PULSE PCN
CONNECTING PRIMARY CARE NETWORKS
WINTER 2021

IIF CAN KEEP YOUR LINK WORKER, WHEN ALL ABOUT YOU ARE LOSING THEIRS AND BLAMING IT ON YOU, IIF CAN CAUSE THE DAILY MAIL TO DOUBT AND INSULT YOU, EVEN MORE THAN THEY CURRENTLY DO; IIF CAN MAKE YOU WAIT FOR FUNDING, AND GET TIRED OF WAITING, FOR THE MONEY THAT MAY NEVER ARRIVE AND INCREASE THE PUBLIC HATRED, FOR THE RICHES ON OFFER TO GPS, WITHOUT EVER TAKING INTO ACCOUNT, THE EXTRA WORK: IIF CAN MAKE YOU DREAM — AND DASH THOSE DREAMS QUICKLY; IIF CAN MAKE YOU THINK ABOUT POPULATION HEALTH; IIF CAN MAKE YOU DO QOF AS WELL AND TREAT THOSE TWO IMPOSTORS JUST THE SAME; IIF TAKES A POSITIVE VISION FOR GENERAL PRACTICE, TWISTED BY KNAVES TO MAKE A TRAP FOR FOOLS, AS YOU WATCH THE THINGS YOU GAVE YOUR LIFE TO, BROKEN, AND STOOP AND BUILD 'EM UP WITH WORN-OUT TOOLS: IIF CAN MAKE YOU ONE HEAP OF EARNINGS, AND RISK IT ON ONE POORLY TICKED BOX, AND LOSE YOUR FUNDING, AND START AGAIN AT YOUR BEGINNINGS WITH THE ICSS DELIBERATELY DISREGARDING ANY WORD ABOUT YOUR LOSS; IIF CAN FORCE YOU, YOUR PRACTICE NURSE AND HEALTH ASSISTANT, TO SERVE YOUR PRACTICE LONG AFTER CONTRACTED WORKING HOURS, AND SO TO HOLD ON WHEN THERE IS NOTHING IN YOU EXCEPT THE KNOWLEDGE THERE ARE SO FEW GPS LEFT, IF YOU CAN TALK WITH THE WORRIED WELL AND KEEP YOUR VIRTUE, OR CONSULT ON TEAMS—FOR THOSE PATIENTS THAT WANT IT, IF NEITHER COMMISSIONERS NOR YOUR PCN COLLEAGUES CAN HURT YOU, IF ALL PATIENTS COUNT WITH YOU, BUT NONE TOO MUCH; IF YOU CAN FILL THE UNFORGIVING 10 MINUTES, WITH 60 SECONDS' WORTH OF BOX TICKING, YOURS IS THE IMPACT FUND AND EVERYTHING THAT'S IN IT, AND—WHAT'S MORE —YOU'LL BE A PCN DIRECTOR, MY SON!

Coming of age: the trials as PCNs navigate new funding P6

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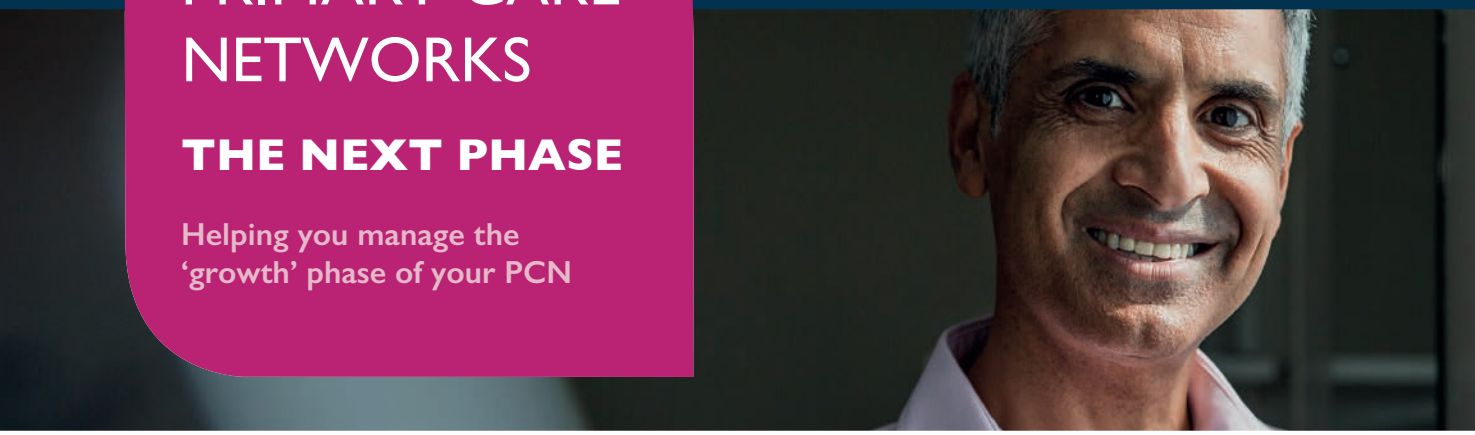
PRIMARY CARE NETWORKS

THE NEXT PHASE

Helping you manage the 'growth' phase of your PCN



PCNs have been incredibly successful. When established 2 years ago, the focus was on getting the whole of England moved into PCNs at speed. Primary Care delivered impressively. Since then, PCNs have proved their worth through the Covid vaccine delivery programme as well as recruiting many additional resources into primary care. But now PCNs are finding it challenging to manage the increasing risks and rapid growth. PCNs need to find a new, more sustainable way of working – we call it the 'managing growth' phase.

Is it time for PCNs to incorporate?

What are the benefits of incorporation?

If done properly, incorporation can solve many of the issues faced by PCNs. All PCN staff, costs and contracts are moved from the member practices into the company, and the company runs as a non-profit making business providing services back to the Core Network Practices. Risks are contained within the limited liability company, and the problem of irrecoverable VAT can be avoided by setting up a 'VAT Cost Sharing Group'.

The governance should be defined to mirror the existing PCN governance, and a much greater deal of transparency can be provided over the money flows. The company can then enter into contracts for additional non-DES funding streams, and can also act as a shared service centre between practices for non PCN DES related activities such as shared back-offices and investment. This solves the inherent problems in both the lead practice and the flat practice models, whilst leaving full control of the PCN with the member practices.

What are the challenges?

