Item 16

Primary Care Networks: Improving access to services

An overview for Brighton and Hove Health Overview and Scrutiny Committee

October 2023

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1. Introduction and Background

What is a Primary Care Network?

1.1 Primary Care Networks (PCNs) were introduced in July 2019 to improve access to primary care and expand the range of services available. This is achieved through better integration with community services and greater involvement of a wider, integrated primary care team.

1.2 PCNs are comprised of groups of local neighbouring general practices that are a mechanism for sharing staff and collaborating, requiring existing providers of general practice to work together and to share funds on a scale not previously seen in UK general practice, with additional national funding being made available to employ Additional Roles Reimbursement staff (ARRS), to deliver services to patients across the member practices. PCNs are not statutory bodies in themselves, however a number of Primary Care Networks nationally have opted to become legal entities.

1.3 NHS England has stipulated that networks should 'typically' cover a population of between 30,000 and 50,000 people (the average practice size is just over 8,000). There are 39 PCNs across Sussex (6 of which are in Brighton and Hove) and approximately 1264 across England.

1.4 There are 31 practices that make up 6 PCNs in Brighton and Hove. The largest PCN in Brighton and Hove is Goldstone PCN. This is made up of three GP (General Practice) practices and has 78,744 registered patients, followed closely behind by East and Central PCN which is made up of nine practices and has 74,460 registered patients as of July 2023.

1.5 The smallest PCN is Deans and Central PCN which has five practices and 37,109 registered patients. This PCN also provides services to the registered patients of Brighton Station Health Centre as well as the Primary Care Hub (previously known as the Walk in Centre) as of April 2023. All six PCNs are classified as being in areas of significant deprivation and are part of the Core 20+5 approach to drive targeted action in healthcare inequalities improvements.

2. PCN Structures and Governance

2.1 Practices are contractually signed up to deliver the PCN DES (Directed Enhanced Service) at the beginning of each financial year unless they actively choose to opt out. A Core Network Practice participating in the Network Contract DES may end its participation in the Network Contract DES by first notifying the commissioner of its intention to opt out.

2.2 If a practice chooses to withdraw, the ICB (Integrated Care Board) has responsibility for ensuring that the practice's patients have access to PCN services and this is often done by allocating the patients to another PCN, however there are instances where alternative providers of primary care have been sourced to provide PCN services to a practice's registered patients list.

2.3 In cases where a practice wishes to move between PCNs, then a proposal is submitted to the ICB's Primary Care Commissioning Group for approval and would need to demonstrate benefits to patients from the new configuration.

2.4 Practices within a PCN are expected to collaborate, agree and set their PCN's Terms and Conditions including agreed processes for how they manage finances, decision making, how they will work together, and how their services will operate through a document called the Mandatory Network Agreement (MNA). Governance arrangements for PCNs and the content within their MNAs cannot be mandated by their local ICB i.e., PCNs have the autonomy to agree and set out their own internal governance and financial arrangements, making interpretations from the guidance set out in the PCN Contract. ICBs (Integrated Care Boards) however are encouraged to work closely with their PCNs with a view to influencing and encouraging them to make appropriate plans and choices that meet the needs of their local population.

3. PCN Contractual Responsibilities and Services

3.1 The main nationally set ambitions for PCNs are to:

- Take collective action – with system partners – to address the wider determinants of health
- Provide increased levels of joined up and coordinated care
- Become more proactive; using predictive tools to better support people to stay healthy
- Provide a differentiated support offer to individuals, thus reducing inequalities and supporting them to take charge of their own health and wellbeing, and
- Attract and retain a multidisciplinary workforce, supported by the Additional Roles and Responsibilities PCN funding scheme (ARRS).

3.2 To achieve the above ambitions, PCNs have contractual responsibility for delivering nine national service specifications:

- Anticipatory Care
- Cardiovascular Disease (CVD) Prevention and Diagnosis
- Early Cancer Diagnosis
- Enhanced Access
- Enhanced Health in Care Homes
- Personalised Care
- Social Prescribing Service

- Structured Medication Review and Medicines Optimisation
- Tackling Neighbourhood Health Inequalities

Impact and Investment Fund

3.3 The Impact and Investment Fund (IIF) forms a key part of the PCN DES. The IIF is an incentive scheme focussed on supporting PCNs to deliver high quality care to their population. The scheme contains indicators that focus on where PCNs can contribute significantly towards the 'triple aim' of:

- Improving health and saving lives
- Improving the quality of care for people with multiple morbidities
- Helping to make the NHS more sustainable.

