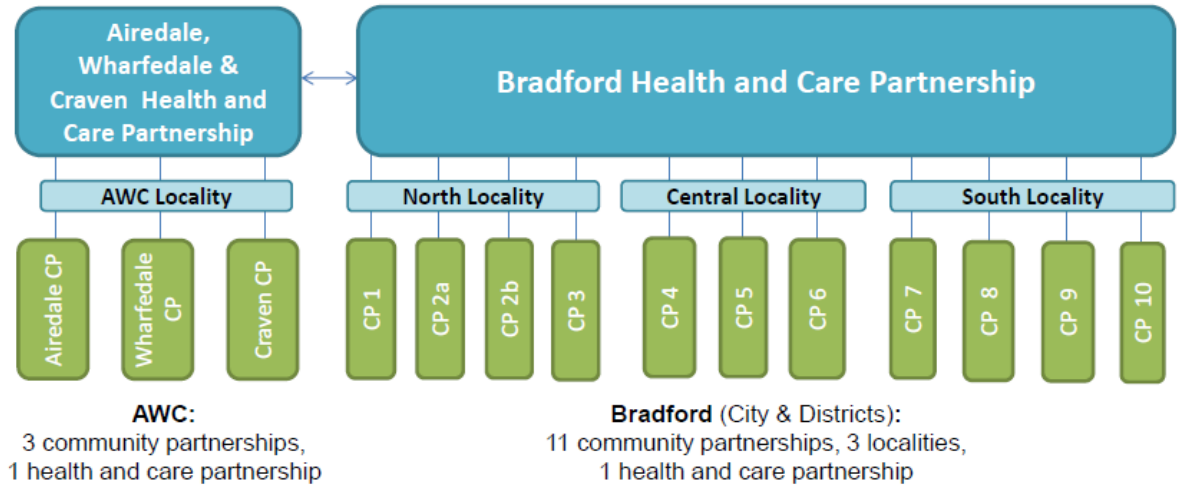
Discussion paper: community partnerships – building blocks to integrated care

Introduction

This document has been written to stimulate debate around the significance of the Community Partnerships (CPs) which are in place across Bradford district and Craven – a model that supports our aspiration to become an integrated care system. This document will be shared with all Bradford district and Craven system partners to invite their insights.

Community Partnerships (CPs)

CPs are Bradford district and Craven's way of delivering integrated community health, care and wellbeing services, through locally led partnerships, covering communities of approximately 30-60,000 people. Across the one locality of Airedale, Wharfedale and Craven there are 3 CPs. Within Bradford there are 11 CPs covering three localities of north, central and south. These were established during 2017 and have been on a developmental journey since then.



CPs have been created to give community-based staff and local people the opportunity to say what is important to them based on local information, to ensure that future health, care and wellbeing services meet their needs. The importance of our CPs is recognised by our entire health and social care system, as they are detailed within the Strategic Partnering Agreement (SPA) as the key building blocks to our integrated health and care system.

Each CP has a community leadership team who are working together to share their knowledge, ideas and expertise to support each other in understanding their roles and how they can work better together to improve the lives and experiences of people in the local community. This new way of working enables CPs to involve and empower their local teams of around 100-150 staff to design, develop and set up new ways of delivering health, care and wellbeing services which they lead on. It provides opportunities for community staff to work in different ways with other organisations. This will overcome some of the long term issues and help us to deliver better care and support that people working and living in communities have told us they want.

The CP leadership teams include people from a variety of health, social care and third sector organisations and include staff from GP practices, community nursing, mental health services, community pharmacy, care homes, home care, voluntary organisations, social workers, the council ward officers, local Councillors and hospital staff. They each have a

Chair and Deputy Chair and there are no restrictions on who can do this role apart from a strong understanding of their communities.

There is a deliberate focus on the holistic needs of our populations, rather than just on the health needs. This is because there is recognition that the wider social determinants of health have a huge impact on the health and wellbeing of our population and communities. We know we can only tackle these if we work together in partnership with organisations not only in health and social care, but those embedded within our communities. This is why each community partnership leadership team member has an equal voice within the team, as there is recognition that not one organisation is more important in supporting our communities than another.

