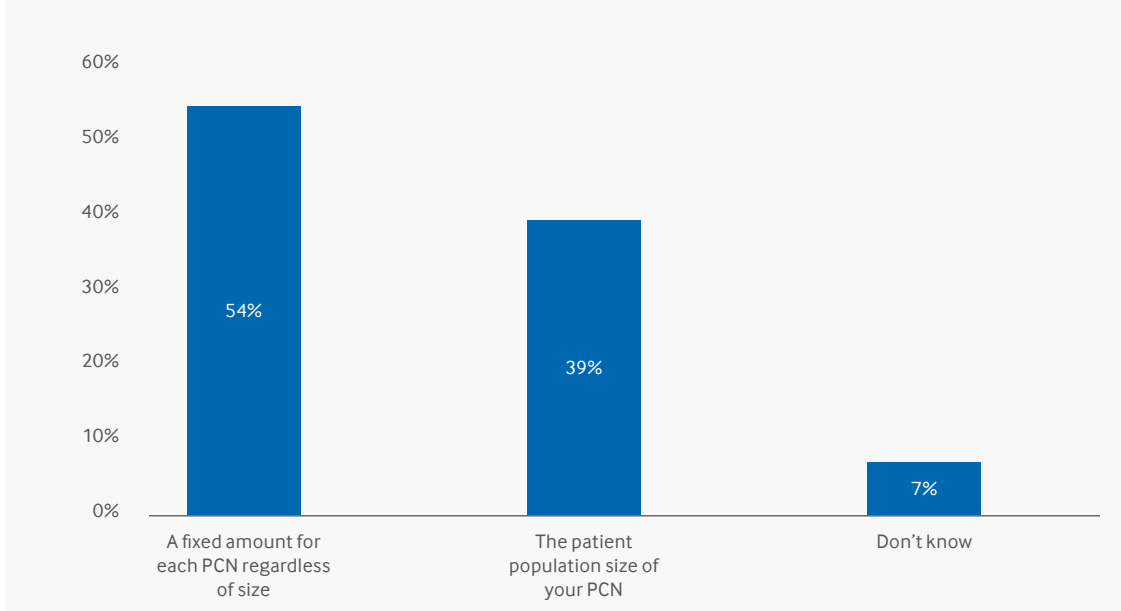
Almost half of the respondents (47%) class the morale of the workforce in their member practices as poor, while (42%) consider it to be neither poor nor good.

Level of morale in member practices



The majority of clinical directors think their remuneration should be based on a fixed amount for each PCN regardless of size, not as currently set out in the DES, based on the size of the PCN's patient list and the national average GP salary rate. Their remuneration was originally designed this way as it was anticipated that clinical directors would have to engage with more practices.

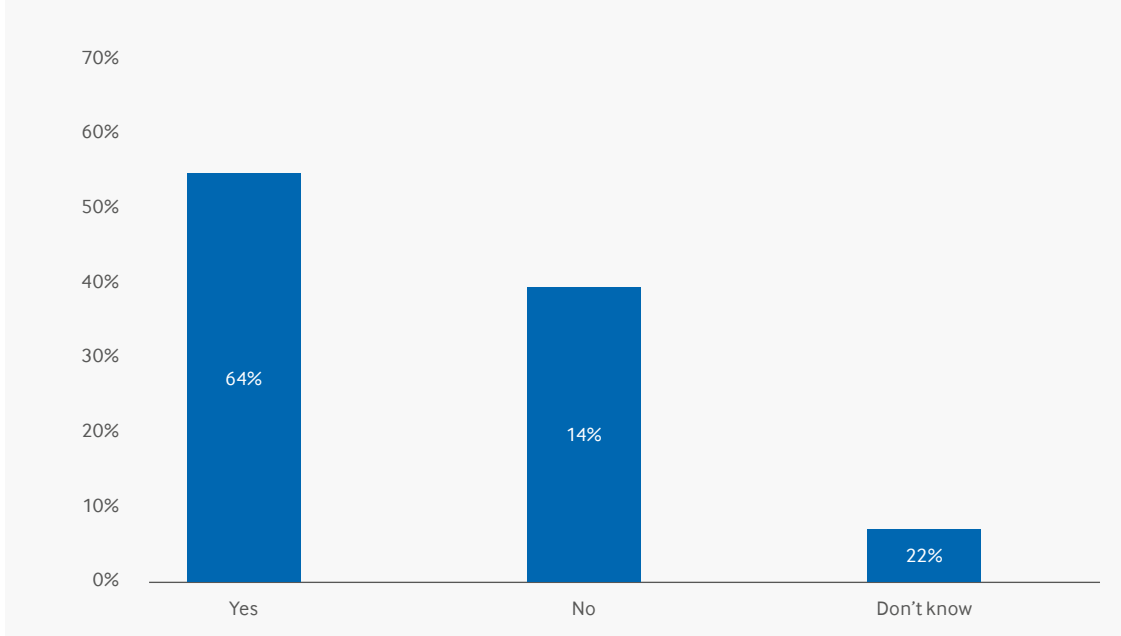
Do you think the remuneration for your role of clinical director should be based on?