3.4 Thresholds and targets have varied year on year since the implementation of PCNs, targets for 23/24 are as follows:

Figure A

Investment and Impact Fund 2023/24: Indicators						
Domain	**Area**	**Indicator**	**Description**	**Points**	**Lower Threshold**	**Upper Threshold**
Prevention and tackling health inequalities	Vaccination and immunisation	**VI-02**	Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2023 and 31 March 2024	113	72%	90%
		VI-03	Percentage of patients aged two or three years on 31 August 2023 who received a seasonal influenza vaccination between 1 September 2023 and 31 March 2024	20	64%	82%
	Tackling health inequalities	**HI-03**	Percentage of patients on the QOF Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	36	60%	80%
Providing high quality care	Cancer	**CAN-02**	Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral	22	65%	80%
	Access	**ACC-08**	ACC-08: Percentage of appointments where time from booking to appointment was two weeks or less	71	85%	90%
			Total Points Available	**262**		

Capacity and Access

3.5 In addition to the standard contractual requirements of the PCN DES Contract as outlined above, April 2023 saw the implementation of the Primary Care Recovery Plan, aimed at supporting local systems and their PCNs/Practices to drive and deliver increased transformation, and resilience across primary care general practice.

3.6 The overall purpose of the Primary Care Recovery Plan and its objectives are to increase access and reduce unwarranted variation in patient experience and choice. It focusses on four central ambitions:

- Empowering patients
- Implementing Modern General Practice Access
- Building capacity
- Cutting bureaucracy

3.7 The Plan included a series of changes made to the GP and PCN contracts and associated funding for 2023/24 which saw the simplification of the PCN Investment & Impact Fund (IIF) i.e., reducing from 36 IIF targets during 22/23 to 5 targets during 23/24 to create opportunity and investment for a new scheme called the "Capacity & Access Improvement" Programme (CAIP). The CAIP requires PCNs and their core practices to plan, develop and deliver several improvements across areas against the following headings:

a. Patient experience of contact:
b. Ease of access and demand management; and
c. Accuracy of recording in appointment books.

3.8 In response to the CAIP, PCNs across the Sussex footprint have been working with their ICBs and practice partners to co-develop and co-own a local improvement plan outlining the approach to how they will achieve the requirements of the CAIP initiative.

3.9 The payment framework for CAIP is set out as follows: -

- 70% of the new CAIP funding will be paid unconditionally to PCNs*, over a 12-month period during 23/24 equating to an average payment across Sussex PCNs of £0.131m.
- The remaining 30% will be retained within ICBs and will be released to PCNs post 23/24 subject to evidenced improvements as pledged in the PCN's CAIP plans.

4. An overview of Brighton and Hove PCN Progress

4.1 Further to the April 2023 PCN Report presented to the Brighton and Hove Health and Social Care Committee, progress, and development across the six Brighton and Hove Primary Care Networks continues, with a key focus on improving access to general practice underpinned by the CAIP scheme as outlined above, as well as maximising all available opportunities for delivering the Primary Care Recovery Plan.

Support opportunities available to Brighton and Hove PCNs

4.2 PCNs across Sussex are routinely supported by the ICB as well as NHS England to access and sign up to various developmental and educational opportunities available.

4.3 Opportunities range from the following suite of programmes and developmental offers as outlined in Figure B below:

Figure B

Name of initiative	Details
GP Improvement Programme (GPIP)	• Introduced as part of the delivery plan for recovering access to primary care in May 2023. • Two-year programme running between 2023-2025 • The programme supports practices and PCNs over to make changes and improvements to how they work, maximising the use of all staff roles and local services, meeting the needs of patients, and providing safe, equitable care.
Redmoor – Digital Solutions for advancing telephony.	• Programme of support aimed at developing digital telephony systems, to improve access, manage demand and operational flows.
Care Navigation	• Training for reception staff and care navigators who will be involved in triaging requests to the correct clinician or service for the patient.
Clinical and Estates Strategy Development Programme	• The programme aims to bring population health improvement and integration into estates planning. The focus is on identifying the information needed to create a Population Health Vision which covers population health challenges and inequalities. • PCNs will then develop and deliver the models of care needed to deliver the changes in population health.
PCN Leadership Programme (NHS Confederation)	• A Leadership Development Programme for PCN leaders, run by the Health Systems Innovation Lab (London South Bank University) in partnership with the NHS Confederation. Participants learn and apply new knowledge with their peers to the challenges they face both immediately in the coming winter but also for the future. Focus is on: • Developing the relationships needed for local and system integration. • Working collaboratively on PCN and cross-PCN level system change to support improved population health. • The programme focuses on the development of a model of primary care, in line with the Fuller Stocktake review, to secure the benefits of integration for our local populations.
Kings Fund Programme	• The King's Fund have been commissioned to undertake some action learning sets for staff within a PCN to explore how they work together on a range of projects and to agree actions to take forward, examples include making the most of the ARRS roles, the utilising the Investment and Impact Fund, and successfully delivering implementing Capacity and Access.