The CCGs recognise that the development of the CPs has been different across our footprint. Some have developed and are maturing at pace, while for others it has taken longer for relationships to develop. This has meant that some have started to implement the plans they have developed for their communities whilst others are still understanding what they hope to do to support their communities.

The CCGs have invested in different ways in the development of the CPs, for example:

- CCG management support
- Development funding to each CP
- Training and development across all CPs
- Self-care champions in each CP
- Organisation Development funding which includes peer workshops and IT portal development
- Utilisation of NHSE funds to recruit dedicated CP project managers and admin support (Bradford) and staff engagement (AWC)

CPs are about system working – GP practices are involved within these and are important. In AWC the CPs were formed within their three natural geographies. Across Bradford, the CPs were formed (adopting the *Primary Care Home* model) primarily around GP practice groupings (affinities) as well as taking account of geographical coherence. GP practices are not (and should not become) the dominant partner within these partnerships – they are equal along with the wider system representatives. The funding allocated to the CPs as detailed above is not for GP practices. Some of this funding may go to practices in recompense for work done or services provided, but the funding is to go where the CP determines, which will also include other partners and to services they provide for that CP population.

Future working as a system

Following the publication of the NHS Long Term Plan and the new GP contract there has been concern locally about the future of our CPs and how they fit with the newly establishing Primary Care Networks (PCNs). There is potential for confusion around the role they each play as, although there are some distinct differences, there are also similarities. It may be helpful to think of Primary Care Networks as being groups of GP practices that are governed and enact their services through a *contract*, whereas Community Partnerships are broad groupings that are governed and enact their services by *consensus*. Additional information on PCNs can be seen in appendix one.

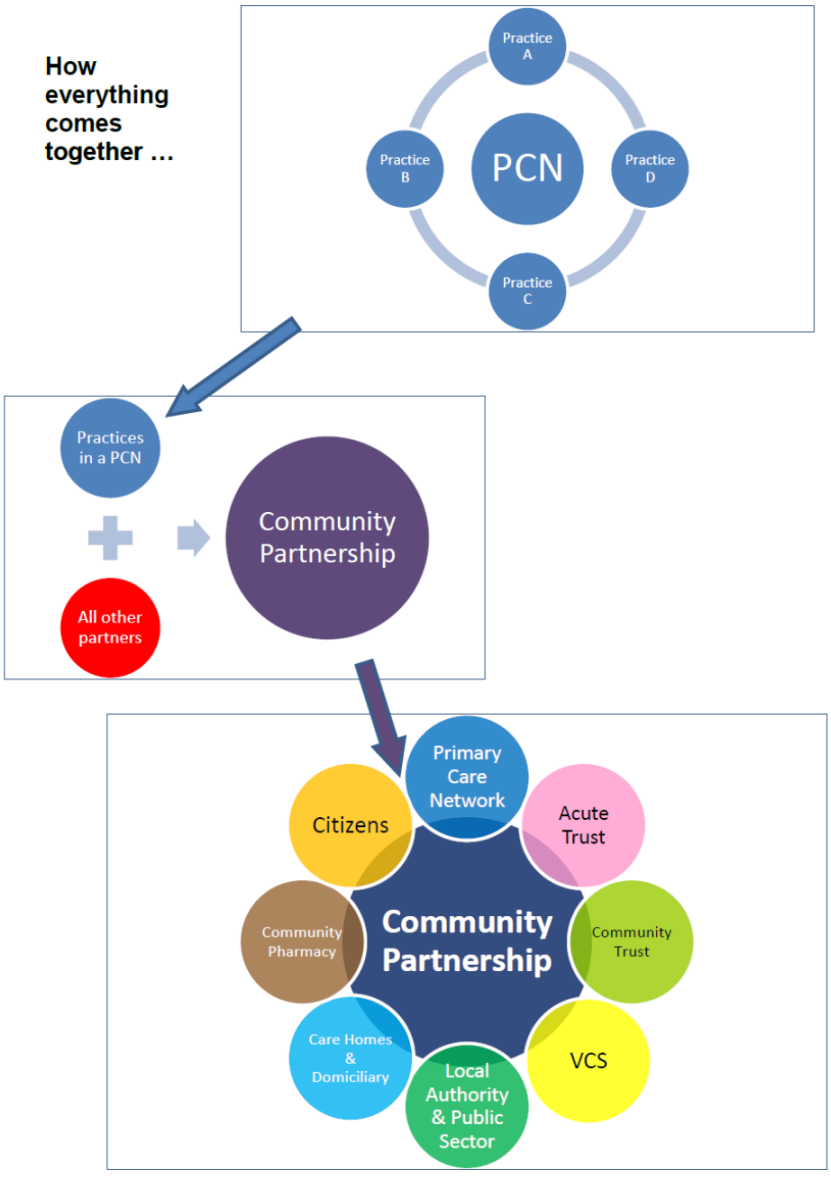
From year two of the PCN Directed Enhanced Service (PCN DES) there is an expectation for PCNs to look beyond the GP practices within their networks and to work with the wider partners that operate within their PCN footprints.

