PCN Network
NHS Confederation

NHS Leadership Academy
North West

Lancashire and South Cumbria – PCN Futures Programme

Building Primary Care Voice at Place and System Level: Insights and Recommendations

January 2022

Contents

Background and Context

This paper explores the role of Primary Care Networks (PCNs) in the health and care system, and in the context of the emerging Integrated Care Systems/Partnerships (ICS/ICP). It seeks to offer insights and make recommendations for exploration and action, based on working over a period of several months with PCNs and with Clinical Directors (CDs) in five places:

- **Fylde Coast**
- **Central Lancashire**
- **West Lancashire**
- **Pennine**
- **Morecambe Bay**

The Lancashire and South Cumbria (L&SC) PCN Development Oversight Group commissioned NHS Confederation and NHS North West Leadership Academy to lead this engagement exercise and the content included within this paper is owned by L&SC PCNs.

In summary, this is an emerging picture – most responses to our inquiry to date have been from the Fylde Coast, Central Lancashire and Morecambe Bay, and the paper will be updated as new knowledge and insights from these and from Pennine and West Lancashire develop over the coming months.

Each PCN is at a different stage in its development, with different levels of experience amongst the CDs and different relationship histories across the networks which serve very different local populations. It follows that there will be no 'one-size-fits-all' formula for determining the role of PCNs within the developing system, nor for defining one shared overall vision of success or determining, in pursuit of that vision, how PCNs can best 'plug-into' the ICPs and ICSs in their locality.

Nevertheless, the work with the PCNs has enabled the identification of commonalities. These themes are presented here with recommendations for actions which will support:

1. The identification of 'design principles' for PCNs as they develop their role, influence and vision.
2. The shaping of the role of PCNs within the developing system.
3. Shared understanding of the benefits and value of PCN engagement with communities and VCFSE organisations.
4. Clarity around 'what good looks like' in relation to effective PCN working in and with ICPs and about some of the benchmarks for clinical and managerial leadership.

"*The extent to which PCNs have progressed has been contingent on good leadership capability, a history of strong local relationships and a clear vision of what they want to achieve and how to use the contract as the vehicle to deliver it*."[i]

This is a reasonable starting point but needs further analysis based on experience with a cluster of 5 PCNs. For example, what kind of leadership is needed, at what levels in the PCN? What does good look like in terms of local relationships between primary care and partners across the system? Clarity of vision is essential to the PCN but must also be understood by those working with primary care and that clarity must extend to the roles and accountabilities of CDs.

These questions are explored in the thematic analysis below. Over-arching themes are further analysed into sub-themes, with each section outlining recommendations for continued exploration and for action. There is overlap between themes and this is reflected in suggestions for action.

Method

Data to inform the recommendations in this paper were gathered and analysed from a number of sources:

- Meetings and facilitated sessions with the networks and network leaders
- Survey responses from individual CDs
- Background papers to test the findings and spot any anomalies

Themes emerging from these sources were collated and triangulated using both data triangulation and investigator triangulation, the latter through a series of meetings with the expert facilitation team.

Theme 1: Leadership

The importance of leadership to the development and influence of PCNs is mentioned by most contributors, but this begs a series of questions: what is meant by leadership? What kind of leadership is most important? How should that leadership be developed and supported?

CD Role

In taking up a leadership role as a CD, clinicians need to be clear about the expectations they hold of themselves, and others hold of them. A survey of CDs in Morecambe Bay showed that despite considerable experience as GPs, and an average of 1-3 years as a CD, many still felt there was a lack of clarity about the expectations of the CD role. They located that confusion outside themselves and the PCN. A typical comment, then:

"*I am clear about my role…(however) others…think CDs can be the go-to person for almost every new initiative*".

Respondents identified a risk that the CD role could try to be all things to all people and in the process become ineffective. This could be compounded by the changing context in which the CD role is developing; the degree of uncertainty and flux in the system as a whole means that inevitably, role boundaries may be blurred initially. Equally, the precise balance of tasks and functions within the role may vary depending on the maturity of the PCN and local need. CDs must balance their attention between place (looking inwards) and system (looking outwards). They must also balance the tension between the needs of the practices and the GPs they represent and the demands from the CCG/ICS.
One CD commented:
"(my role) is to represent my PCN practices and the PCN Collective interests, (but) there is challenge….there is often a drive from CCG/ICS to push PCN population care but a resistance from some of the practices I represent as they simply do not have the resource, willing or resilience to fulfil the ask…is my primary responsibility to practices that elected me in position or to the demand from ICP/ICS/CCG that drive targets and feel PCN are the modality to implement their strategies?"