4.4 Across Brighton and Hove, the majority of PCNs are either signed up to one, or more, of the above opportunities. A review of how these programmes have directly impacted the participating PCN and increased successful delivery of services will be included as part of a six-month evaluation of PCNs across Sussex that is due to take place later this year. Further details on this can be found on page 14.

4.5 In the meantime, the PCN spotlight story below demonstrates a good example of how a Brighton and Hove PCN is progressing and taking advantage of available offers to support them in their development and maturity, resulting in an innovative and proactive PCN that is consistently seeking to improve services and patient satisfaction.

PCN SPOTLIGHT – East and Central Brighton PCN

4.6 East and Central Brighton PCN are committed to the Five Ways to Wellbeing – Connect to Others; Stay Physically Active; Keep Learning; Help Others; Be Present.

4.7 They have developed a programme of weekly activities ranging from art, Tai chi, yoga and crafts aimed at helping patients increasing their wellbeing and improving their mental and physical health. The activities are free and take place at locations across the city. They are operated on a 'drop in' basis and facilitated by expert tutors and teachers. The Activities provide opportunities for patients to chat to a range of PCN Staff such as physiotherapists, pharmacists, mental health advisors and occupational therapists. If the team of specialists are unable to help with a matter that requires an alternative clinical or social care opinion/treatment, they also provide onward signposting to the other professional or service.

4.8 One example activity is the free *Mindful Movement Outdoors* (Qi Gong) and *Talks on Trauma/Mental Health*, every Tuesday held in East Brighton Park. A brief description of the drop-in Qi Gong session is that it is a form of gentle exercise composed of movements that are typically repeated. It is suitable for beginners and the sessions are led by a qualified tutor and take place outdoors at East Brighton Park.

4.9 After the mindful movement session, local GP and PCN Clinical Director (Dr A. Fazakerley) gives talks on trauma and mental health support.

4.10 This PCN also commissions several charities, such as those highlighted below:

- Amaze -A charity for families with disabled children and young people living in Sussex, offering a weekly cuppa, cake, and chat at St Cuthmans Church, BN2 5HE and Parish Church of the Holy Cross, BN2 6BD
- ADHD Aware - A charity supporting adults impacted by attention deficit hyperactivity disorder. Sessions are held monthly offering peer support drop ins and group discussions.
- Cascade Recovery - A peer led community of recovering people, offering recovery coaching and drop-in groups, including peer support, yoga, mindfulness, art, drama, and choir.

Enhanced Access Services

4.11 All Brighton and Hove PCNs continue to offer Enhanced Access Hours to registered patients of their PCN's practices. PCNs are commissioned to provide appointments between the hours of 6.30pm to 8pm Mondays to Fridays and between 9am and 5pm on Saturdays. The services are currently in their infancy and are being closely monitored to ensure that that there are no gaps in provision and that the Sussex population can easily access these services.

4.12 The Enhanced Access Service delivers an additional 329 hours of appointments per week across Brighton and Hove, beyond core hours of 8am-6:30pm, which includes:

- a mix of face-to-face and remote (telephone, video or online) appointments.
- appointments delivered by a multi-disciplinary team of healthcare professionals, including GPs, nurses and other "additional roles" such as mental health practitioners, physician associates, physiotherapists, and Social Prescribers.
- a blend of appointments offered on the same day or pre-booked for a future day.

4.13 These flexibilities enable patients to be offered targeted interventions in addition to regular appointments, such as specific screening clinics, support for patients' groups as well as support for the system in times of surge demand, i.e., winter.

5. PCN workforce update including ARRs overview

Recruitment and Workforce Development

5.1 The expansion of advanced practice (AP) roles continues. Advanced Practitioners (APs) are advanced clinicians who are autonomous practitioners able to deliver care without the supervision of GP's, enabling not only career progression but the retention of an experienced multi-professional workforce. There are currently 3 AP trainees in Brighton and Hove with a further 4 starting their MSc from September 2023. NHS Sussex currently supports 32 AP trainees.