This is where the strength of the approach we have taken in Bradford district and Craven comes in as we already have these established ways of working through our CPs.

The system does not see this as meaning that the PCNs 'take over' the CPs, but they are an important and equal partner around the table as depicted in the image below. This meets the needs of the PCN in regards to delivery of the DES, but also meets the needs of wider system working and transformation as our CPs are the building blocks from which our integrated care system will continue to grow.

Due to CPs and PCNs being two different entities, the Chair of the CP does not need to be the Clinical Director of the PCN even if the footprints they are working across are the same. The Clinical Director would be expected to fully participate in the CP meetings as the PCN is a critical player within the CP, but they do not also need to be the Chair of the CP (unless that is agreed by all the CP partners).

Community Partnerships and Primary Care Networks



Appendix 1 – Primary Care Networks (PCN)

PCNs are set out by NHS England (NHSE) as a Directed Enhanced Service (DES) as part of the changes to the GP contract for 19/20 and were originally outlined within the Five-year framework for GP contract reform published on the 31st January 2019. As the framework is a DES, all practices have a contractual right to sign up to the new Primary Care Network DES which will commence in July 2019.

Although this is a DES, this sets out a new way of working for practices. Individual practices sign up to the DES but the majority of the funding that is allocated to the DES does not go to the individual practices, but to their PCN as a whole (excepting the £1.761 per weighted patient which is paid to each participating practice). Within 19/20 other funding associated with and paid directly to the PCNs includes:

- £1.50 per registered patient to support PCN administration
- £0.514 per registered patient to fund a Clinical Director (9 months funding)
- £1.099 per registered patient for Extended Hours (9 months funding)
- Maximum of £71,923 to fund one Clinical Pharmacist (70% funded) and one Social Prescriber (100% funded) on recruitment to the posts (up to 9 months funding).

In the following four years of the DES, further funding will be available to PCNs around additional workforce roles (Physician Associates, Physiotherapists and Paramedics), extended access, investment and impact fund and seven national service specifications related to: 1) structured medication reviews and optimisation; 2) enhanced health in care homes; 3) anticipatory care; 4) supporting early cancer diagnosis; 5) personalised care; 6) CVD prevention and diagnosis; 7) tackling neighbourhood inequalities.

The CCG is very clear that the funding identified via the PCN DES is for practices (where applicable) and the PCNs. This DES is part of the GP contract and in year one the focus is very much around general practice and getting established ways of working embedded.

Each PCN will appoint/elect a Clinical Director using the funding allocated to them (based on per registered patient). The role of the PCN Clinical Director is specified by NHSE and includes:

- *The Clinical Director will work collaboratively with Clinical Directors from other PCNs within the ICS/STP area, playing a critical role in shaping and supporting their ICS/STP, helping to ensure full engagement of primary care in developing and implementing local system plans.*

- *They will support PCN implementation of agreed service changes and pathways and will work closely with member practices and the commissioner and other networks to develop, support and deliver local improvement programmes aligned to national priorities.*

- *They will develop local initiatives that enable delivery of the PCN's agenda, working with commissioners and other networks to reflect local needs and ensuring initiatives are coordinated.*

- *They will develop relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs.*

It is envisaged that the PCN Clinical Directors will fulfil much of the above by working within the model of the 14 Community Partnerships and 4 Localities.