Establishing and running a company has a cost, requires reporting and disclosures to Companies House and HMRC, and adds a layer of complexity in the event PCNs cease to exist. Companies are also taxed very differently to partnerships. Originally there were problems with NHS pensions and sub-contracting rules, but these have now been resolved so long as the company is properly structured.
In short, incorporation is not something to be embarked on lightly, but with proper advice from specialist professionals there is a well-trodden path to follow.

Is incorporation right for my PCN?

The incorporation model looks increasingly attractive to those PCNs that are employing staff themselves through lead practice or flat practice models, or who want to secure additional PCN-level income streams. At DR Solicitors we have worked with over 250 PCNs, have incorporated about 15% of them, and have the largest team of experienced primary care solicitors in the country.

To read more about incorporating your PCN, visit pcn.drsolicitors.com

DR Solicitors has been instrumental in designing PCN operating models and has advised over 250 PCNs to date.

We only advise healthcare professionals, and we understand the political and regulatory landscape within which you work.

Contact us for a free, confidential discussion about your plans.

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WINTER 2021

Cover poem adapted by Pulse editor Jaimie Kaffash

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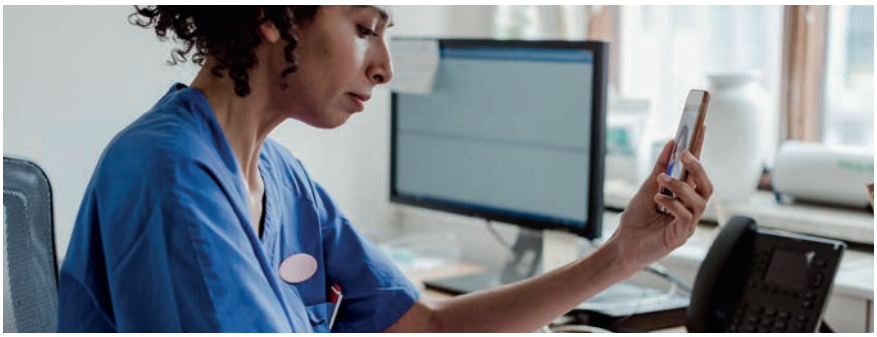

INCENTIVE SCHEME TO REWARD PCNs ON WAITING TIMES

PCNs' funding will depend on meeting targets for the number of online consultations they conduct from October, and for seeing patients within two weeks from 2022.

In new guidance published in late August, NHS England set out the Investment and Impact Fund (IIF) indicators that will reward PCNs for work completed in 2021/22 and 2022/23. It confirmed that despite the delayed introduction of services, the IIF will be worth £150m in 2021/22 and £225m for 2022/23 'as previously set out' – equating to around £120,000 and £180,000 respectively for an average PCN.

Since October, PCNs were being rewarded for achieving 'continued delivery of online consultations' – measured by the number of such consultations they carry out.

And from next year, they will be measured against a two-week-wait appointment target. NHS England said: 'Long waits for routine general practice appointments... are a leading cause of dissatisfaction with primary care services and can result in the escalation of clinical needs.' It said it will 'guard against the creation of perverse incentives for practices to refuse to book appointments more than two weeks in advance'.

Other indicators include:

- The number of emergency admissions per 100 care home residents in 2022/23, to reward PCNs for 'moderating' this.
- 'Follow-up' of patients with one-off high blood pressure readings to 'confirm or exclude' hypertension in both years, as well as the resulting rate of hypertension diagnoses.

As part of the service specifications, PCNs have also been told they must 'improve identification of those at risk of atrial fibrillation' through 'opportunistic pulse checks' when checking blood pressure, from 1 April 2022.

Meanwhile, all PCN clinical staff must complete mandatory 30-minute online 'refresher' training on shared decision-making, by 30 September 2022.

Dr Partha Ganguli, a GP in Preston, Lancashire, and clinical director (CD) of Ribble Medical Group, says the IIF funding is welcome, but adds: 'As usual we are given responsibility to improve patient care, but we don't have the time, resources or authority to do so. There is the risk that we will not be able to deliver any sustainable change and only undertake some minor alterations to fulfil the criteria outlined. Some of the requirements are set really high and can be difficult to achieve.'

PCN EXTENDED ACCESS SCHEME DELAYED TO OCTOBER 2022

The planned transfer of CCG-commissioned extended access services to PCNs will now be postponed by a further six months, until October 2022, NHS England has said.

Commissioners should 'ensure that they make the necessary arrangements to extend existing services' until the new deadline, it said.

The announcement is the second delay to the transfer. Plans for the wider CCG-commissioned extended access service to become part of the Network DES were originally scheduled to be implemented by April 2021.

In January 2021, Dr Nikita Kanani, medical director for primary care for NHS England, confirmed that the plans and the associated transfer of funding would be delayed until April 2022.

This is part of plans to transfer CCGs' commissioning powers to ICSs, scheduled to take place next year.

In its announcement, published in October, NHS England said the postponement would prevent PCNs diverting their resources away from clinical capacity into admin.

It clarified: 'This also allows more time for PCNs to explore how best to unlock synergies with in-hours services at practice level, as well as consider the option of collaborative working at larger scale than individual PCN footprints.'

However, it added that in cases where a PCN can 'demonstrate its readiness', commissioners are encouraged to make local arrangements for a transition of services before the new deadline.

These measures come as part of a £250m 'package of support' for general practice announced in October, which aims to 'increase the proportion of appointments delivered face to face'.

GETTY

PCN SERVICE SPECIFICATIONS

CVD PREVENTION AND DIAGNOSIS REQUIREMENTS

2021/22 **From October 2021, requirements will focus solely on improving hypertension case-finding and diagnosis**

2022/23 **Requirements for PCNs to increase diagnosis of atrial fibrillation, familial hypercholesterolaemia and heart failure from April 2022**

TACKLING NEIGHBOURHOOD HEALTH INEQUALITIES

2021/22 **From October 2021, identify populations experiencing health inequalities, and design plan to address unmet needs of this population to be implemented from March 2022**

2022/23 **Continued delivery of the co-designed intervention**

ANTICIPATORY CARE

2021/22 **Introduction of requirements for this service is deferred**

2022/23 **By 30 September 2022, PCNs will be required to agree a plan for delivery of anticipatory care in line with forthcoming national guidance**

PERSONALISED CARE

2021/22 **Introduction of requirements for this service is deferred**

2022/23 **From April 2022, there will be three areas of focus: further expansion of social prescribing; digitised care and support planning for care home residents; and shared decision-making training for clinical staff**

Source: NHS England. *Primary Care Networks – Plans for 2021/22 and 2022/23 – New PCN service requirements*

HEALTH SECRETARY 'BEATING' GENERAL PRACTICE WITH 'A BIG STICK'

Working with the Government on general practice issues is 'a real challenge', the now former BMA GP Committee chair has said, emphasising health secretary Sajid Javid's short time in the role as a major factor.