5.2 The Sussex Training Hub runs an education and training programme which upskills and updates the Primary Care Workforce to deliver evidence-based care to their population alongside access to clinicalskills.net (an online educational development service) and has successfully recruited 3 academic, 3 multi-professional and 1 simulation fellows which gives the workforce the opportunity to expand their skills, starting in September 2023.

5.3 To support further, the Primary Care Workforce Training Hub Team has been working closely with practices and PCNs across Brighton and Hove, focusing on expanding placement capacity to increase workforce. Below is a summary of progress to date:

- Multi-Professional Student taster days, which enable pre-registration healthcare professionals an opportunity to see patient care delivery in Primary Care by spending a few hours in practice and virtually receiving an educational session regarding the primary care speciality. The August 2023

Cohort had 27 students who spent half a day across practices in Sussex, 19 of the attendees are now looking for first career opportunities in Primary Care.

- Increase Learner Placement capacity & the number of practices supporting learners. This is to increase the numbers of GP's who are trained in Brighton and Hove and enable as many other learners as possible to experience Primary care with the purpose of encouraging an increased number of qualified professionals to take up roles in primary care. 22 Brighton and Hove Practices are currently supporting learners.
- Apprenticeships - Apprenticeship programmes are available for a range of clinical and non-clinical roles and can be undertaken by both existing and newly recruited staff. 70 apprentices are on programme or have completed the scheme as of September 2023, of which 8 apprentices work within practices in Brighton and Hove. A further 14 learners are due to start on programme at the end of the month (of which 2 are in B&H) and a further 15+ are in the pipeline for the coming 6 months (of which 2-3 are in B&H). Most apprentices are on pathway to practice programmes including the Senior Healthcare Support Worker, Trainee Nursing Associate and Registered Nurse Degree Apprenticeship.

5.4 In addition to the above opportunities, the PC Sussex Training Hub continuously supports practices and PCNs with workforce development and recruitment opportunities, through running a series of targeted visits. These visits support practices struggling with recruitment or retention of any of their workforce, offering workforce solutions and training opportunities.

PCN Education Leads

5.5 PCN Education Lead teams across Brighton and Hove have been established to provide evidence based, innovative and accessible education to primary care, to advance the quality of patient care, promote professional collaboration and foster a culture of lifelong learning within PCNs. In Brighton and Hove there is 100% sign up from PCNS, and 92% sign up across all of Sussex.

5.6 The recruitment, retention and workforce development opportunities detailed below are examples of the workforce activity delivered by Sussex Training Hub and are supported by utilising the PCN Education Leads to encourage engagement in opportunities and programmes offered as follows:

New to Primary Care Programmes

5.7 The new to practice Fellowships and the Preceptorship programme are to embed, train and support new to primary care workforce.

- **New to Practice Fellowships -** The New to Practice Fellowship recruits' new starters on to appropriate programmes to include newly qualified GPs, newly qualified nurses and nurses who are new to primary care. Since the programme has commenced, 16 GPs and 4 Nurses have joined from Brighton and Hove, with 10 GPs and 2 Nurses currently active on the programme. The next steps are to develop a 'New to Primary Care Programme' with menu options to cater to staff needs whilst meeting the NHSE (NHS England) mandate and guidance for the new to practice GPs and nurses.

- **Preceptorship -** The purpose of preceptorship is to provide support, guidance, and development for all newly registered practitioners (NRPs) to build confidence and competence as they transition from student to autonomous professional. This has been developed to support multi-Professional clinicians new to primary care. There have been 51 preceptees in Sussex. In Brighton and Hove 30 clinicians have joined the programme since it commenced and 18 are currently active.

ARRS roles from a workforce perspective

5.8 To support the ARRS scheme, Brighton and Hove has facilitated peer network meetings and offered advice to all PCN stakeholders to support recruitment and retention. In addition to this, Southeast wide Occupational Therapy has delivered Podiatry and Dietitian role promotion webinars for PCNs. A further Dietitian and Podiatry online seminar is planned for November 2023. Across Brighton and Hove, plans are being prepared to engage with specific PCNs to understand and support with their recruitment intentions.

5.9 NHS Sussex has also commissioned a PCN ARRS advisor for one session a week, to offer support around supervision and development of personalised care and ARRS roles, and how to embed them into practices and PCNs.