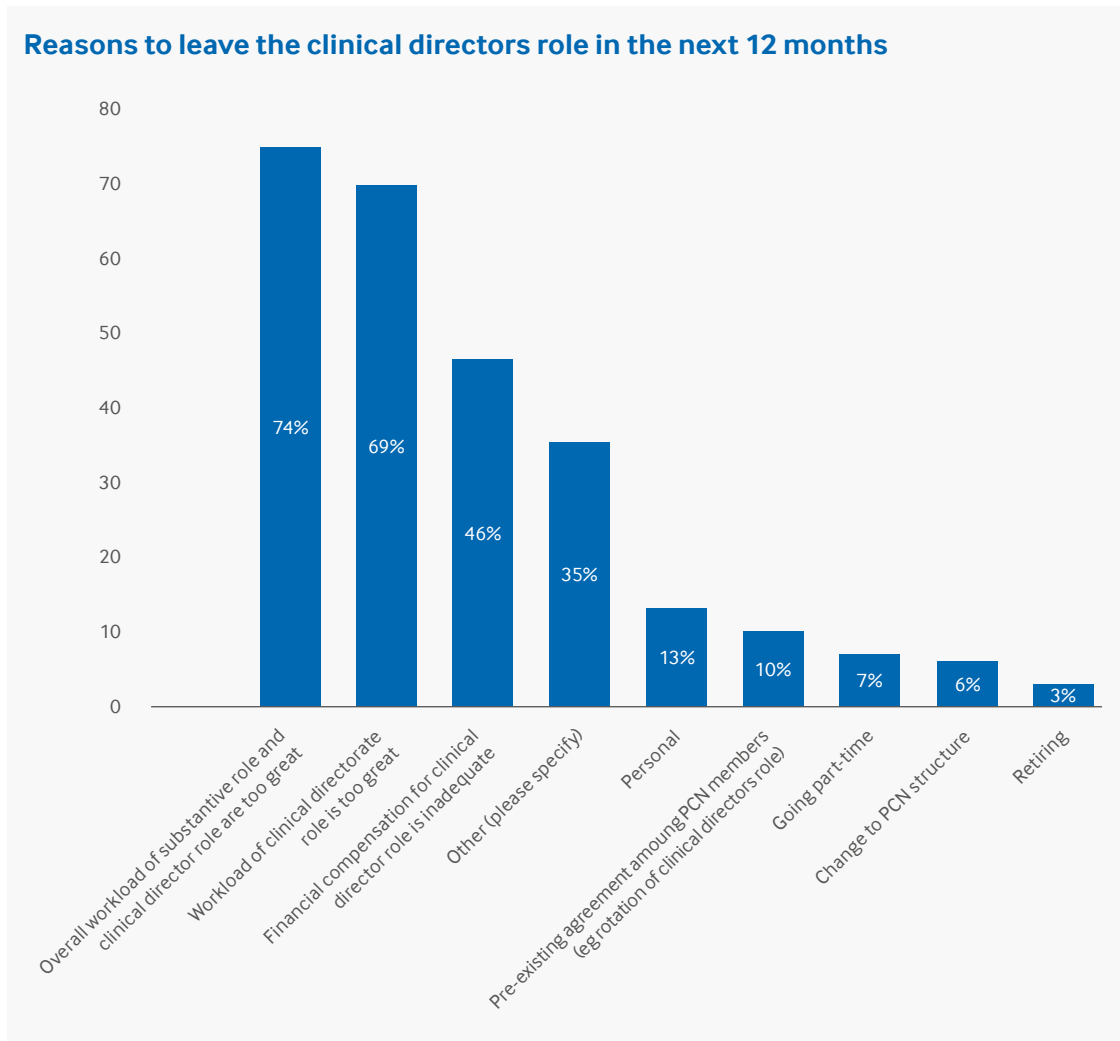


Despite these challenges most clinical directors plan to stay in post over the coming year