Speaking at the Pulse PCN conference in October, Dr Richard Vautrey (pictured, right) said that Mr Javid, who took up the role in June, is 'very new to the job' and has not yet 'got a feel for the issues in general practice'.

Dr Vautrey added that Mr Javid had taken a 'very old-fashioned' approach of 'beating a big stick to try to whip everyone to work harder and faster'.

His comments come a week after NHS England published its plan for improving access to GP practices, which set strict targets for practices, including plans to take 'immediate' action against the 20% of practices with the lowest face-to-face appointment levels.

The new access plan – which is attached to a £250m winter fund – also stated that practices that do not reach pre-pandemic levels of face-to-face appointments by November will not receive access to this funding.

PAUL STUART

Dr Vautrey described the Government's current focus on face-to-face appointments as 'bizarre', suggesting it stood in conflict with the previous health secretary's plan to prioritise remote GP appointments.

Speaking at the conference, which was held in Birmingham on 20 October, he said: 'I think we jointly need to be convincing the Government, convincing NHS England that this is not the way to support general practice, to improve access to patients or to get better quality care.'

Dr Richard Vautrey

It comes after the BMA linked NHS England's 'arbitrary' plan to anti-GP campaigns in the media.

These include a *Daily Mail* campaign calling for GPs to see patients face to face by 'default', which GP leaders warn might fuel further abuse and violence against practices.

Dr Vautrey said: 'If you've got media campaigns from powerful organisations like the *Daily Mail* or the *Daily Telegraph* with a particular demographic – which is an older population, maybe more Conservative voting – a Government that wants to stay in power and please its voters will try to do the populist thing without thinking about the ramifications.'

Responding to Mr Vautrey's comments, a Department of Health and Social Care spokesperson said: 'Patients should be able to see their GP promptly and in the way they choose. Our plan will improve access and drive up face-to-face appointments. It includes providing a further £250m to GPs in order to boost capacity.

'We are also cutting bureaucracy. GP teams will be given targeted support that will take pressure off staff and free up their time so it can be spent with patients.

'The number of full-time-equivalent doctors in general practice increased between March 2016 and March 2021 and, last year, a record-breaking number of doctors started training as GPs.'

Since the conference, the BMA has ramped up its dispute with the Government over the GP access plan, including a bid to ballot the profession on industrial action and proposals to disengage with the PCN DES.

For more news from this year's Pulse PCN conferences or how to join future events, visit pulsepcn-events.co.uk/about/

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SHOW ME THE MONEY

As the latest set of indicators for the next phase of the Impact and Investment Fund are digested, PCNs are getting to grips with how to approach, access and use the funds. *Emma Wilkinson* reports

The Impact and Investment Fund (IIF) will invest up to £150m in PCNs in this financial year if they achieve what is being asked.

It will be introduced in a phased 'stepwise' approach with 19 initial indicators where points can be earned. This will build to a more comprehensive package for 2022/23 (see box below).

Ultimately the overall goals in the IIF are laudable, say PCNs. But as always, the devil is in the detail. Some of the indicators will be challenging to achieve. Not everyone is starting from the same position. And the current pressures in general practice mean there is little capacity to meet yet more requirements.

There are also big questions about the data and how PCNs can check their current position against the new requirements. It is envisaged the IIF targets will be 'a QOF for PCNs', and therefore a familiar process, but some PCNs have observed that this might mean they become a tick-box exercise instead of delivering meaningful change.

Dr Pramit Patel, chair of the NHS Confederation's PCN Network, says the IIF will provide significant and badly needed extra investment in primary care. But it must be in 'a format that is manageable, with targets that are achievable and will lead to improved patient outcomes', he says.

It is likely that clinical directors (CDs) will find the IIF complex initially, he adds, and in the current climate it will not be easy to find the necessary time and space to manage that.

Beccy Baird, senior fellow at The King's Fund health policy think-tank, said NHS England has paid attention to the fact that delivering the service specifications will be tough at the moment and have reined back the demands.

But even the most upbeat and forward-looking GPs are currently very stressed, she says. On top of increasing patient demand, PCN CDs already have a lot on their shoulders with the supervision and management of the additional roles reimbursement scheme (ARRS) and large vaccination programmes, she adds.

'And I don't think enough thought has been paid to the infrastructure to support primary care providers,' she says. Providers who had a history of working together and had operational support for this before the pandemic now have an advantage. 'Having that infrastructure for data analytics and all that kind of stuff is really critical,' she says. 'Now we're getting more outliers who aren't part of these networks,' she adds.

Sheinaz Stansfield, a practice manager and director of transformation at Birtley, Oxford Terrace PCN in Gateshead, Tyne and Wear, says her PCN has a very clear structure with delegated areas of work that will help it achieve what's required, but the PCN has a huge variety in patient population across its three practices. For some, screening is a real challenge; one has nine care homes, another has none.

The PCN has created an action plan for what it will achieve as a group. 'We never wanted to be in the position where we were having to performance-manage each other. We support each other to do what's needed.'

PCNs are about strengthening population health and the IIF does fit with this, she says. 'I really welcome the focus on health inequalities and better outcomes in communities. But I would be lying if I said it wasn't hard.'

"We need more infrastructure to support primary care providers to work together

Beccy Baird

Dr Emma Rowley-Conwy, clinical director at Streatham PCN, south London, says while the IIF indicators broadly make sense, networks should still take a critical approach. 'If you're currently way off a target, will the effort to achieve it be worthwhile? We can probably do around two-thirds of it.'

This year will be an interesting exercise that will probably affect how PCNs engage with the IIF in the future, she adds.