5.10 There is a dedicated webpage for educational resources and planned webinars and there is scope to develop a training package for non-clinical staff around Personalised Care.

5.11 The training hub has progressed other retention initiatives which include FCP (First Contact Practitioner) supervision support and the example of Personalised Care roles peer support groups.

ARRS overview

5.12 PCNs draw on the expertise of staff already employed by their constituent practices as well as receive funding to employ additional staff under the Additional Roles Reimbursement Scheme (ARRS).

5.13 ARRS is the most significant financial investment within the Network Contract DES and is designed to provide reimbursement for PCNs to build the workforce, establishing MDT (Multi-Disciplinary Team) models of care required to deliver the national service specifications.

5.14 ARRS roles that PCNs can recruit as part of this scheme currently are as follows:

- Clinical pharmacists
- Pharmacy technicians
- First contact physiotherapists
- Physician's associates
- Dietitians
- Podiatrists
- Occupational therapists
- Community paramedics

- Nursing associates and trainee nursing associates
- Social prescribing link workers
- Care coordinators
- Health and wellbeing coaches
- GP Assistants
- Digital Transformation Leads

5.15 Full details of the ARRS scheme can be found via the link below. Network Contract Directed Enhanced Service - Contract specification 2023/24 – PCN Requirements and Entitlements (england.nhs.uk)

5.16 In 2023/24 the following changes were made to the ARRS scheme:

- Increasing the cap on Advanced Practitioners from two to three per PCN where the PCN's list size numbers 99,999 or fewer, and from three to six where the PCN's list size numbers are 100,000 or over.
- Reimbursing PCNs for the time that First Contact Practitioners spend out of practice undertaking education and training to become Advanced Practitioners.
- Including Advanced Clinical Practitioner Nurses in the roles eligible for reimbursement as Advanced Practitioners.
- Introducing Apprentice Physician Associates as a reimbursable role.
- Removing all existing recruitment caps on Mental Health Practitioners and clarifying that they can support some first contact activity.
- Amending the Clinical Pharmacist role description to clarify that Clinical Pharmacists can be supervised by Advanced Practice Pharmacists.

Personalised Care Roles

5.17 Personalised care represents a new relationship between people, professionals and the system. It happens when we make the most of the expertise, capacity and potential of people, families and communities. There are three roles within Personalised Care of Social Prescribing Link Worker, Care Coordinator and Health & Wellbeing Coach. These aim to reduce and support the workload of GPs and other staff by supporting people to take more control of their health and wellbeing and addressing wider detriments of health, such as poor housing, debt, stress and loneliness. These roles are intended to become an integral part of the core general practice throughout England, embedding personalised care within PCNs and supporting all professionals to take a personalised care approach.

5.18 Social Prescribing Link Workers connect people to community-based support, including activities and services that meet practical, social, and emotional needs that affect their health and wellbeing.

5.19 Care Coordinators help to co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at the right time.

5.20 Health and wellbeing coaches support people to increase their ability to self-manage, motivation levels and commitment to change their lifestyle.

5.21 To meet the PCN DES around Peer Support for these roles, NHS Sussex has commissioned a year-long Sussex wide offer of peer support to social prescribers, care coordinators and health and wellbeing coaches, with a view to then providing training to continue this support and embed it within the PCNs to be sustainable long term. The offer will also provide clinical supervision, support and training.

5.22 Across Sussex there has been a 40% up take to date, 34 staff, which is broken down into specific roles as below:

- 19 Social Prescribing Link Workers
- 9 Care Coordinators
- 6 Health and Wellbeing Coaches

5.23 For Brighton and Hove, the breakdown of the 16 expressions of interest are as follows:

- 9 Social Prescribing Link Workers
- 5 Care Coordinators
- 2 Health and Wellbeing Coaches

5.24 This offer is still available, and a second reminder has gone out via PCN Education Leads, Federations Newsletters and websites as well as reminders sent to the original 68 expressions of interest to encourage take-up.

The ARRS picture across Brighton and Hove Workforce -

5.25 The PCN employed ARRS roles across Brighton and Hove

- As of July 23, the total ARRS workforce has increased by 46.3 FTE (Full Time Equivalent) (51%) to 136.9 FTE compared to staff levels in July 2022. The clinical ARRS workforce is 135.1 FTE; non-clinical 1.8 FTE.

