

# Primary Care Networks in Sefton

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**Director of Place**  
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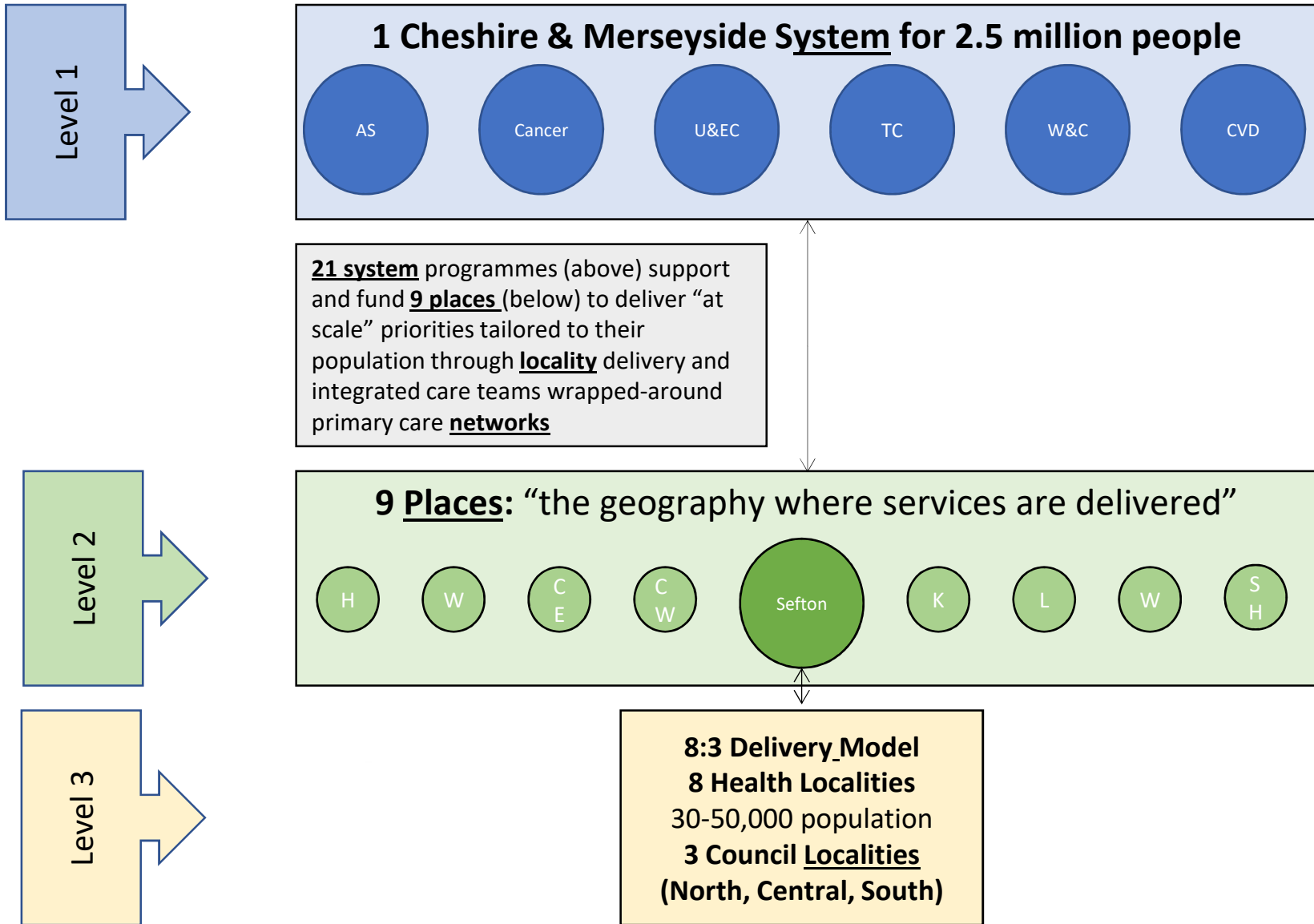
Staying **local & together**  
**together** with you