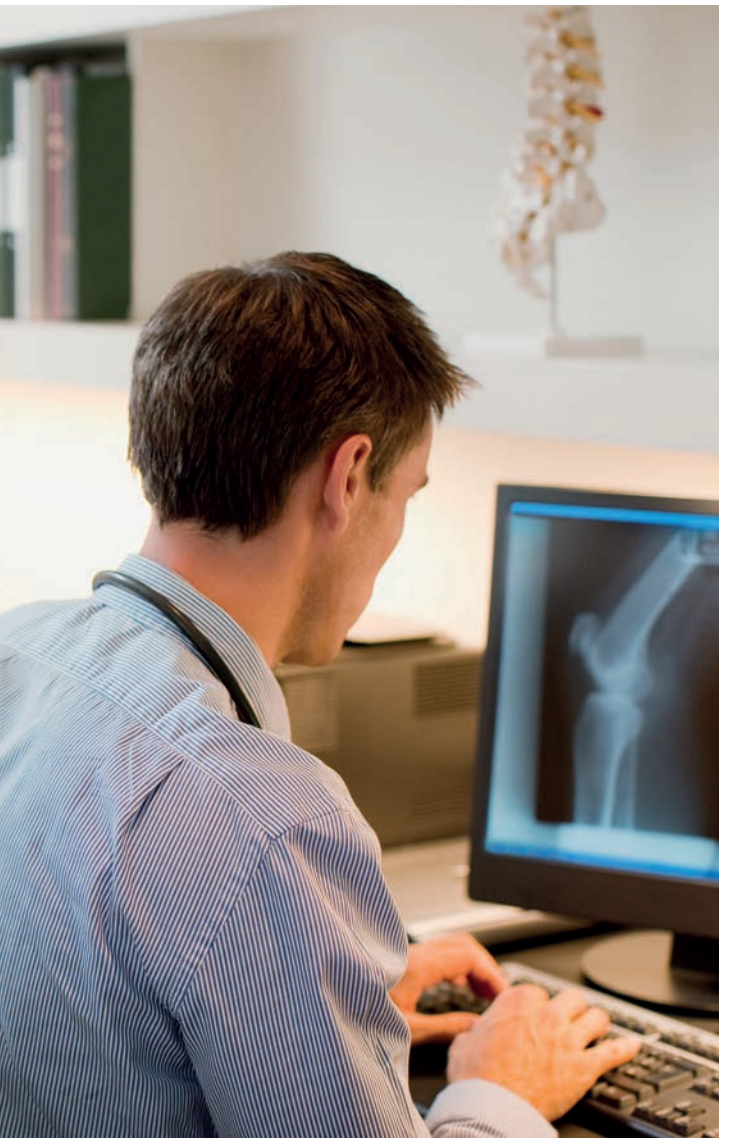
Dr Stephanie Mason, joint CD at Holderness Health PCN in the East Riding of Yorkshire, believes its set-up as a single practice PCN has some advantages. Her PCN has started to look at how its priorities and existing projects line up with the IIF.

'We have clinical leads for different areas and my role is to co-ordinate so we don't have two people doing the same piece of work,' she says. 'A lot is still in the planning phases.'

Some of the indicators will be easier to achieve than others, she adds. 'Some of them are really challenging. Things like – and we haven't fully started on it yet – analysing A&E attendance, which will all depend on the quality of data. I'm not sure the outcome will be what they think, which is to dramatically reduce A&E attendance, because that's been the holy grail we have been seeking for years.' →

FIRST PHASE OF IIF

• For 2021/22, there are 19 indicators. Six of these started in April and the rest were introduced in October.
• They are split into three categories – prevention and tackling inequalities, providing high quality care and creating a sustainable NHS.
• For 2021/22, each PCN can earn a maximum of 666 IIF points. Each point is worth £200 adjusted for list size and prevalence.
• Indicators can either be qualitative (where PCNs can either earn all the points or no points based on meeting all the criteria) or quantitative (based on how many interventions have been delivered in the eligible population and may be measured by numbers, standard or improvement over time).
• There is an upper and lower threshold for points that a PCN can earn for standard and improvement quantitative indicators. Above these, PCNs get all the points, and below they get zero. In between the thresholds they get the points proportional to achievement.
• Exceptions known as personalised care adjustments can be applied, for example if patients are offered a flu vaccination and refuse it.
• The 2022/23 IIF will be based on improving prevention and tackling health inequalities; supporting better patient outcomes in the community through proactive primary care; supporting improved patient access; delivering better outcomes for patients on medication; and helping create a more sustainable NHS. It will be worth £225m rising to £300m in 2023/24.



This indicator is the one that generally seems least welcome. It asks PCNs to analyse and discuss the implications of data on A&E rates for minor conditions with the local ICS and make a plan to reduce unnecessary attendances and admissions.

Dr Tom Rustom, clinical director at Healthy Horley PCN in Surrey, says: 'It's like someone has decided we need to reduce A&E [attendances], so let's stick that in. It seems out of keeping with the rest of it.'

Broadly speaking, his PCN's approach will be to have accountable people for each of the different areas, with the first step to look at coding and monitoring. There are parts – for example online consultations – where Healthy Horley is confident it is achieving above the threshold, but it will need to invest in admin time to prove it. 'It's quite a big exercise in showing we're doing what we're already doing,' he says.

Healthy Horley has also decided to invest in blood pressure checks, which is worth about £10,000. For this, the PCN will need a healthcare assistant and admin support and will buy blood pressure monitoring devices for patients.

'The biggest challenge – as it is for the NHS as a whole – is not lack of funding or resource,' he says. 'It's lack of people. Identifying people who are not exhausted and burnt out and want to do more work is the hard bit.'

"PCNs should check each target will be worth the effort required to meet it

Dr Emma Rowley-Conwy

Dr Rustom is very clear that his PCN doesn't want to just tick boxes. 'We're going to set our own priorities that make sense to us and make the national guidance fit that – rather than the other way round. I'm not taking the IIF as a set of specifications but as broadly the direction we want to travel.'

A large part of the IIF is work that is already being done, but for a lot of practices, the two indicators for decarbonising inhalers will be a lot of work, predicts Dr Mason. 'We have already been doing some work on this so we're quite lucky. As a goal and aspiration we absolutely should be doing it. Rather, the question is, is now the right time, with all the other challenges we have.'

Her CCG has produced a spreadsheet to show what the indicators mean for practices – hers is rural, coastal and very deprived. 'There will be conversations about what areas are prioritised,' she says. 'And not just for income; we will have to discuss whether we focus on things we can achieve. There is an assumption that all PCNs are the same and they're really not.'

Not having up-to-date figures on the PCN dashboard is causing frustration and preventing PCNs from doing the IIF work, some network leaders warn. Dr Rowley-Conwy says her PCN has repeatedly been promised the figures would be available by now.

