



## **Primary Care Networks: exploring primary care commissioning, contracting, and provision**

### **Telephone survey two: PCNs and COVID-19**

**Lynsey Warwick-Giles**

**Jonathan Hammond**

**Kath Checkland**

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## Introduction

This short report comprises data collected between August and December 2020. Data is from eighteen qualitative telephone interviews with Clinical Commissioning Group staff from across England. All commissioners had previously been interviewed during 2019 to explore the development of Primary Care Networks (PCNs) (see interim report). The purpose of the telephone survey was to try and understand the role PCNs had played in response to the COVID-19 pandemic; focussing on whether the pandemic had influenced and shaped the development and operation of PCNs and whether PCNs had worked collectively or as individual practices in their COVID-19 response.

## The role of PCNs during the COVID-19 pandemic

Commissioners referred to a number of different roles PCNs had performed in response to COVID-19. The most commonly identified roles were the creation of hot and cold COVID-19 sites (8/17) and the formation of buddy/sharing practices (6/17).

### *Hot/cold sites*

Hot sites are restricted areas that are specifically for COVID-19 or suspected COVID-19 patients, providing patients with a place to see a clinician, if required. The establishment of hot and cold sites varied across different CCGs and PCN groupings. Factors shaping the establishment of sites were geography, practical issues, and experience of the PCNs and the intentions of the local commissioner. Four of our CCGs described the PCNs as leading the establishment of hot hubs. Within these sites, their operation was influenced by either the PCNs themselves or the geography in which the PCNs were situated.

*Our inner city practices in [xxx] have a more fragile infrastructure which is why the walk in centre was taken over. They saw more activity than other areas because they served some of the more at risk groups (BAME). In the [xxx], larger but more rural. They were more automatically socially distanced. They had a lower footfall but the hot hub was implemented to protect the practices and keep them as cold sites. We changed the offer as the pandemic evolved as the number of appointments were not required and this was taking resource away from general practice. IDNS2.9*

Three commissioners described the introduction of hot hubs as a combined effort between PCNs and other system partners. One commissioner suggested that PCNs did not have the system knowledge to be able to deliver the hot sites alone. In one area, the CCGs commissioned the GP Federations to establish hot sites, with PCNs choosing to support the service through the provision of staff. The value of the hot site was felt in general practice, enabling them to focus on the services they needed to deliver.

*...We had 2 hot hubs that were set up by the GP Federation. PCNs were encouraging their staff from within their practices to support the delivery of services in hot hubs & looking at the data to make sure that hot hubs are still required. The CCG stood down the hot hubs when they were no longer required but the PCNs continued to fund them directly to keep them going. They wanted more time to get services running in practices before they started seeing hot patients in their own practices. IDNS2.26*

Only two commissioners reported that no hot sites were established within their area. The local approach taken was to continue to support general practice.

#### *Sharing/buddying practices*

This approach taken by PCNs was to ensure practice resilience. PCN practices were able to share their staff to help other practices if members of staff became ill or were isolating. In some practices the main staff support was for administrative staff. The purpose of creating buddy practices was to provide business continuity, supporting neighbouring practices and deal with on-going pressures.

*We established a structure: GP co-ordination group (chaired by the CCG) & then we have 5 PCNs... Underneath the GP Co-ordination group we had a daily huddle that was across the PCN footprint. A daily phone call for all the practices from the PCN, escalate issues, discuss things, get information etc... Through that we have provided IT updates, PPE pathways to help with ordering, we did some work on resilience so they knew who their buddy practice was (mainly admin staff). IDNS2.12*

#### **The varied approaches taken by PCNs to the pandemic**

Thirteen interviewees spoke of the variation and the notable differences that were taken by PCNs when responding to the pandemic. One CCG commented on the way in which people describe PCNs as a thing, whilst acknowledging that in effect they are currently a single person, a Clinical Director.

The variation of PCNs was not a surprise to commissioners; six respondents spoke of the variation and differences in maturity, prior to COVID-19 and the influence this had on the PCN response to the pandemic. PCNs are not homogenous they have their own identities and are not necessarily a single solution to system problems. It was suggested that the more mature a PCN was, pre COVID-19, the more it enabled them to be in a better position to work collaboratively with others.

*It was all there before covid. We have a history of collaborative working which meant we have some PCNs that work really well together and others that are a PCN but their biggest task is how to share the PCN budget across the member practices. Consequently, this impacted on covid-19 responses. The more mature PCNs were in a better position & could work more collaboratively with others. IDNS2.27*

Furthermore, the maturity of the PCN influenced the amount of support that was required from the CCG. The COVID-19 pandemic shaped the development of PCNs in different ways, providing some with opportunities, whilst others struggled to move forward.

*This isn't unsurprising, all PCNs are in different places in terms of their evolution & maturity. We have seen what we would have expected to see in relation to their maturity at that point. For some, it has fast tracked them. Enabled them to work together. Those that were mature have got on with things, setting up primary care treatment centres and frailty work supported by the CCG. For those where relationships were strained, they have struggled to move that forward. IDNS2.37*

When discussing PCN variation, one commissioner discussed different factors that had influenced PCN evolution including geography, inexperienced leaders, PCN governance arrangements and the number of practices that make up the PCNs. For example, PCNs that comprise of a single practice will have simpler and more straightforward governance arrangements in place, for employing staff

and dealing with finances. No arrangements or agreements need to be in place, to decide how staff time and resources are shared. With regards to the COVID-19 response, geography and the patient population for each PCN will have potentially added more pressure. A number of these influencing factors are outside of the control of the PCNs, however, they will have informed the response to the pandemic.

### **Additional Roles and COVID-19**

Twelve commissioners informed us that some of the additional roles had been utilised differently in the COVID-19 response. Three commissioners described how pharmacists had been used to increase practice resilience and keep non-COVID work going. Nine commissioners discussed the role of the social prescribing link workers and how they had worked with the shielding patients, proactively calling them, sign posting them to support services and escalating to primary care where necessary. Pre-COVID there was a lack of understanding of their purpose from some PCNs. However, the work they have done with the shielding patients and being proactive with population health management systems during the pandemic has demonstrated their worth.

*Social Prescribers have been active with the shielding population. This has taken the pressure off general practice. They have shown what they can do which wasn't understood before. They [the PCN] are now keen to employ more social prescribers into the ARRS. IDNS2.26*

### **Conclusions**

The heterogeneity of PCNs is an important defining characteristic and this has been illuminated through the COVID-19 response. COVID-19 can be seen as an uneven catalyst for collaborative working, potentially intensifying the imbalance between PCNs founded on strong, functional collaborative relationships and those where such relationships are underdeveloped or difficult for historical reasons.

The PCN COVID response has been largely GP focussed and inward looking, comprising of ensuring that general practice was sustainable and manageable throughout the pandemic. Little reference or comment was made about working with other system partners when responding to the pandemic. CCGs have played an important role in supporting PCNs, particularly where the PCNs are less well developed.

The pandemic provided an opportunity to influence how people worked together and illustrate potential workforce skills that were not fully understood in general practice prior to the pandemic. COVID-19 has demonstrated the value of some of the ARRS roles, in particular the Social Prescribing Link Workers (SPLWs). This has led to SPLW role being perceived more positively and in some areas, increased the recruitment into these roles.