Primary Care Network Maturity Matrix

August 2019

NHS England and NHS Improvement

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What is the PCN Maturity Matrix?

The Primary Care Network (PCN) Maturity Matrix outlines components that underpin the successful development of networks. It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for their neighbourhoods.

The matrix was built through learning from the initial wave of Integrated Care Systems who commenced early work on the design and development of PCNs during 2017/18. It has since been refreshed in light of the NHS Long Term Plan and the GP Contract Framework. A number of systems have developed their own version of the maturity matrices to meet local need.

Purpose of the Maturity Matrix

The PCN maturity matrix is not a binary checklist or a performance management tool. It is designed to support network leaders, working in collaboration with systems, places and other local leaders within neighbourhoods, to work together to understand the development journey both for individual networks, and how groups of networks can collaborate together across a place in the planning and delivery of care. Using the matrix as a basis for these discussions will allow networks to:

- Come together around a shared sense of purpose, identify where PCNs are in their journey of development and consider how they can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.

- Make plans for further development that help networks to continue to expand integrated care and approaches to population health, and that can best meet the health and care needs of the population served by the network.

- Identify support needs using the PCN Development Support Prospectus as a guide for framing support plans

A development journey for PCNs

Across England, PCNs will be at varied stages of development. A number of networks will be building on already established integrated ways of working and emerging population-health based new care models, with GP practices, other primary care providers, community services, secondary care, mental health, local authorities, the voluntary sector, local people and communities already collaborating on existing transformation schemes and initiatives. It is important the momentum of these existing ways of working is retained where that is already adding value for patients, staff and the wider population

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan sets out a trajectory for how networks can build over time, for example with the planned introduction of the contract service specifications. The matrix is designed to complement that framework and to set out the wider supportive development journey in how networks can grow their capabilities to support local priorities. It will help STPs and ICSs to work with providers within networks to enable those journeys in a way that also reflects the priorities systems identify in their 5 year delivery strategies. As for the prospectus support domains, the PCN maturity matrix covers areas that may, from April 2020, be part of PCN service specifications.

General practices are central to the successful development of PCNs but the matrix is intended to support a holistic multi-agency view of the development of networks. 'Neighbourhoods' are the cornerstone of integrated care, served by groups of GP practices working with NHS community services, social care, mental health, other providers, voluntary organisations, local people and communities to deliver more coordinated and proactive services. It is important that development discussions framed around the matrix are able to bring together the insights and expertise of a range of local stakeholders who will be working together to provide improvements in integrated care.

How to use the matrix

Components of the matrix

The matrix is set out as a table of components for the development of PCNs and is organised as follows:

- There are four columns showing a development journey over time – organised into 'Foundation', Step 1, Step 2 and Step 3
- The columns are subdivided in to components that PCNs may find it helpful to consider as part of their development journey and components that ICSs and STPs will also want to consider as part of the wider supporting infrastructure that enables network development
- There are five rows which organise the components into the following
    - Leadership, planning and partnerships
    - Use of data and population health management
    - Integrating care
    - Managing resources
    - Working in partnership with people and communities

A basis for development discussions

Experience from the initial community of Integrated Care Systems shows that the matrix was most effectively used when it provided the basis for local development discussions. Practices within a network came together with their CCGs and other local organisations – for example local authorities and community services – for a shared discussion on current progress and future plans for integrated care and networks. The output of these discussions was typically a shared set of priorities and actions for how the network would evolve. There is no 'one size fits all' approach on how best to organise and hold these discussions. System primary care leaders, CCG primary care directors and PCN clinical directors should come together to agree an approach that works best locally – which could, for example, inform the development of system and place level priorities and actions to support networks. The PCN Development Support Prospectus and the funding available to systems for PCN development can be utilised to support these local development discussions.

The matrix should be used pragmatically and flexibly, with networks viewing PCN development as a multi-year journey, and one that can build on progress that has already been made in improving and transformation care and services for patients and populations. **Initial discussions may want to reference the maturity matrix and focus on the following questions: Where are you now? Where do you want to be in a year? How will you get there and what do you need? Within this discussion networks will need to think about the time needed, the capacity required, the support needed to build sustainable skills and confidence to deliver.** This will enable PCNs to identify where the network wants to focus its development activity during the remainder of 19/20 and subsequent years. Network development should be a continuous improvement process, which enables plans to grow and mature, and therefore systems and their networks should consider holding further periodic reviews using the matrix – for example on an annual or bi-annual basis.