Despite, high levels of workload, insufficient funding and low morale among their staff, most clinical directors (64%) told us they intend to still be in their role in 12 months' time, which is roughly the same proportion as in 2019 (62%). The proportion of clinical directors who are uncertain about their future (22%) has gone down (27% in 2019), while the number of those planning to leave their role over the next 12 months has gone up slightly (14% in 2020 compared to 11% in 2019).

Do you intend on being in the clinical director role in 12 months?





When asked about the reasons behind their intention to leave the role over the next 12 months, clinical directors planning to leave their posts indicated that the combination of the workload from their substantive and clinical director role was too great, that the workload of their clinical director role alone was too great or that the financial compensation for the role was inadequate.

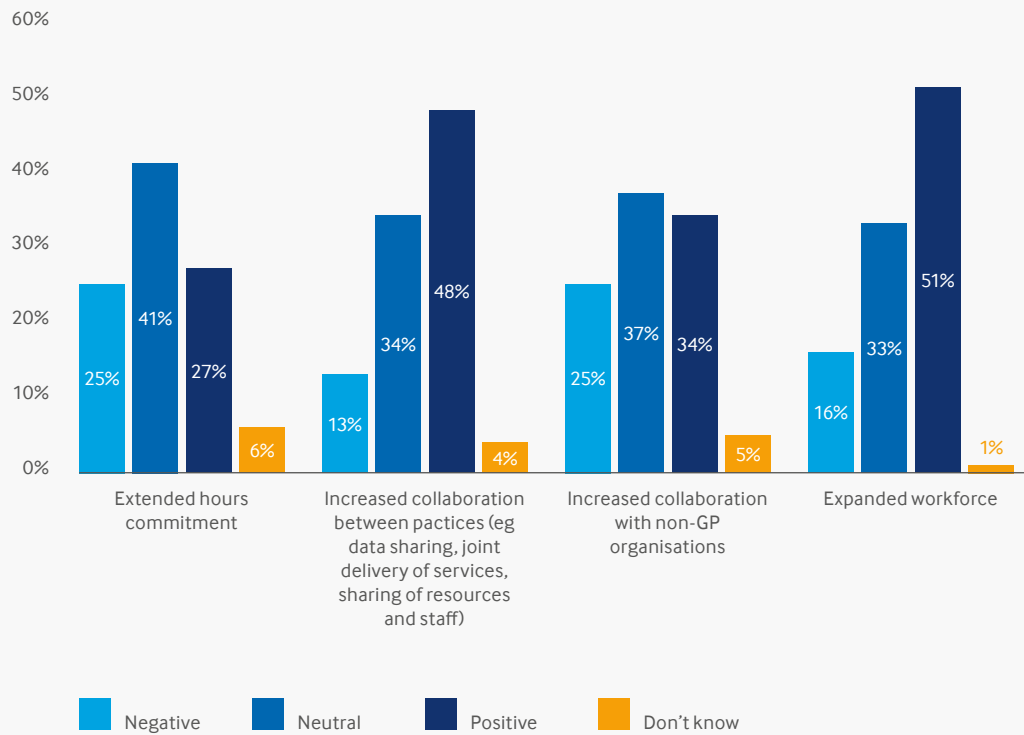
PCNs have reinforced relationships between practices and other partners in primary care, but more support is needed to develop new ones with the wider system.

PCNs were created in the context of already existing collaborative working arrangements between local practices across the country⁷. When we surveyed⁸ clinical directors in 2019, 76% of them confirmed that most of their member practices had already been engaging in at scale working prior to the adoption of the PCN DES.

In 2020 84% of clinical directors say the relationships between their network member practices are strong.