# This update will cover

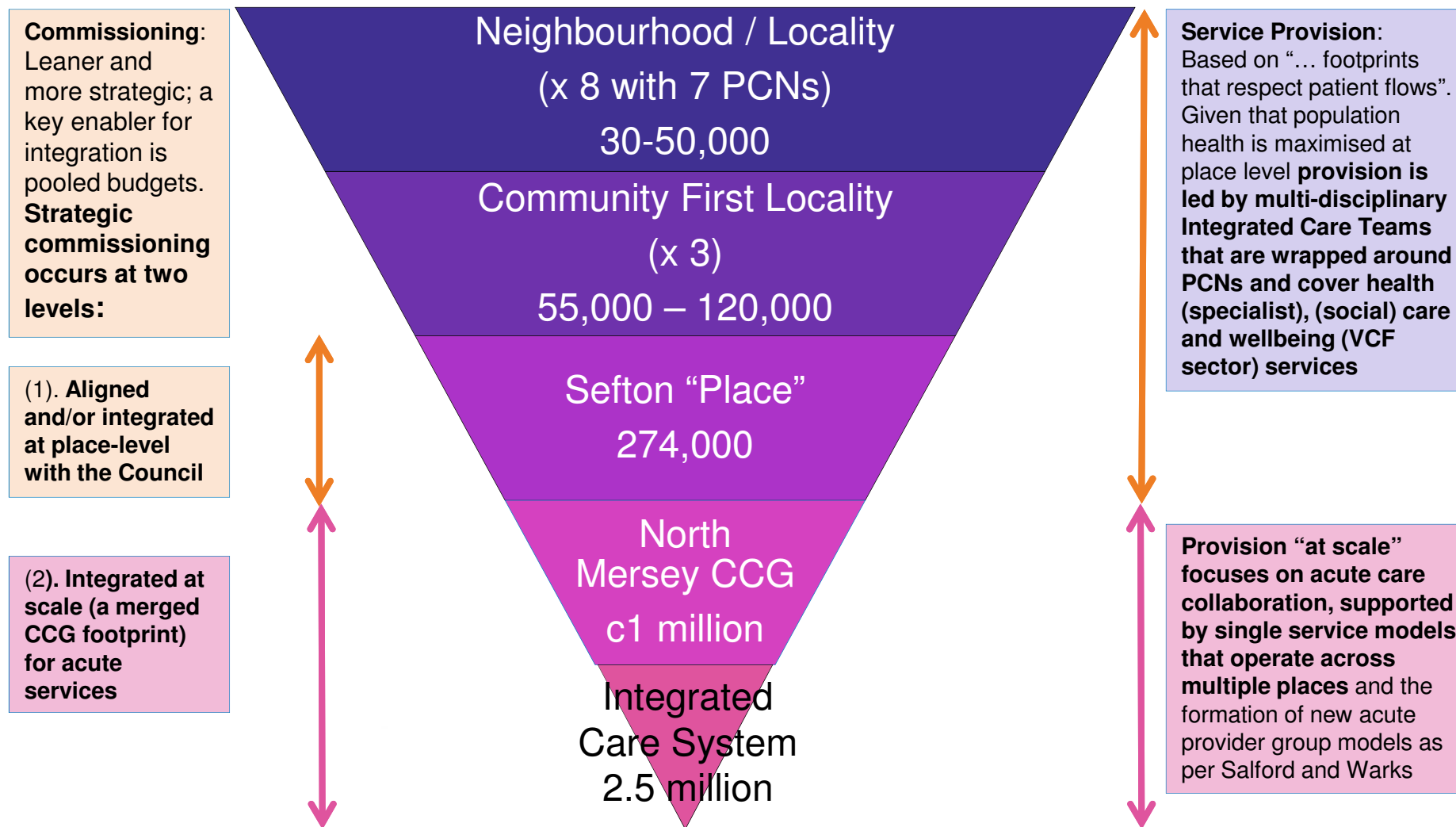
- The context of PCNs in the system
- What are Primary Care Networks? (PCNs)
- National Policy for PCNs
- PCN relevance to local plans & priorities
- PCNs in Sefton
- Initial Priority Areas