That isn't an exact science: the balance will shift depending on local and system priorities, and on the interest and focus of CDs themselves. It is important therefore for CDs to see this as a collective, as well as an individual, challenge, to be explored through the network of networks.
There is a necessity therefore for CDs to establish, in dialogue with external partners, clear boundaries from the start of taking up a CD role. Clearly that clarity will be facilitated by collaboration amongst CDs so that mixed messages aren't inadvertently transmitted to those 'on the receiving end'.

Clinical Leadership

Clinical leadership is highlighted as one of the most critical elements of PCN and CD development. The role of the CD is expected to provide "..*strategic and clinical leadership to the network, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices*". So, we can define clinical leadership as leadership of and on behalf of member practices and practitioners, and, in the context of the PCN and the ICS, strategic leadership.

This is contrasted with operational leadership in the work of the PCNs which best describes the management and governance tasks required to fulfil the role of CD. Time required on managerial or operational leadership is frequently under-estimated and given that funding for the CD role only covers 0.25 WTE, it can quickly become a barrier to CDs taking up a more strategic leadership role. As the NHS Confederation points out, many CDs have had little or no management help to date.
"*I do feel we need the system to offer tangible support to PCNs/CDs with management support and help*".

So, there is an important focus of support and development in helping CDs develop the strategic leadership aspects of the role and not get diverted into the management, technical and administrative elements where some may feel more comfortable in any case.

Collaborative Leadership

Collaboration is the bedrock of system working. It takes time to develop and sustain, particularly in a system which has encouraged competition for resources and between different parts of the same system. Experience in developing collaborative leadership approaches teaches us that a) the skills of collaborative leadership have to be learned and b) it takes time. Technology has enabled collaboration in some, significant, ways: for instance, virtual meetings have allowed people to join and engage from different locations, and data-sharing will continue to be facilitated in the coming months and years through digital advances. Data-sharing is an enabler but won't in itself drive collaboration. Collaboration is built on trust – it's likely that in networks with clinicians who have worked together over many years there will be higher levels of trust and therefore potentially more confidence for CDs in acting on behalf of the network. How can newer CDs accelerate that process, given that, as the NHS Confederation points out, more than half of CDs are in their first clinical leadership role.
Research by The King's Fund found that collaboration in general practice was most successful when it had been generated organically by general practices over a number of years, underpinned by trust, relationships, and support, and where there was a clear focus and agreement on the role of the collaboration[ii].
Equally, collaborative leadership is required across the wider ICS. System leadership emerges as a connected but separate sub-theme in terms of actions and development.

System Leadership

The fundamental principle of an ICS is that the system must operate in a more integrated way with leaders connecting across structural, professional, cultural, and geographical boundaries.

To be effective in the system, PCN leaders must be adept at working collaboratively in complex, adaptive systems: working with multiple stakeholders in volatile, uncertain environments to design and deliver healthier healthcare systems which improve outcomes for local populations.

As noted earlier,

"*Local systems range widely in size, complexity and stage of development and will need local solutions that are developed at different speeds in different places*"[iii]

Systems leadership involves a radical re-thinking of how services are designed, coordinated and delivered. Therefore, as well as building technical skills and capability, development must pay attention to the need for:

- **Mind-set change**: to shift people's mind-set from competition to collaboration.
- **Behavioural change**: to move from a focus on speeding up the pace to the development of longer-term, more relational leadership approaches.
- **Building relationships**: through facilitation of connections and collaborations in real time and in real work.