Accuracy of data will be an issue for targets involving online consultations, social prescribing, A&E attendances and care home beds, she explains, because some of it comes from outside general practice and isn't easily coded. 'It's very difficult to understand some of the targets when you haven't got the data in front of you. Having really good data will be crucial otherwise you're set up to fail.'

Ms Stansfield agrees: 'I do worry about the thresholds because we've got no way of looking at what we're achieving. We're 18 months into PCNs and we still don't have the dashboard.'

Some PCNs have started to ask for the operational support The King's Fund said is sorely needed. Dr Rowley-Conwy says PCN directors locally have made the case for a flexible business support unit offering a range of services because everyone needs different things. 'My nine-and-a-half hours a week is not enough; you could spend that just trying to sort the IIF,' she adds.

PCNs will also need to have clear discussions about how this money will be reinvested fairly between them, she says. She wants to do more community projects but her GP colleagues are keen to invest in staff and other initiatives that have an immediate and clear impact on capacity.

Those trying to get their heads around the IIF may not yet be thinking about how to invest the money, which has to go back into services, but everyone needs to have those conversations now, Dr Rustom advises.

'The fairest way is that the money follows the patient. But this leaves struggling practices behind.'

He adds: 'Our LMC advised this is a really important discussion for PCNs to have early, to make sure it's clear how that money will be divided. Get it written down.'

Dr Sayanthan Ganesaratnam, South London's East Merton PCN clinical lead and NHS Confederation PCN network board London representative, believes that while the current targets are reasonable and phased, the work being done now won't realistically make an impact for years and PCNs must be empowered to have a strong voice at every level in ICSs in order to achieve change.

'Over time, all PCNs have the potential to succeed with the IIF. In order to deliver, up-front funding is needed rather than retrospective performance-based funding.

'PCNs need to work on the assumption they will receive the funding. The majority of the indicators will take 10 years to make an impact and require collaborative system working. I do think the IIF specifications take this into account. I just hope PCNs are given time to mature and develop so we get the opportunity to see this through.'

More detailed guidance on achieving the indicators can be found at **england.nhs.uk/wp-content/uploads/2021/10/B0951-vi-network-contract-des-iif-implementation-guidance.pdf**

GETTY

Is malnutrition impacting the outcomes of your frail patients?

National guidelines (NICE CG32/QS24) highlight the need to identify and manage malnutrition[3,4]. The 'Malnutrition Pathway', endorsed by NICE, is an evidence-based pathway to help community healthcare professionals (HCP) to implement guidance on malnutrition management[5].

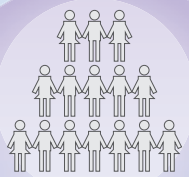
Low body mass index (BMI) (less than 18.5 kg/m^2) is an independent risk factor for fragility fractures[1,2]

Up to 86% of hip fracture patients are malnourished or at risk of malnutrition[6]

Malnutrition/risk of malnutrition is related to an almost 4-fold increase in risk of frailty[7]

Up to 64% of frail elderly adults are malnourished, compared to just 2% of fit elderly adults[8]

The Additional Roles Reimbursement Scheme (ARRS) as part of the Directed Enhanced Service (DES) contract can provide the resources to enable your Primary care Network (PCN) to screen and manage malnutrition in Primary Care. Patients at risk of malnutrition in the community often go undetected and untreated. These new additional roles can support in identifying and managing those patients and help reduce healthcare usage within your PCN.



93% of malnourished patients are in the community[9]

Implementation of the Malnutrition Pathway in a primary care setting, featuring malnutrition screening and dietary interventions, including ONS for high risk individuals, resulted in[10]:

- **25% less GP appointments**
- **21% less HCP visits**
- **29% less antibiotic prescriptions**
- **Cost saving of up to £997 per high risk individual**

Embedding nutritional care into your PCN pathways can improve patient outcomes and reduce the burden on your healthcare system. Contact us for further resources, best practice and support:

DL-SN-UK-HDM.Solutions@danone.com

SCAN ME

https://www.malnutritionpathway.co.uk

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September 2021

NUTRICIA
LIFE-TRANSFORMING NUTRITION

MIND GAMES

GPs are asked to carry out an impossible workload as PCNs. And they're told they're lazy for not seeing patients face to face

A sense of fatigue is setting in for GPs at the helms of PCNs.

There is no doubt that the formal structure of a PCN has been a game changer when organising the initial response to Covid, planning vaccinations or, more recently, looking after refugees from Afghanistan (as featured in our profile, page 28). But the original remit, of freeing up clinician time by getting more people into general practice via the additional roles reimbursement scheme, is actually adding to workload– because of the need to train and manage these new employees.

Add to that the rhetoric around face-to-face appointments and the requirements attached to the Impact and Investment Fund, explored in our feature (page 6), and you can start to see why there is fatigue.

I'm wondering if the Department of Health and Social Care has forgotten that PCNs are actually made up of and run by GPs? Clinical directors (CDs) are not a new breed of manager, they are GPs – invested in GP practices.

It seems like some sort of weird mind game is afoot. On the one hand, they are asked to carry out an impossible amount of work as fabulous PCNs. At the same time, they are ordered to be less lazy and see more patients face to face to increase access.

And of course, this will actually decrease access as more patients can be seen in a day with online and telephone consultations. Data from the BMA show that the total number of appointments delivered by general practice in August, 25.5 million, is higher than pre-pandemic levels – 23.3 million in August 2019. And currently more than half (57.7%) of consultations are being delivered face to face. The CDs I've spoken to report that patients opt for remote consultations even when offered them face to face. It's more convenient than missing work or sitting in a waiting room full of sick people.

Here's another thing that's perplexing. NHS England and NHS Improvement proudly circulate the Covid booster vaccine figures. 'More than 371,000 people were recorded as receiving a top-up on November 6, meaning almost 8.5 million have received one in the seven weeks since the latest phase launched,' says the latest press release. This is the booster programme the health service was asked to do at a moment's notice. This – and the flu vaccine programme – are not delivered by online appointments. Many are taking place in practices. So are they breaking records or under-performing?

So what exactly is the end game? If GPs go off the idea of PCNs, how will the leading few achieve anything? How will they get their voices heard at the ICS? How will they keep morale up? This is discussed in the roundtable (page 13) where one participant wonders how to future-proof the PCN leadership in the face of these challenges.