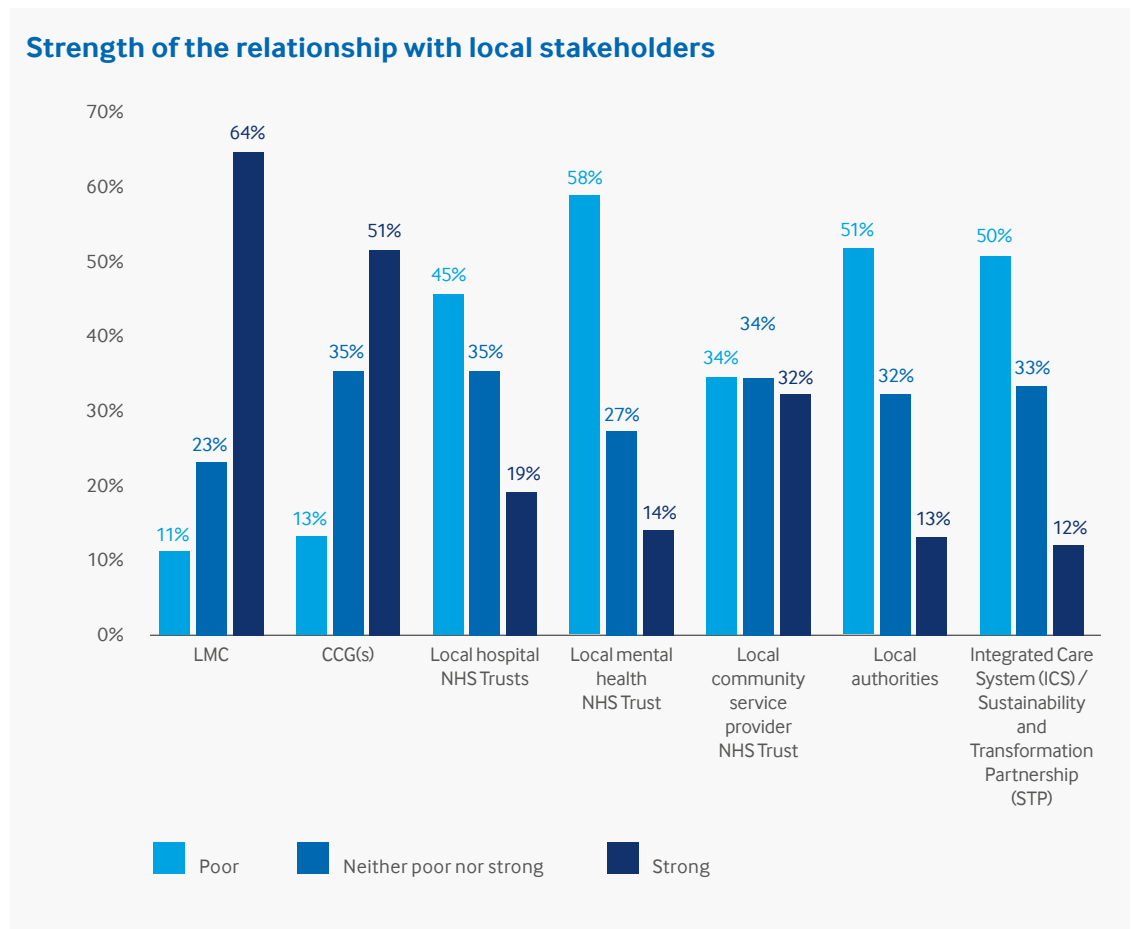
In addition, when asked about which aspect of the formation of a PCN had the most positive impact on workload management, one of the most popular choices for clinical directors was the collaboration between practices within the network. Over 48% of this group of clinical directors thought that increased collaboration between practices through data sharing, joint delivery of services, sharing of resources and staff, contributed positively to the management of workload in PCNs. 13% thought that PCNs had a negative impact on this.

Which aspect of PCNs had a positive impact on the ability of your member practices to manage workload?



The relationship between PCNs and LMCs has also grown in strength since 2019. In 2020 over 64% of clinical directors indicated that their relationship with their LMC was strong compared to 57% the year before. This year's survey result also confirms that the relationship with CCGs remains relatively strong for the majority of PCNs. 51% of clinical directors said so, down from 55% last year.

While the relationships between practices, LMCs and CCGs had already been well established prior to the creation of PCNs and were further reinforced as they developed, clinical directors have indicated that less progress had been made with relationships between PCNs and non-primary care stakeholders. The results are showing that a high number of clinical directors consider the relationship between their networks and local NHS Trusts (44%), local authorities (50%) and Integrated Care Systems (49%) as poor. This represents a slight improvement on 2019's figures of 49%, 53% and 53% respectively.