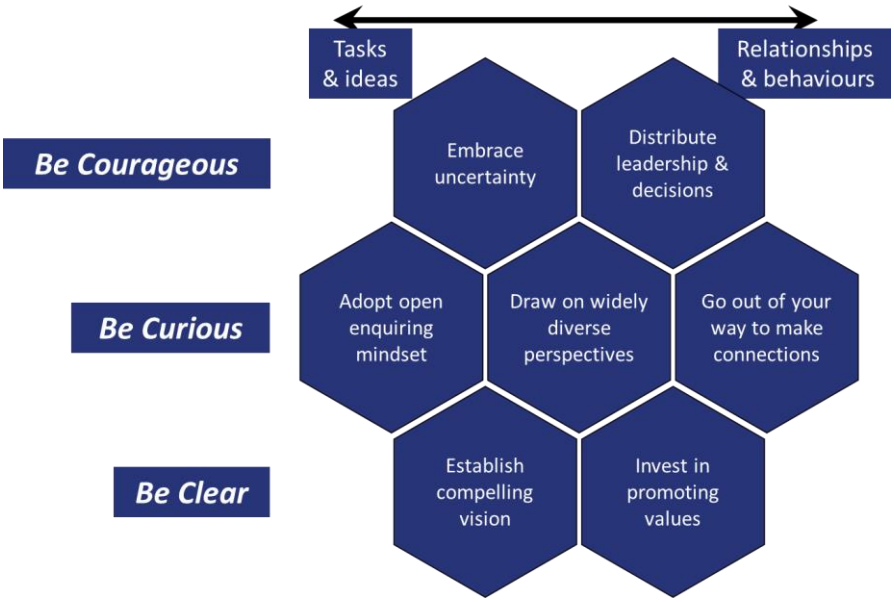
The characteristics of those who can lead effectively in uncertain times have been well-researched and documented.

Welbourn and colleagues summarised vital system leadership attributes as clarity, curiosity, and courage, and identified a series of leadership behaviours to support systems approaches.

Of course, these apply to all those taking up leadership roles in the health and care system but there is a particular significance for CDs, since clinical practice often focuses on specialisms, and medical training supports having answers rather than embracing uncertainty.

The development of skills required to work effectively in a system (as opposed to practice or individual) context is often most effective when delivered collaboratively. This implies finding opportunities for CDs to come together to learn from and with each other.

There is some reason to believe primary care leaders can be adept at working across systems boundaries, connecting and collaborating because that is key to primary care effectiveness, and this may well be an area where CDs bring added value to the ICS through modelling system leadership behaviours.



Resilient Leadership

Many respondents made the point that leaders in the health system generally, and perhaps in primary care in particular, are facing unprecedented levels of stress with a host of causes, leading to burnout.

There are two key aspects of this observation which are relevant for CD development:

1. Providing coaching support to CDs to develop capacity and capability to cope with the additional pressures of the CD role
2. Succession planning for future CDs. CDs have a role here and this also must be central to the PCN strategy and vision.

As noted earlier, collective leadership approaches can also add value. This might imply developing collaborative approaches to attending meetings (one CD representing their own, and other places for example) and spending time building trust as a necessary precursor to partnership working at all levels.

"(One of my biggest priorities) is helping colleagues achieve a better work-life balance. The PCN was meant to increase the workforce into primary care. We have started employing ARRS roles, but they need to be trained and embedded and supervised - this takes 6-12months minimum."

Chairmanship, Engagement & Strategic Vision

The role of the Chair is critical, in the development of the PCNs as a thriving space in which multiple perspectives can be heard and a shared vision defined. Chairing skills – which incorporate facilitation, convenor, communication, engagement, influencing and effective meeting management – are often learned 'on the job' and yet where PCNs are seen to be working well and developing collaborative relationships both internally and externally, the role of the lead clinician as chair is often cited, particularly in the context of the network of networks.

The lead CD has a particular role in helping the network define a collegiate approach and a strategic vision: one which is meaningful to all stakeholders, ambitious and rooted in the needs of the population served by the network of networks. But to an extent all CDs need to be skilled at facilitation since their role on the PCN calls for an ability to gather, synthesise and represent not just their own views but those of colleagues across the network.

One suggestion that has started to emerge from the work with PCNs is that the leadership concerns and interests of CDs may lie more in the technical and managerial aspects of the

role and less in the strategic, visionary functions, so that this is an area where development support may be called for, both to develop capability and to understand why this is needed.