Conversations between providers operating across the network's footprint are crucial for building, trust and confidence and helping develop partnerships. Where any ICSs or STPs are confident that they have already undertaken a level of local development discussions against previous or locally developed versions of the matrix, it is expected those systems will apply a proportionate approach in how any further discussions are taken forward. In these cases, systems should assure themselves through appropriate local governance channels (including in dialogue with PCN Clinical Directors) that there is sufficient existing intelligence on network development to inform support activities during 19/20, including for the deployment of any transformation funding, and there is an understanding of local PCN level priorities that can in turn inform the development of system primary care strategies.

There is also an important role for systems in support the development of PCNs. The maturity matrix draws out how systems can do this across each theme of the matrix, ensuring that PCNs have the infrastructure, resources and relationships to thrive operationally and financially and make an important strategic contribution.

To complement the maturity matrix, there is a simple diagnostic spreadsheet tool that can support systems to understand local PCN maturity, target support and inform any local development plans. The tool enables PCNs to put the matrix 'into action'.

PCN Maturity Matrix

	Foundation	Step 1	Step 2	Step 3
Leadership, planning and partnerships **Prospectus Domains:** Leadership, OD, Change management, CD leadership	For PCNs: • The PCN can articulate a clear vision for the network and actions for getting there. GPs, local primary care leaders, local people and community organisations, the voluntary sector and other stakeholders are engaged to help shape this. • Clinical directors are able to access leadership development support. For Systems • Systems are actively supporting GP practices and wider providers to start establishing networks and integrated neighbourhood ways of working and have identified resources (people and funding) to support PCNs on their development journey. • Systems have identified local approaches and teams to support PCN Clinical Directors with the establishment and development of networks and for clinical directors in their new roles.	For PCNs: • The organisations within the PCN have agreed shared development actions and priorities. • Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint. • There are local arrangements in place for the PCN (for example through the PCN Clinical Directors) to be involved in place/system strategic decision-making that both supports collaboration across networks and with wider providers including NHS Trusts/FTs and local authorities. For Systems: • Primary care is enabled to have a seat at the table for system and place strategic planning. • As set out in the LTP, there is a system level strategy for PCN development and transformation funding, with support made available for PCN development. System leaders supports PCN clinical directors to share learning and support development across networks.	For PCNs: • The PCN has established an approach to strategic and operational decision-making that is inclusive of providers operating within the network footprint and delivering network-level services. There are local governance arrangements in place within networks to support integrated partnership working. • The PCN Clinical Director is working with the ICS/STP leadership to share learning and support other PCNs to develop. For Systems: • Primary care is enabled to play an active role in strategic and operational decision-making, for example on Urgent and Emergency Care. Mechanisms in place to ensure effective representation of all PCNs at the system level. • PCN Clinical Directors work with the ICS/STP leadership to share learning and work collaboratively to support other PCNs.	For PCNs: • PCN leaders are fully participating in the decision making at the system and relevant place levels of the ICS/STP. They feel confident and have access to the data they require to make informed decisions. For Systems: • Primary care leaders are decision making members of the ICS and place level leadership, working in tandem with partner health and care organisations to allocate resources and deliver care.
Use of data and population health management **Prospectus Domain**: Population Health Management	For PCNs: • The PCN is using existing readily available data to understand and address population needs, and are identifying the improvements required for better population health. For Systems: • Infrastructure is being developed for PHM in PCNs including facilitating access to data that can be used easily, developing information governance arrangements & providing analytical support.	For PCNs: • Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon. • Basic population segmentation is in place, with understanding of key groups, their needs and their resource use. This should enable networks to introduce targeted interventions, which may be initially focussed on priority population cohorts • Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions. For Systems: • Basic data sharing, common population definitions, and information governance arrangements have been established that supports PCNs with implementation of PHM approaches. • There is some linking of data flows between primary care, community services and secondary care.	For PCNs: • All primary care clinicians can access information to guide decision making, including identifying at risk patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system. • Functioning interoperability within networks, including read/write access to records,. For Systems: • There is a data and digital infrastructure in place to enable a level of interoperability within and across PCNs and other system partners, including wider availability of shared care records • Analytical support, real time patient data and PHM tools are made available for PCNs to help understand high and rising risk patients and population cohorts, and to support care design activities.	For PCNs: • Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts. • Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care For Systems: • Full interoperability is in place across the organisations within PCNs, including shared care records across providers. • System partners work with PCNs to design proactive care models and anticipatory interventions based on evidence to target priority patient groups and to reduce health inequalities.