Perhaps the health secretary Sajid Javid could consider working with the cornerstone of the health service, as allies in managing patient flow rather than taking a punitive stance. And maybe he'll acknowledge that for networks to achieve anything they need a GP workforce that is not demoralised.

Victoria Vaughan is editor of Pulse PCN

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Reference: 1. Elia M, Russell CA. Combatting malnutrition: Recommendations for action. Report from the advisory group on malnutrition. Led by BAPEN, 2009.

This is intended for healthcare professionals only.

SCALING UP WITH NEW HOPE

This winter looks set to be like no other. The NHS is already under incredible strain. We have experienced winter pressures in the summer, we are still – despite what some people would like to think - in a pandemic while continuing to vaccinate people against Covid-19 and, latterly, flu. We are also trying to recover from the pandemic, to make headway against backlogs. Fortunately, more patients feel secure in coming forward but this is exacerbating access issues. Indeed, a recent NHS Confederation poll shows 88% of healthcare professionals say their job is 'unsustainable'.

Although this paints a sorrowful picture, there is cause for optimism in the shape of increased commitments to support primary care. In the recent spending review, the Government confirmed the NHS in England will receive £30.3bn to 2024/25 in recognition of the struggles we are facing. Both the Elective Recovery Fund and the Winter Access Fund are new funding streams. And NHS chief executive Amanda Pritchard has commissioned a review of how integrated primary care can be achieved and supported in ICSs.

To me, this looks like an acknowledgement of where the barriers to integration lie as well as the beginnings of an action plan, with the wider primary care system as the beneficiary.

It is also recognition of the power of primary care at scale, working collaboratively and with other partners. As PCNs, in many cases working with GP federations, we delivered a life-saving vaccination programme. As multi-professional clinical teams, we stepped in to staff Covid wards alongside our hospital colleagues. This is the mentality we need this winter. As a GP practice and as a PCN we are preparing by piloting a project with the discharge team at our local acute hospital, interfacing with our anticipatory care hubs, and I know of colleagues who are doing similar.

However, we cannot do this alone. We need the Government to defend us as a profession and take every step, alongside NHS England and NHS Improvement, to condemn abuse of primary care staff. We also need a Government that communicates honestly with the public about access. This includes clear central communications to help people understand the best way to access care, consulting us on announcements before they are released to the press, and candidness about the seriousness of rising Covid-19 cases and the protection that vaccinations provide. ICSs and commissioners could also do more to enable primary care, including fostering dialogue, relieving some of the administrative burdens and treating us as equal partners in the system.

It will certainly be a tough winter, but I know primary care will always put patients first. Covid is here to stay so we must find a way to recover and reform. It is only through working together at scale and with our partners that we can meet these challenges. The clear support for integrated primary care is testament to the good work of PCNs, providing enhanced services in the community and growing our depleted workforce. This, coupled with the transition to statutory ICSs, is an opportunity for primary care to transform how services are delivered, advocating for our patients. By working together, primary care can transform service delivery from the ground up.

This looks like the beginning of an action plan, with primary care as the beneficiary

ONLINE
Read more blogs by clinical directors at pulsetoday.co.uk/pcn

Dr Pramit Patel
is chair of the NHS Confederation's PCN network and GP clinical director for Care Collaborative PCN, Surrey Heartlands

PCN ROUNDTABLE

PLACE-BASED PARTNERSHIPS

PCN clinical directors joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss working at place level

GETTY

DELEGATES

Dr Reshma Syed
Joint CD at Sittingbourne PCN, Kent

Dr Robin Harlow
CD at Gosport Central PCN, Hampshire

Dr Riz Noor
CD at West Enfield Collaborative, north London

Chair Victoria Vaughan
Pulse PCN editor

JOIN IN
Take part in a Pulse PCN roundtable. Email pulsepcn@pulsetoday.co.uk

ON A SCALE OF ONE TO FIVE, HOW ADVANCED IS YOUR WORK AT ICP LEVEL?

Victoria What is the current status of work at the integrated care partnership (ICP), or place-based partnership board level for your PCN?

Reshma In the partnership board they're looking into the health inequalities of the area. There are various projects being undertaken in population health management (PHM) and also on developing PCN networks. There's also work on secondary care trusts and their issues. Other proposals that are being developed include setting up diagnostic hubs.

In our area – the Medway and Swale Health and Care Partnership Board – we've got nine clinical directors (CDs). I was elected to be the representative, so I sit on that board. There are other boards that require PCN clinical directorship, which is the clinical, professional and advisory board, which I also sit on. That's probably more of use to us as PCN directors because we're in touch with the plans on ground level – patient management and healthcare needs.

Robin I'm not directly involved within the ICP board but as a group of PCNs we've got a CD representative in different work streams. These work streams include urgent care and community mental health. More recently we've been looking at some of the transformation [work], place-based care, health in communities, and then health inequalities and PHM. That's a large piece of work we're undertaking at the moment.

Riz We've got very good working relationships with all the CDs, and with the community trusts as well, and we're working closely with the acute trust. We have huge problems in Enfield with deprivation. Enfield's a borough that is divided in two. East Enfield has huge deprivation problems and west Enfield has a very elderly population. On the east side, the acute trusts are really struggling with workload, A&E attendance and things like that, so we're working closely to see how we can support the acute trust in managing that, how much can be taken up by general practice, how we can provide input into urgent care centres to support that system. Health inequalities are a major part of the discussions at the moment.

Victoria Robin, do you feel like you've got a link to the ICP?

Robin We have regular clinical leads meetings. We have regular meetings with our primary care director in the CCG, and regular news bulletins and things like that, so we get information passed down. We are engaged and involved in particular projects as they are developed. I've had another role where I've been involved in some of the transformation work in the trust. But we're very much a PCN in the PHM [area of work], and that's probably one of the advantages of working with an ICP and ICS, is that they can deliver projects at scale. We're one of 11 PCNs involved in a PHM pilot. And they're doing that at different levels as well – at PCN level, ICP level, and ICS level. Then there'll be other projects. We've got a GP who is interested in digital and is involved a lot in that. People bring their skills to the different work streams that are required.

Victoria With place-based care operating on a larger scale, do you see PHM work happening on a larger scale too?

Reshma I think so. In our area we're conducting two pilots at two PCNs. They will be distributing their findings and these will be escalated. They want to see how that goes before they do that on a large scale.

DO YOU THINK THE ICP WILL HAVE MORE SWAY AT ICS LEVEL THAN PCNs?