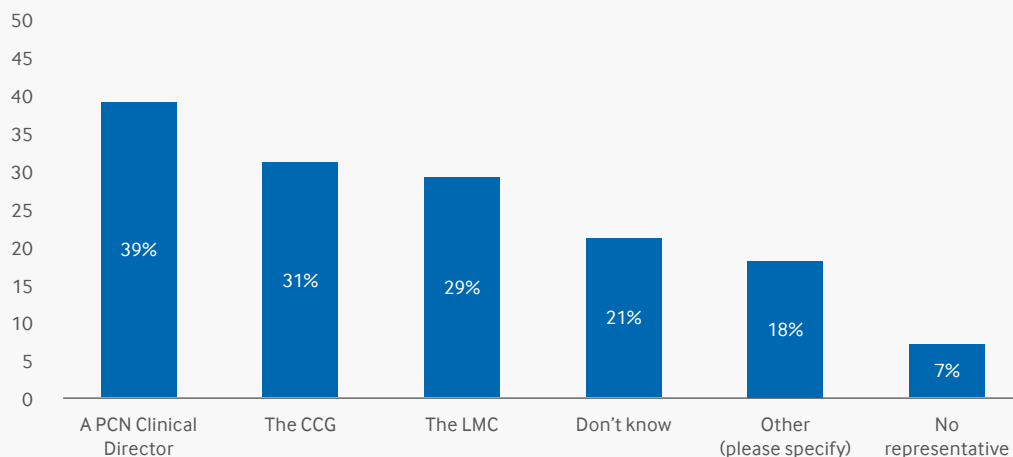
The poor state of PCNs' relationships with the wider health system beyond primary care is also reflected on clinical directors' lack of confidence (48%) on the role that PCNs could play in facilitating collaboration between primary and secondary care.

The development of good relationships with the wider NHS environment will become crucial as clinicians play an increasing role in representing general practice at the system level

At a time where NHSE/I are consulting on possible changes to [commissioning arrangements as well as the planning and delivery of healthcare services](#)⁹, PCNs are likely to have an increasingly important role in ensuring that primary care providers have a strong voice in local and regional decision-making. As indicated above, clinical directors have highlighted that there is still a great deal of room for improvement in strengthening the relationships with their ICSs and Local Authorities.

The results also highlighted some differences in the representation of PCNs on their ICS board. They demonstrate that PCNs could be represented by varying combinations of LMCs, CCGs and a PCN clinical director, in some situations at the same time. Only 7% of clinical directors told us that GPs in their network were not represented at the ICS level, and 21% did not know.

Who currently represents GPs in their provider roles on your ICS/STP board?



Endnotes

- 1 *Exploring the early challenges facing Primary Care Networks, Survey of PCN Clinical Directors*. BMA (January 2020): <https://www.bma.org.uk/media/1971/bma-pcn-member-survey-jan-2020.pdf>
- 2 The second edition of the BMA's annual PCN survey was carried out in October 2020, with a 16% response rate from clinical directors.
- 3 *Consultation: Integrating care: building strong and effective integrated care systems across England – a consultation on new proposals for legislation intended to reinforce and advance its longstanding aim of integrating health and care*. NHS England and Improvement (November 2020): <https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf>
- 4 *Investment and Impact Fund 2020/21: guidance*. NHS England and Improvement, September 2020: <https://www.england.nhs.uk/wp-content/uploads/2020/09/IIF-Implementation-Guidance-2020-21-Final.pdf>
- 5 *LMC England Conference Agenda*. BMA (November 2020): <https://www.bma.org.uk/media/3486/bma-lmc-conference-agenda-november-2020.pdf>
- 6 *Network Contract Direct Enhance Service*. NHS England and NHS Improvement (September 2020): <https://www.england.nhs.uk/wp-content/uploads/2020/03/Network-Contract-DES-Guidance-2020-21-October-update-.pdf>
- 7 Smith JA, Parkinson S, Harshfield A, Sidhu M. Early evidence of the development of primary care networks in England: a rapid evaluation study. Southampton: *NIHR Health Services and Delivery Research Topic Report; 2020*. DOI: <https://doi.org/10.3310/hsdr-tr-129678>
- 8 *Exploring the early challenges facing Primary Care Networks, Survey of PCN Clinical Directors*. BMA (January 2020).
- 9 Ibid. iii.

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