More pressingly, while a few CDs expressed confidence in the existence of a shared vision within the PCN, most said they were 'somewhat unclear' about the shared vision and there was widespread recognition that communicating the vision and purpose of the PCN across the wider system and understanding the role of the PCN and CDs in contributing to the wider system vision was not without challenges. Likewise developing a shared vision at network of networks level which is inclusive and coherent is key to maintaining a strong primary care 'voice' and countering any hint of 'divide and conquer' approaches in the wider system.

Recommendations for Leadership:

1. Clarity about the leadership function of the CD role. It is often confused (by CDs themselves) with management tasks. The leadership aspect is strategic, centred around developing, and helping the network of networks to develop, a shared vision, purpose and ways of working together.
2. Use a method such as Lencioni's 5 Dysfunctions model to explore the characteristics of effective collaboration such as trust, accountability, and conflict management. The Thomas-Kilmann index is useful here. Conflict is inevitable and not a sign that collaboration isn't working, although it can feel like that for new CDs.
3. Ensure CDs are included in wider system leadership development opportunities such as Leading for System Change, and that they have access to collective development around systems leadership and systems thinking, as well as opportunities to share their leadership approaches.
4. Encourage CDs to undertake system mapping, to gain further insight into the wider system. Mentoring and buddying schemes can be particularly valuable for CDs new to leadership, and peer coaching builds capability as coach and coachee.
5. Develop a role profile for the Chair of the Network of Networks
6. Define and widely socialise a shared vision, which belongs to all the PCNs at place and at system level aligned to the overarching ICS vision.

Theme 2: Building Relationships Across the ICS

"*For PCNs to be successful, they will need strong local partnerships with community, acute, mental health, local authority and voluntary services to deliver care to local populations*"[iv].

Partnership Working

Frequently when inquiring about partnership capability and the quality of local relationships CDs focus on the acute sector - this may be a reflection of the perception that hospitals are viewed as the main 'player' in the ICS, with many having incomplete knowledge and awareness of what primary care can and does deliver.

Several respondents expressed a need for primary care to be on a 'level playing field' with an implication that this hasn't always been the case. To be equal partners, PCNs must be able to act in concert, in a way that hasn't always been evident. Partnership working is as much about how the network of networks collaborates (internal partnership) as about how primary care takes up a role in relation to the ICS.

"*I am clear about my role. It is the view of external bodies and others who think CDs can be the go to person for almost every new initiative. This is not the case and education of others is needed."*

Partnerships with the voluntary, community and faith sector are also critical and one of the hallmarks of effective PCNs. This is key to the notion of creating a sense of a 'primary care community', rooted in and responsive to the needs of local people.

Survey respondents identified significant challenges in partnership working. Relationships can be summed up as a 'curate's egg' – good in parts, and across some partners.

Role Clarity

In order to develop strong relationships with colleagues across the system, CDs need to be clear about their role and they also need to know that others in the system are clear. This is particularly the case for those new to the CD role, who need to take time to understand prevailing politics and power.

On the Fylde Coast it was noted that "*there are different interpretations of the CD role*". In Morecambe Bay CDs expressed more confidence about the requirements of the role: "*I know exactly what's expected of me and what I expect from others*" but that clarity wasn't necessarily shared by others, calling for a need to widen "*knowledge of what PCNs/CDs can and cannot do as we move forward*".

The London-wide LMC advises CDs, "*In some areas, commissioners are offering their view on the responsibilities of the role/producing JDs….we recommend that you do not agree to a role description that goes beyond the responsibilities negotiated nationally and cannot be delivered within the resources made available through the nationally-agreed contract*".

With role clarity comes a recognition that the CD role must look beyond the immediate needs of the practice. The CD role is centre-stage but, as one respondent pointed out, " *we need to move beyond practice-centric attitudes*" to considering the needs of the wider PCN.

Working with the VCSE

There is a sense that PCNs are well-placed to support the engagement of the VCSE in the system, that is, to partner on delivering a shared vision for local populations. Then too there is acknowledgement that while relationships are often characterised as good, or even excellent, between primary care and VCSE organisations, they could deliver more if they were developed to their full potential. This requires real knowledge of the sector, the range

and scope of offers and the ways in which the sector is working to address health inequalities and the wider determinants of health.