Policy and delivery remain focused on three levels:  
(1) C&M "System" (2) Sefton (3) Networks



# A possible future landscape for Sefton



## A confident and connected borough - future health, care and wellbeing in Sefton

*Health, care and wellbeing services are joined-up, with many provided in local communities. Empowered people make positive changes to their lives and it is easy to get the right support in the right place first time and they live longer, healthier and happier lives as a result. There has been a reduction in health inequalities and key identified needs have been addressed*

### SEFTON2GETHER

#### **Healthy behaviours and lifestyles\***

Early Intervention, Self-Care and Prevention: coordinated and seamless healthy living.

Health, care and wellbeing services offer **prevention and early intervention services** in partnership with **voluntary, community and faith sector services**.

**Mobilised communities** are empowered to actively engage in self-care and wellbeing for **all ages**. **Integrated intelligence systems** support self care and prevention; 'make every contact count' is embedded and enables risk stratification for targeted and personalised services.

#### **Integrated health and care system\***


**Primary Care Networks** are part of a multi-disciplinary and multi-agency **integrated care team** across all **health, care and wellbeing** providers with a **digitally enabled single point of access** and targeted care coordination supporting geographies of 30-50k population, with **GPs as the senior clinical leader** and an overseer of patient care.

People know what **local services** are available to access for **any urgent needs** and will have access to **care navigators** to help them access services. People will experience **seamless care between the hospital, community and primary care** with integrated services making sure they are home and accessing community care as quickly and as safely as possible. Services are available closer to home and outside of the hospital setting wherever possible with **Integrated Specialist Teams**.

#### **Optimised acute care**


**Urgent & Emergency Care and Planned Care** are focussed on whole pathway optimisation for physical and mental health and people only **attend hospital when they need inpatient or specialist outpatient care**.

People can access to **acute services** which will provide quality services that meet **national standards**, achieve **best practice** and deliver the **best possible clinical outcomes**. This, in most cases, will be **delivered locally**, but for **some areas this may be further away** to ensure the **best possible expertise, facilities and care** are available.

 **21<sup>st</sup> Century digital and technological solutions**

 **An integrated trained flexible workforce supports care delivery; system leadership enables empowered teams to work 'without walls'**

 **Financially sustainable and working to a capitated budget maximising the Sefton £**

 **Whole system optimised estates across Sefton**

 **System level coordinated communication and engagement**

The wider determinants of health\*

Living, working and having fun

Integrated Care Partnership

Integrated Care System

Strategic commissioning

Primary care networks

A clean, green and beautiful borough

On the move

Visit, explore and enjoy

Ready for the future

Open for business

*Starting well... living well... ageing well... dying well...*

# What are PCNs?

- PCNs are groups of GP practices who have agreed to work together, through a formal agreement to:
  - to support the development and sustainability of general practice services
  - work with other partners in their community to improve the health and wellbeing of local people.
- Whilst focusing on the needs of their local populations, PCNs have also agreed to deliver the requirements of a national PCN contract.