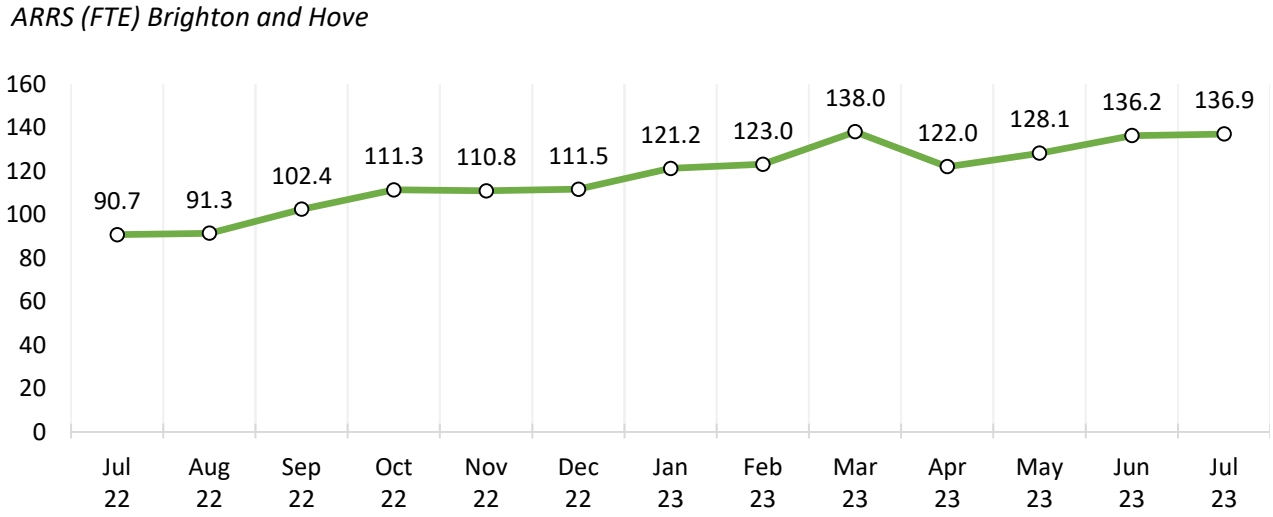
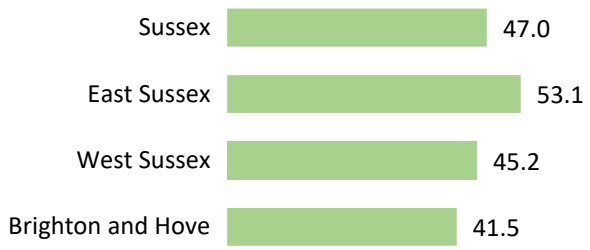


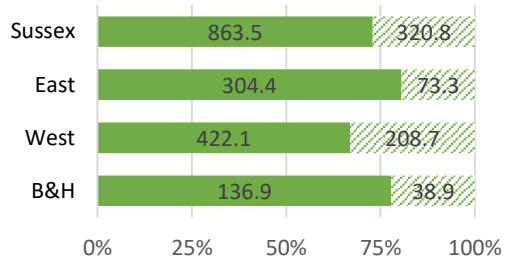
Chart 1 – ARRS Staff Recruited in FTE per 100,000 Registered Patients

Chart 2 – ARRS Staff FTE Recruited & Planned

FTE/100k patients Jul 2023



Hired Jul 2023/planned 23/24



5.26 Chart 1 above, shows that PCNs in Brighton & Hove recruited the equivalent of 41.5 FTE ARRS staff per 100,000 registered patients as of July 2023.

5.27 Chart 2 above, shows that Brighton & Hove PCNs recruited 77.9% ARRS staff as of July 2023 (136.9 FTE of a planned 175.8 FTE).

5.28 Key Points of Note for Brighton and Hove**:**

- In July 2023, Brighton and Hove primary care workforce numbers totalled 875.9 Full Time Equivalent (FTE) employees, with a clinical workforce of 487.7 FTE and a non-clinical workforce of 388.2 FTE. Compared to July 2022 the total workforce grew by 23.3% (165 FTE): clinical by +27.1% and non-clinical by 18.7%.
- There are currently 137.3 FTE Fully Qualified GPs. This is an increase of 10.3 FTE (8.1%) since July 2022. Compared to March 2019, staff levels have increased by 12.3%.
- Current nursing staff numbers in Brighton and Hove total 107.8 FTE. This is an increase of 21 FTE (24.2%) since last year. Since March 2019, nursing staff levels have increased by 31.6%.
- Direct Patient Care (DPC) staff employed by practices has increased to 82.6 FTE, a growth of 19.5 FTE (30.8%). Since March 2019, staff levels have increased by 102.5%.