PCN Maturity Matrix

	Foundation	Step 1	Step 2	Step 3
Integrating care **Prospectus Domain:** Collaborative Working (MDTs)	For PCNs: • The PCN is starting to build local plans for improving the integration of care for their populations, informed by the Long Term Plan, GP contract framework and locally agreed system/place priorities. • The PCN is aware of the organisations they need to engage to develop multi-agency approaches to integrated care and are beginning to make initial approaches. For Systems: • Systems support the PCNs to build relationships across physical and mental health service providers and social care partners to facilitate the delivery of Integrated care.	For PCNs: • Integrated teams, which may include social care, are working within the network and supporting delivery of integrated care to the local population. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care. • Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans. For Systems: • Systems support the building of relationships across providers of physical and mental health services, and social care partners. • System workforce plans supports the development of integrated neighbourhood teams.	For PCNs: • Early elements of new models of care defined at Step 1 now in place for most population segments, with integrated teams including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review takes place. • The PCN and other providers have in place supportive HR arrangements (e.g. formalised integrated team governance and operational management) that enable multi-agency MDTs to work together effectively. For Systems: • There is continued development of partnerships across primary care, community services, social care, mental health, the voluntary sector and secondary care that are enabling on-going MDT development. Workforce sharing protocols in place.	For PCNs: • Fully integrated teams are in place within the PCN, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high risk patients. • There are fully interoperable IT, workforce and estates across the PCN, with sharing between networks as needed. For Systems: • Systems have developed and implemented integrated care models that meet with objectives of the LTP.
Managing resources	For PCNs: • Primary care, in particular general practice, has the headroom to make change • There are people available with the right skills to make change happen. For Systems: • System plan in place to support managing collective financial resources that includes PCNs. • PCN development support funding is being used to address PCN development needs.	For PCNs: • Steps taken to ensure operational efficiency of primary care delivery, such as delivering the Time to Care programme, and support general practices experiencing challenges in delivery of core services. For Systems: • Systems have put in place arrangements that support PCNs with improvements in the efficiency of primary care delivery and enable PCNs to make optimum use of their resources.	For PCNs: • The PCN has sight of resource use and impact on system performance and can pilot new incentive schemes where agreed locally. For Systems: • Systems support networks to have sight of resource use and impact on system performance and that can enable piloting of new incentive schemes.	For PCNs: • The PCN takes collective responsibility for managing the resource flowing to the network. Data is used in clinical and non-clinical interactions to make best use of resources. For Systems: • Systems support PCNs to take collective responsibility for managing the resource flowing to the network and use data in clinical and non-clinical interactions to make best use of resources.
Working in partnership with people and communities **Prospectus Domain:** Asset based community development & social prescribing	For PCNs: • Approach agreed to engaging with local communities. • Local people and communities are informed and there are routes for them contribute to the development of the PCN. For Systems: • Systems are providing PCNs with expertise to support local involvement of people and communities.	For PCNs: • The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets. • The PCN has undertaken an assessment of the available community assets that can support improvements in population health and greater integration of care. • The PCN has established relationships with local voluntary organisations and their local Healthwatch. For Systems: • Systems have put in place arrangements to support PCNs to develop local asset maps in partnership with their local community to enable models of social prescribing for personalised care.	For PCNs: • The PCN is routinely connecting with and working in partnership with wider community assets in meeting their population's needs. • Insight from local people and communities, voluntary sector is used to inform decision-making. • Community networks are understood and connected to the PCN. For Systems: • Systems are facilitating effective partnerships with local community assets within PCN footprints. • The system is developing a strategy to support communities to develop and build particularly in those areas that face the greatest inequalities.	For PCNs: • The PCN has fully incorporated integrated working with local Voluntary, Community and Social Enterprise (VCSE) organisations as part of the wider network. • Community representatives, and community voice, are embedded into the PCN's working practices, and are an integral part of PCN planning and decision-making. • The PCN has built on existing community assets to connect with the whole community and codesign local services and support. For Systems: • The community assets and partnerships developed by PCNs are being connected in to strategic planning at place and system level.