# National Policy on PCNs

## Purpose of PCNs

- Stability: support for and sustainability of GP services
- Better health and care: “dock” for other NHS community services in the “place” to meet health and wellbeing needs
- Integration: an essential building block for integrated working, based on populations of around 30-50k
- Investment: joint investment and delivery vehicle
- Additional specified roles to be developed over 5 years
- Community leadership: Clinical Director role – strategic and clinical leadership



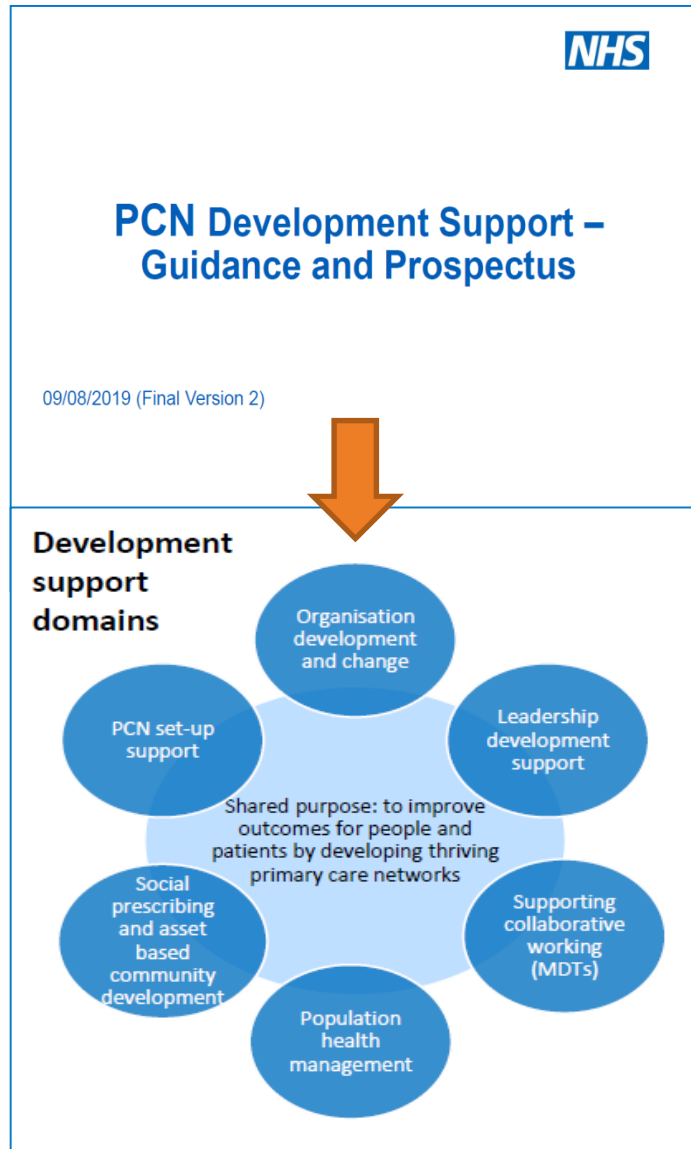
# National Policy on PCNs

- Key components of the PCN contract:
  - Workforce: five additional roles - clinical pharmacists, social prescribers, physician associates, physiotherapists, first contact community paramedics
  - Improved Quality Outcomes Framework for general practice
  - PCN establishment, registration and governance
  - Urgent care : Extended hours
  - Digital innovation
  - Seven national service specifications : medication reviews, care homes, anticipatory care, personalised care, cancer diagnosis, CVD and tackling health inequalities.





# Recent announcements have focused on level three: Primary Care Network (PCN) Development



- **Re-cap: PCNs are seen as the foundation for delivering integrated care**
- Prospectus published in August 2019, together with a self-assessment maturity matrix
- *“In 2019/20 we expect PCNs will prioritise specific service improvements ... focused around the needs of local people and communities”*
- The HCP has written to Clinical Directors requesting **two outputs by the end of November**:
  1. An **annual plan** for 2019/20; and
  2. A **self-assessment** covering five areas: leadership, planning and partnerships, integrating care, managing resources, population health management and working with people and communities
- PCN RightCare opportunity packs have also been published.