Working with the ICS

The majority of respondents to a specific question on relationships with the ICS characterised them as '*poor*'. Several respondents reported challenges in engaging with the ICS, characterising it as "*invisible, remote"* or *"not engaging with us (in primary care) in a meaningful way*".

Some framed this as a structural issue. "*There's no clear structure for primary care to have a voice (in the ICS)*" while others located the issue at least partly in the lack of a unified approach from the PCNs and constituent practices.

"*There has to be full engagement from each practice in the PCN…some do not seem to be fully committed* (*to the approach*)."

Respondents have noted the plethora of meetings and the need for clarity around representation, which is addressed in the next section.

However, a resounding theme from the data so far gathered is the desire for the ICS to fully appreciate what primary care can offer in the healthcare system, and some recognition of the value the PCNs can provide through extensive local knowledge at place level.

"*There has been poor communication…(and) little appreciation of what good looks like at local level*."

Alongside this theme, a common thread in responses was the need for primary care to be an equal partner, and for the ICS to acknowledge this, against the background of a continued emphasis on hospital settings.

"…*every document (from the ICS) seems to focus on hospitals…(there's) little appreciation for the problems we face in general practice*."

Recommendations for Building Better Relationships:

1. Ensure the CD role profile is clear, not only within the PCN, but for stakeholders in the acute and VCSE sectors.
2. There is potential for developing a behavioural compact to support partnership working. This goes beyond a specification for the purpose and outcomes of partnership and looks at the behaviours that support true partnership working. See also the Partnership Profile Tool (attached) for specific partnering opportunities.
3. Use networking tools such as RCTs to develop relationships across the wider system. These can be done virtually and build connections between CDs and other leaders in the healthcare system.
4. System mapping, with other partners, can help to identify where people are not system-sighted and where there are gaps in knowledge.
5. Ensure there is a reach-out to the VCSE sector which enables the articulation of what the sector can offer, particularly in relation to co-production, social value, and patient engagement.
6. Find ways for primary care to work alongside ICS and acute colleagues to develop a shared understanding of each other's 'worlds. Spaces for listening, perspective sharing, or similar tools could be very well-used.

Theme 3: Management & Technical Priorities

Whilst it's arguable that many of the challenges arising for CDs in PCNs as they develop their role and influence within the wider system are relational – and the recommendations have a strong emphasis on this – there are immediate management issues and technical challenges which need to be addressed.

Management & Administration

As already noted, administrative support for CDs is vital.
"…*tangible support - financial and staffing - with named individuals to help PCNs would be very helpful*" said one respondent.

Some PCNs have recruited to management posts under the ARRS but there have been practical issues. "*We don't have the physical space for ARRS roles*" commented one respondent. This sub-theme includes a focus on workforce, recognising that people already feel stretched after long months dealing with the pandemic and that there are resource gaps. At the same time as managing the workforce as-is there is a need to look to the future, to succession planning and growing the next generation of CDs, as we have noted.

Technology

A further element of this theme is the use of technology to support improvements in the way services are delivered in primary care. Covid-19 has been an enabler of this process but managing the message is critical. Our experience suggests that CDs have been proactive in the use of technology to support development, with virtual meetings showing high levels of engagement. However, remote working is a steep learning curve for everyone and there is the opportunity to do more and be more effective in the use of technology to support CD and PCN development.
Alongside this is a clear need to manage the message, given continued public debate about the use of virtual consultations in primary care, for example.

Workforce

Recruiting to ARRS roles is recognised as a key step forward in addressing some of the workforce issues but, as one respondent noted, recruiting to and training staff in new roles carries its own challenges.
"*(We need) a shift in internal processes to account for different types of clinicians and communication to patients - that is a lot of work whilst in the midst of a pandemic and we haven't got through that yet. It is very difficult to look beyond the internal when we are so busy".*

Finance

The common theme emerging in relation to funding and financial issues was the need for clarity about funding flows and resource allocation. Without clarity, the sense that there might be deliberate obfuscation could develop unhindered. Several respondents expressed a need for more knowledge about resources, the potential for resources to be pooled, and the decision-making processes around resources and service design.

Personal & PCN Development

Respondents identified several areas for further development, although a minority felt they had all they needed in terms of ongoing support and development and saw the priority issues to be addressed as structural and administrative.