Robin It depends what can be done at scale and what can be done at a local level. I think that's always the tension and the challenge with the top-down and bottom-up approach, and ownership, and development of services that meet your local population. As a PCN doing the PHM pilot at a local level, we're looking at our system data, and working with our partners in the voluntary sector and the community trust, to understand and deliver something that meets that local need. But then, we can use those skills, attributes and tools on different scales, and different scales have a different agenda, and a different drive. It's multi-level.

Victoria Do you think the GPs in your PCN are in favour of carrying out PHM as it seems like a large public health task, which is not the traditional role of a GP?

Reshma It's a workload issue, because obviously there's great pressure on PCNs to do lots of different types of work. We're being pulled in all sorts of directions, and this is a massive piece of work, which is why it's only being conducted as a pilot, because a lot of the issues in these practices could be representative across the area. This is why it's not been done at scale presently.

Robin As GPs and as a PCN we are very much at the heart of our population and delivering population healthcare. General practice is not just about diagnosing and prescribing. It is addressing those wider social

determinants of health and working in partnership to get the community engaged and look for a wider solution to the health of your population and to the NHS. You can't do that in an isolated manner.

Reshma Being in a PCN has actually given us the opportunity for working a lot more with community providers. We're having monthly meetings, getting into the crux of the issues that have affected our region for a very long time, and they're also helping us convey that in the ICP board meetings and in the hierarchy.

Robin For our PHM pilot, we've had three sessions now. In our very localised area, we've decided to concentrate on blood pressure in the younger population, the 30-50-year-olds, in a phased approach to try to help prevent health consequences later down the line and [look at] how we get engagement with that population. [We're also looking at] how we address those wider health and social determinants – obesity, physical activity, smoking, which are the other key factors with hypertension. Within our PHM group, as a PCN, we've got representation from our patient participation group, our voluntary, public health and the community trust. It's real partnership. Although we've got a very specific health aspect we're focusing on, we can look at all those wider determinants of patient behaviour and engagement. It's really exciting to be part of that. The other thing we're doing is community mental health transformation. That's been a really good relationship across the PCNs.

"We're in touch with plans for patient management at ground level
Dr Reshma Syed

Victoria Do you think the ICP amplifies the PCN voice at a system level?

Reshma I'm only one representative of general practice on this board, and although I try to convey the message as best I can, I have to appreciate that a lot of these members have a lot of machinery behind them. They've got data, they've got internal knowledge, and so I can feel like very small fry in this big setup. This can be a huge problem and it is the worry going forward with the development of the ICSs. Is that view going to be watered down further, or will we have any direct connection to the ICS? The way they're setting it up, [at the moment mandates] we're only going to have one representative on that.

My real worry is that healthcare requires a lot of clinical input and that seems to be diluted. For example, we've got a clinical professional advisory board, and with the restructuring they tried to get rid of it. So, there wouldn't be a clinical input whatsoever. It's only by standing up for it and having people say, 'Well, no, you do need clinical oversight on all of this,' that it was maintained. →

GETTY

DO YOU THINK THAT THE WORK DONE BY PARTNERSHIP BOARDS WILL HAVE MORE IMPACT FOR PATIENTS THAN WORK DONE AT PCN LEVEL?

No

0

PCN will have more impact

1

Both will have an impact in different ways

2

Victoria Does the ICP have a representative at ICS level yet?

Reshma No, and it's not very obvious how that selection's going to be made. I don't think it will necessarily be a CD from a PCN. It could be any GP.

Robin We have a number of ICPs that feed into our ICS. Each of those place-based boards has a GP CD, ours isn't a PCN CD, and they then represent the ICP in the ICS. Our ICP has a PCN primary care clinical lead, but I am not aware that this role is replicated in the other ICPs and it isn't represented at the ICS.

Riz Ours is a slightly bigger system because we have the North Central London (NCL) ICS, or currently the NCL CCG, so our five borough CCGs combined to become a CCG, and that's where the ICS will sit, and each of the boroughs will have their own footprint within that. The system will be quite large and it's unclear how much of a clinical voice from general practice will be on that board and how can it represent such a large group, as each of the boroughs have very different needs. How do we keep that place-based partnership in the boroughs as well as at the NCL level, to meet the individual needs of each borough? The whole idea with the PCNs was to meet local needs and small was beautiful. Now suddenly everything has changed, and getting away from that. That whole bottom-up approach... we might start losing some of that if it's coming from above. We need to build up trust that we're all doing it for the same reasons, and I feel that there's a risk that we might lose some of that trust and that ethos of equal partnership. It feels as if it's in the balance, and that the GP voice might be lost.

Victoria How worried are you that the foundations you've been laying as PCNs are being undermined as the system develops?

Riz There is a concern. We're trying on a borough level to make sure we still work collaboratively and have a distributive leadership model where different PCNs can say, 'I can do this', and we learn from each other. If one PCN has a greater need, we try to focus some of the funding towards that site.

As I said, in the east of Enfield, we have a real issue with inequality, so we say, if that's where the need is, that's where the funding should go.

Having that sort of relationship is easy when there is trust behind it, but as it gets bigger and bigger, [there is a] worry that those decisions will be taken out of our hands and I'm not sure we'll get the same results at the end.

Victoria What's the danger of the ICS not listening to the PCN voice?

Reshma It's a huge concern, because the ICS for Kent and Medway will cover 42 PCNs. CCGs have amalgamated into that one Kent and Medway CCG, and already we've noticed they're a little bit more distant from us. We've lost a bit of that knowledge. Even though we're all Kent, we all have slightly different issues. There are more deprived areas, such as in Swale and Thanet, so [it's difficult for the ICS to make sure each region is heard and not treated unfairly]. I've always said in our ICP board, 'Please, what are the discussions with the other [three Kent] ICP boards?' We need to be more collaborative so that we will have some kind of positive outcome.

ALAMY

Robin It's such a difficult challenge. I was involved in another project before looking at the equity of services across the whole of the ICS, instead of piecemeal at ICP level. Historically, we've had four or five CCGs commissioning and funding individual services slightly differently, which has led to inequity of services. We have the advantage that the ICS can give oversight and say, 'these are the standards we expect across the entire ICS. This is the best evidence approach'. But how [should that be] delivered at a local scale and where [should it] be done? The ICS is about being able to channel that resource [alongside] wider oversight and outcomes, rather than saying, 'This is specifically what you must do in this area, and we're expecting you to deliver this outcome at X, Y and Z'. It's tools they are giving us to respond in a local way and have local ownership and autonomy in the ICP or at PCN level. As an individual PCN we are very small. We're lucky that we are, but we're trying to bring [even smaller units like] individual GP partnerships together to work as one PCN and have a voice within an ICP and have that voice represented at ICS level. That's very difficult when there might be an acute or community trust that has a much larger voice. [There is] a huge tension about acute trusts; there always has been, [as long as] I've been involved in these sorts of roles. The priority ends up being to support the acute and emergency department or elective admissions.