# Local relevance of PCNs

- PCNs are a core component of our Sefton Health and Care Transformation Programme model
- They are central to Sefton2gether - our refreshed five year plan and Health and Wellbeing Strategy
- They enable stronger collective voice and engagement of general practice with other partners to improve health and wellbeing

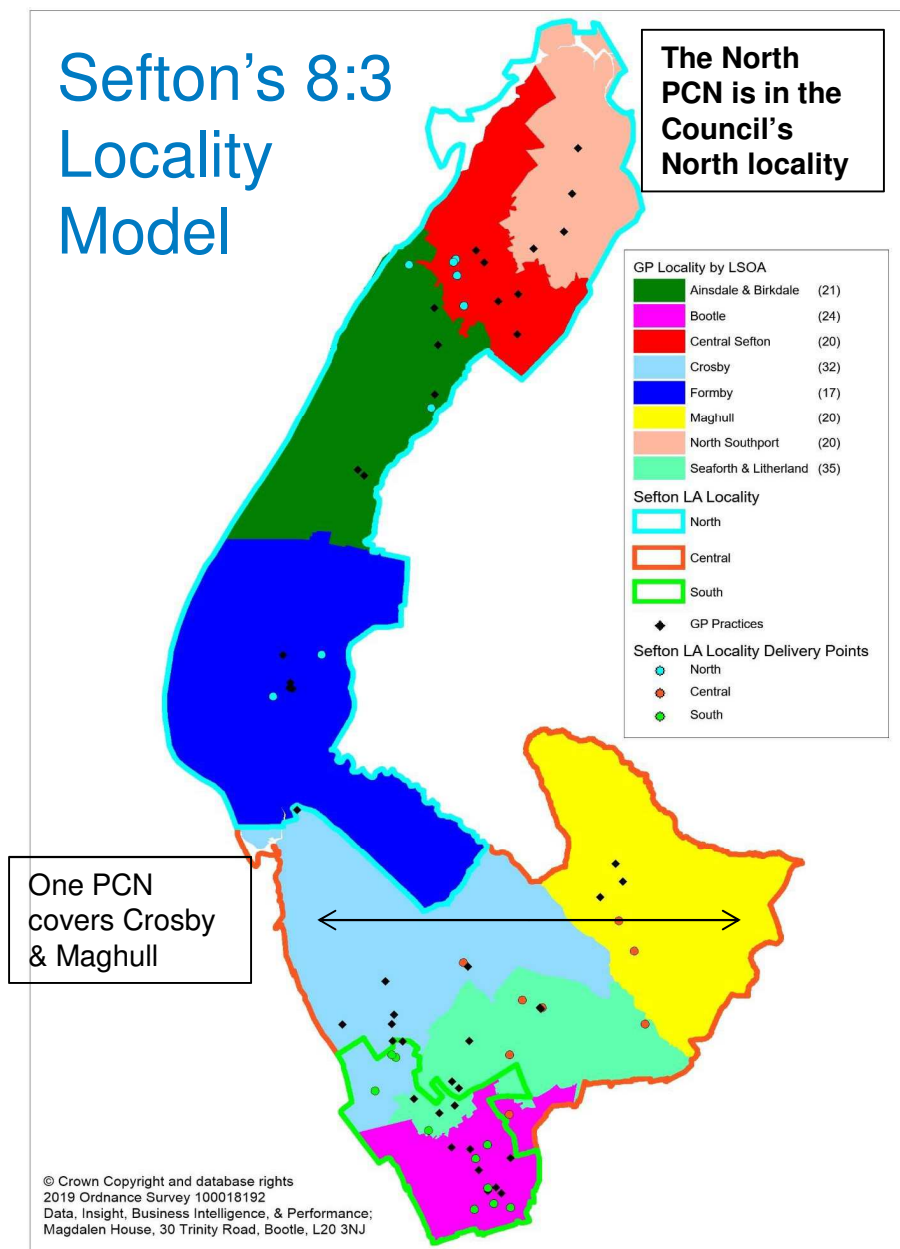


# Our Sefton PCNs

- There are seven PCNs established across our eight “health” localities in Sefton. One PCN covers two of our localities – Crosby and Maghull
- Initially established in April 2019 through a local NHSE scheme which was then adapted to meet the requirements of the national scheme which commenced on July 1<sup>st</sup> 2019