The priority needs for CD development and support were identified as:

- Management skills (leadership, influencing, negotiating)
- Understanding the wider system, financial flows, policy
- Coaching, personal impact, confidence
- Time management, frameworks for building an effective management team
- Technical tools and knowledge (finance, governance)
- Opportunities to build relationships, networking

Of course, this will vary by individual and by PCN. But it seems clear that in this and other areas there is potential within the network of networks to pool resources.

Recommendations for Management & Technical Priorities

1. There is potential for a skills audit or training needs analysis across the network of networks which could firstly help CDs focus on their own individual development needs, and secondly build awareness of the wealth of knowledge and skill that exists within the PCNs and which is of immense value to the ambition for integrated care.
2. Alongside this, some time out for the PCNs to map the system, develop a shared awareness of the system architecture, and agree the criteria for a 'single voice' perspective versus where diverse views can be not only accommodated but encouraged.
3. Recognise that particularly in relation to the ARRS roles and developing the administrative and management infrastructure necessary to support new ways of working there will be short-term problems which don't negate or derail the longer-term vision. That's not to minimise their impact.
4. Practices could explore how to pool resources, including management resource.
5. Develop a training strategy, and particularly explore coaching/peer coaching as a model for CDs. This would also help to identify strategies for succession planning.

Summary

From the places we have talked to there has been evidence of positive engagement in this inquiry into the ways in which we can build primary care voice, both at place and at system level. There has been clear understanding of the value of this as a purpose, shared recognition of the challenges and frustrations inherent in the undertaking, and a desire to offer solutions that go beyond 'get others to sort themselves out'. There has also been recognition across the system of the immense pressure under which the whole of primary care is operating. Particularly in light of new Covid variants, we know this has impacted on engagement with the process.

Recommendations are presented for discussion, rather than as a shopping-list for action. Some can be implemented fairly readily and at low cost. Others need further exploration to determine feasibility or desirability.

As noted at the beginning of the paper, there is no one-size-fits-all formula. An attempt to identify common themes shouldn't be read as reductionist or an opportunity to ignore the diversity of voices and perspectives shared by those working in primary care to improve the healthy lives of their local populations.

A final recommendation then is that the paper and the recommendations within it are shared widely, so that as primary care develops its voice as a networked group of practitioners, we continue to add to the knowledge of how best to support the PCNs.

September 2021

[i] NHS Confederation PCN Network Report 2021
[ii] https://www.kingsfund.org.uk/publications/effective-teams-general-practice
[iii] https://www.necsu.nhs.uk/wp-content/uploads/2019/02/2018-LettingLocalSystemsLead-NHSFederation-1.pdf
[iv] https://www.health.org.uk/publications/long-reads/nhs-reform

Checklist of Recommendations, identifying who should take lead responsibility, and the resources and tools to support the action.

Recommendation	Lead	Tools & Methods
Produce a clear shared role descriptor for the CD role	CDs/PCN	Sample role profiles
Develop approaches to understanding and managing conflict and to building collaboration	PCN PCN/ICS	Lencioni's 5 Dysfunctions model Thomas Kilmann Instrument
Engage CDs in wider system leadership work & development	ICS NHSEI	e.g. Leading for System Change
Develop system-sightedness for CDs	CDs	System Mapping Randomised Coffee Trials
Build CD networks & system connectedness	CDs	Buddying Mentoring
Produce a specification for the Chair function	Chair/NoN	Sample spec
Define and agree a vision for the PCN	PCN	AI (what does good look like?)
Explore a Behavioural Compact to support collaborative working & clarify expectations	Joint e.g. PCN with ICS/VCFSE	Compact examples
Conduct a skills audit or Training Needs Analysis	PCNs with CDs	Mentimeter
Plan time-outs for the PCN to focus on development	PCNs	Skilled Facilitation
Ensure adequate management & admin support	PCNs	Funding
Explore opportunities to pool resources across networks	NoN	Clear vision Skills audit
Develop a CD succession plan	PCN	CD role descriptor
Develop some positive stories of primary care involvement & value	PCN	Narratives, use cases
Emphasise the impact on patients	CDs PCN	Patient stories, experience