Service development opportunities linked to multi-disciplinary ARRS workforce models

5.29 The drive to broaden the professionals who can work in Primary Care teams is intended to take pressure from GPs and Practice Nurses but also to develop the services that are offered. Examples of new clinical models, and approaches through maximising ARRS are explained in the sections below.

Preston Park Community PCN Frailty Team

5.30 Preston Park Community PCN has nine care homes within its PCN with circa 250 patients. There are also at least 300 patients with moderate to severe frailty living in their own homes within the PCN (measured using the Electronic Frailty Index).

5.31 To address this, the PCN has formed their own frailty service. This team includes ARRS roles consisting of Advanced Nurse Practitioners, First Contact Physiotherapists, and Care Coordinators. The service involves regular

multidisciplinary meetings held within care homes and at GP practices where health professionals help ensure that residents receive the additional care they need. The team manages the Frailty needs across the PCN, provides training to practice and Frailty team staff, and ensures the workload under the Enhanced Health in Care Homes framework, and any new care home beds, are shared across all practices. The Frailty Team consisting of clinical and non-clinical roles focused on providing personalised, preventative, and proactive care to targeted patient groups.

5.32 Brighton and Hove's Joint Strategic Needs Assessment states that by 2030, Brighton and Hove's age profile is predicted to get older, with 29% more people aged 75 or older (5,200 people) compared with 2017. Life expectancy in Brighton and Hove was 83.0 for women and 79.1 for men in 2015-17. Healthy life expectancy, however, has fallen, meaning that on average, a large proportion of life is spent in poor health, increasingly with multiple long-term health conditions. Brighton and Hove have more adults with Multiple Long-Term Conditions (MLTCs) <65 years old (54.4% or 28,000 people) than those 65 or older (45.6%, or 23,500) - this group has higher health and social care needs in later years, highlighting the need for a focus on prevention and well-being. In Brighton and Hove, 88% of 65-year-olds and over have some degree of frailty, with 11% categorised as having moderate or severe frailty (9% moderate and 2% severe).

5.33 The Frailty Team work with this targeted cohort to meet key objectives for anticipatory care; mental health service provision, and planned care, and to improve health outcomes across the PCN's practices whilst progressing its strategic and operational development. The service also enables further development and embedding of joint systems of working both between the practices and with community services and the voluntary community sector.

5.34 The key aims of the service are:

- To improve Primary Care Resilience by enabling practices to work in new and collaborative ways through embedding value for money models of service delivery and robust workforce planning based on empirical evidence.
- To promote further integration of services through the creation and development of best practice models in back-office systems and maintain impactful key stakeholder partnerships with NHS, local government, third sector organisations, network colleagues and service users.
- To improve quality of care and patient access to services by achieving targets for service provision including maximisation of service uptake and co-produced service development with Patient Participation Groups.
- To reduce demand for secondary care through the development of services and successful achievement of objectives as set out in PCN's Network DES and LCS specifications.
- To play an integral role in achieving overarching aims of reducing demand for GP appointments, supporting quality improvement measures, and contributing to the Quality and Outcomes Framework and enhanced services.
- The PCN report improvements in meeting patient needs, clinical leadership, and sharing best practice for clinical and non-clinical processes. The team are delivering impactful service developments to the PCN's patient population which align with the NHS values of working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives, and everyone counts.

Emotional Wellbeing Services

5.35 new models are being developed for population based mental health care built around PCNs. They bring clinical Mental Health Practitioners alongside non-clinical Mental Health Support Coordinators within every PCN. They aim to establish individual Emotional Wellbeing Services that work at a neighbourhood level to provide easy and timely access to mental health support for a wide range of individuals.

5.36 In Brighton and Hove, PCN depending on their population size, will have 0.5 – 1.0 whole time equivalent Mental Health Practitioners alongside 1.0 - 2.0 whole time equivalent Mental Health Support Coordinators. Currently these professionals are working in East and Central Brighton, Deans and Central Brighton, West Hove, and Preston Park Community PCNs.

6. Brighton and Hove PCN Activity and Audit

6.1 Plans are currently being developed to carry out a 5 year stocktake of Sussex PCN development, delivery of services, impact on population health, patient satisfaction and value for money. This exercise is expected to commence later this year, with a target end date of completion and published summary of findings, expected in June 2024.