# Sefton's 8:3 Locality Model



- The map highlights Sefton's 8:3 locality model which includes:
- **8 Health localities** (covering 7 PCNs) based on 30-50,000 populations
- **3 Council localities** based on equalised demand and serving increasingly larger population footprints, from 55,000 in the South to 120,000+ in the North
- **4 Health localities** (with 4 coterminous PCNs) are in **Southport & Formby** and align to the Council's North locality (turquoise border)
- **4 Health localities** (with 3 PCNs) are in **South Sefton** and align to the Council's Central and South localities (orange and green borders)
- Partner services are aligned to the 8 or 3 locality approach – **the goal is to strengthen working relationships across partners so that there is a seamless offer for local people**

# Sefton PCNs

## PCN Clinical Directors

South Sefton PCNs	Clinical Director
Team Bootle PCN	Dr Catherine Aspden
Crosby and Maghull PCN	Dr Craig Gillespie ( Deputy Director Dr Pete Chamberlainlink for Maghull)
Seaforth and Litherland PCN	Dr Sandra Oelbaum
Southport & Formby PCNs	Clinical Director
Birkdale & Ainsdale PCN	Dr Simon Foster
Formby PCN	Dr Doug Callow
North Southport PCN	Dr David Smith
Central Southport PCN	Dr Tim Irvine



# Progress so far – getting established

- Governance arrangements established and Clinical Directors appointed
- Managerial support in place and CCG/PCN support team identified
- Initial PCN plans in place and accessing NHSE support
- PCN involvement in Sefton Transformation Programme and Provider Alliance
- Clinical Directors meeting established to develop collaborative working across PCNs
- Data and budget packs in development to enable focus on population health management



# Progress so far: Team and service development across Sefton PCNs

- Innovative medicines hub model established across all PCNs
- Social Prescribing Link Worker service commissioned from Voluntary Community and Faith sector commencing Jan 2020
- Extended Hours service in place
- Development of integrated care teams including piloting of social care link workers in three PCNs
- Practice Participation Group (PPG) development in conjunction with Healthwatch Sefton



# Individual PCN priorities

South Sefton PCNs	Initial areas of focus
Team Bootle PCN	Bootle No Wrong Door - integrated care team pilot, access to mental health services, GP recruitment and retention, collaborative flu vaccination, families in crisis or complex needs, social prescribing, medicines hub, PPG development and community engagement.
Crosby and Maghull PCN	Focus on dementia, older people's care, end of life care , digital innovation, integrated care team pilot, GP recruitment & retention. PPG development and community engagement. Non-fatty liver disease project, medicine's hub, social prescribing.
Seaforth and Litherland PCN	Future employment models, additional roles such as physician associate and physio, safeguarding, mental health, social prescribing, medicines hub, early cancer diagnosis, housebound service, development of patient engagement activities.





# Individual PCN priorities

Southport & Formby PCNs	Initial areas of focus
Ainsdale & Birkdale PCN	Different models of collaborative working for GP resilience, skill mix, acute visiting scheme, medicines hub, social prescribing, integrated care team pilot
Formby PCN	GP sustainability & workforce, patient engagement, social prescribing, medicines hub, partnership working, digital innovation.
North Southport PCN	Medicines hub, social prescribing, exercise and dietary advice, care homes, older people, future models of PCN working, integrated care team working
Central Southport PCN	Sustainable working within the PCN, flu vaccination nursing home project, care homes, homelessness project, social prescribing, medicines hub



# Summary

PCNs are new and need time to develop, however they present a significant opportunity to strengthen our collective ambition to support the sustainability of general practice, integrate care and improve the health and wellbeing of local people.

PCNs are keen to work alongside local communities and partners to make this a reality.



# Contacts

Any questions or queries, please contact

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