6.2 In the meantime, NHS Sussex is actively monitoring the performance and delivery of PCN services through regular contact between delivery managers and PCNs, along with specific reporting on implementation of Personalised Care and Tackling Neighbourhood Inequalities, Enhanced Access performance, Capacity and Access plans and Impact and Investment fund indicators.

6.3 Monitoring continues regarding the recruitment of ARRS roles and ongoing recruitment plans within each PCN.

7. Development of Integrated Community Teams (ICTs)

7.1 The development of Integrated Community Teams (ICTs) is a key ambition in NHS Sussex' system's Integrated Care Strategy *Improving Lives Together* and as such is one of a number of priorities for health and care partners in Sussex over a five year period, commencing this year.

7.2 Improving Lives Together sets out the ambition across health and care in Sussex over the next five years. Its aim is to improve the lives of local people by supporting them to live healthier for longer and making sure they have access to the best possible services when they need them.
Priority areas are focused on:

- Long Term Improvement Priorities of building Integrated Community Teams, growing and developing our workforce, and making better use of digital technology and information.

- Immediate Improvement Priorities to improve our operational performance in primary care access, urgent and emergency care, planned care and discharge.

- Continuous Improvement Priorities on health inequalities, mental health, clinical leadership and making the best use of our financial resources.

- Place-based Priorities and the implementation of the Health and Wellbeing Strategies in Brighton & Hove, East Sussex and West Sussex.

7.3 Also known in other areas as 'Community Neighbourhoods' or 'Neighbourhoods Teams', the NHS Sussex Community Integrated Team model is built on the founding principles of stakeholders and partners in local communities, working together to deliver joined up care to local populations via a range of co located multi-disciplinary team models and pathways that are delivered by integrated health, social, local authority and voluntary sector teams. Local populations will be supported to stay well for longer through a joined-up approach to increasing health and wellbeing and proactive prevention.

7.4 In May 2023, the ICB held an ICT stakeholder engagement event in Brighton introducing the initial thinking and approach to the development of ICTs across Sussex.

7.5 The event was attended by a number of stakeholders, including colleagues from Brighton and Hove PCNs and their practices, who contributed significantly to the day and provided valuable feedback along with other stakeholders from across health and social care, the voluntary sector and public health. The workshop helped to shape and define the importance of co-producing the development of ICT's.

7.6 Following this event and working in partnership with working with the system's ICT Programme Team, work continues across Brighton and Hove to develop in the planning and future development of the ICT model, with four ICT footprints established across Brighton and Hove and a further 12 footprints located across other parts of Sussex. A map setting out the Brighton and Hove footprints can be found at Appendix A.

7.7 A Brighton and Hove ICT co-design steering group has been implemented with two primary care providers having a place on the group, West Hove Primary Care Network and Wellsbourne Healthcare CIC.

7.8 Steering group members are responsible for actively championing the development of ICTs across their networks, mapping our community assets and developing early frontrunner programmes to test integrated models of health and care within the four ICT footprints across Brighton and Hove.

7.9 Our Community Oversight Board is currently the formal Place-based governance for ICTs in Brighton & Hove and current reviews of governance are seeking to ensure strong primary care membership on the Board, with a focus on driving and improving engagement with primary care, ensuring they are a key stakeholder in the development of local ICT's.

8. Conclusion and next steps

8.1 The continued development and sustainability of PCNs and their position in the development of Integrated Community Teams across Brighton and Hove is essential in improving and driving positive health outcomes to our local population.

8.2 NHS Sussex will continue to focus on the following key areas to support the on-going development and innovation of Primary Care Networks and their role within integrated communities by providing:

- time and support for collaboration with wider stakeholders
- organisational development and leadership support.
- meaningful monitoring, support and advice packages aimed at struggling networks.

Appendix A

Demographics: Brighton and Hove

Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk) (2021)

Lower layer Super Output Area population estimates (National Statistics) - Office for National Statistics (ons.gov.uk) (2020)

ICT FOOTPRINT POPULATION	TOTAL	M	F	Age <18	Age 18-64	Age >=65	IMD Decile 1-2 (most deprived)	IMD Decile 3-7	IMD Decile 8-10 (least deprived)
West	59,795								
East	57,889								
Central	74,313								
North	87,547								
		135,355	140,979	47,118	189,986	39,230	59,822	213,562	18,354

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