General practice is about a wider solution to better health

Dr Robin Harlow

Victoria Do the ICPs and place-based partnerships help with this as they involve the acute trust?

Reshma It's always about the acute trusts. It's always about crisis point. Now it will be about Covid again, as the cases go up. 'Please stop admissions. Stop people coming into ED.' [There will be a] pushback into general practice and an increase in workload, and a workload transfer as well. We did a huge survey that demonstrated how much workload was being transferred from secondary care to general practice, so we've got these →

ALAMY

issues to deal with. The problem is that the funding should follow the patient and general practice does 90% of the consultations, whereas only 10% of the activity [is done] in acute trusts, but that's not conveyed in these discussions.

Riz The problem is the acute trusts seem to have a louder voice. That catches the media a lot more in terms of the long waiting times in the ED. As a result, the funding will follow. We can have those conversations with the acute trusts, but nothing comes of them because their agenda is very different from general practice's agenda. And sometimes, it's hard to have the conversation about how things could be done in a different way in their ED, to get them to grasp that general practice delivers in a very effective and efficient way, and perhaps they can learn from us.

Victoria What's the potential of the PCN working with the ICP or partnership board and what's required to meet that?

Reshma We have a really good working relationship with them. It's very difficult to say what could be achieved. It will probably be more of the same. We have our own workload and our own targets to address, and the ICP also is trying to work on that. It all comes down to funding, [time and workforce]. A lot more funding is needed for the deprived areas. We need time to engage with meetings and be able to input our thoughts. We also need the workforce. It's always these things that we need.

"How will we develop future clinical leaders at all levels?
Dr Riz Noor

Robin I think [we need an] acknowledgement that outcomes take time to deliver, that there are disparities and different priorities even within one ICP. Acknowledging this will enable us to deliver at an ICP level and an ICS level, along with funding and the sharing of workforce, of ideas of what has worked well and what hasn't. How do we collaborate as ICPs instead of remaining as fragmented CCGs? And why are we not putting more funding into public health and supporting that?

Riz The main issue for the PCNs is having the headspace. At the moment, we feel like headless chickens going from one thing to another, not being able to give our full time and energy to any project fully. It's meeting after meeting, and I think all the CDs are struggling. I think there's a lot of enthusiasm and people want to do the best for both their patients at a PCN level, borough level and ICS level, but I feel there just isn't enough capacity, and the workload is going up. I think they're being dragged in to get their clinical work done as well as all the administrative and managerial work. That clinical leadership is struggling just to get the time to do that, and yet, it's so necessary at each of these levels to have adequate clinical leadership.

My biggest worry for the future is how we will develop future clinical leaders. I can see people at the moment are going to either burn out and step down or are coming close to retirement. How are we going to get the younger generation involved in leadership at PCN level, [partnership] board and ICS levels?

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Prescribing information – on reverse for print and next page for digital

NOVARTIS

UK | June 2021 | 132797

Prescribing Information:

ENTRESTO® (sacubitril/valsartan)

Important note: Before prescribing, consult Summary of Product Characteristics (SmPC).

Presentation: Film-coated tablets of 24 mg/26 mg, 49 mg/51 mg and 97 mg/103 mg of sacubitril and valsartan respectively (as sacubitril valsartan sodium salt complex).

Indications: In adult patients for treatment of symptomatic chronic heart failure with reduced ejection fraction. **Dosage & administration:** The recommended starting dose of sacubitril/valsartan is one tablet of 49 mg/51 mg twice daily, doubled at 2-4 weeks to the target dose of one tablet of 97 mg/103 mg twice daily, as tolerated by the patient. In patients not currently taking an ACE inhibitor or an ARB, or taking low doses of these medicinal products, a starting dose of 24 mg/26 mg twice daily and slow dose titration (doubling every 3 - 4 weeks) are recommended. A starting dose of 24 mg/26 mg twice daily should be considered for patients with SBP ≥100 to 110 mmHg, moderate or severe renal impairment (use with caution in severe renal impairment) and moderate hepatic impairment. Do not co-administer with an ACE inhibitor or an ARB. Do not start treatment for at least 36 hours after discontinuing ACE inhibitor therapy. Sacubitril/valsartan may be administered with or without food. The tablets must be swallowed with a glass of water. Splitting or crushing of the tablets is not recommended. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. Concomitant use with ACE inhibitors. Do not administer until 36 hours after discontinuing ACE inhibitor therapy. Known history of angioedema related to previous ACE inhibitor or ARB therapy. Hereditary or idiopathic angioedema. Concomitant use with aliskiren-containing medicinal products in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m^2). Severe hepatic impairment, biliary cirrhosis and cholestasis. Second and third trimester of pregnancy. **Warnings/Precautions:** Dual blockade of the renin angiotensin-aldosterone system (RAAS): Combination with an ACE inhibitor is contraindicated due to the increased risk of angioedema. Sacubitril/valsartan must not be initiated until 36 hours after taking the last dose of ACE inhibitor therapy. If treatment with sacubitril/valsartan is stopped, ACE inhibitor therapy must not be initiated until 36 hours after the last dose of sacubitril/valsartan. Combination of sacubitril/valsartan with direct renin inhibitors such as aliskiren is not recommended. Sacubitril/valsartan should not be co-administered with another ARB containing medicinal product. Hypotension: Treatment should not be initiated unless SBP is ≥100 mmHg. Patients with SBP <100 mmHg were not studied. Cases of symptomatic hypotension have been reported in patients treated with sacubitril/valsartan during clinical studies, especially in patients ≥65 years old, patients with renal disease and patients with low SBP (<112 mmHg). Blood pressure should be monitored routinely when initiating or during dose titration with sacubitril/valsartan. If hypotension occurs, temporary down-titration or discontinuation of sacubitril/valsartan is recommended. Impaired or worsening renal function: Limited clinical experience in patients with severe renal impairment (estimated GFR <30 ml/min/1.73m^2). There is no experience in patients with end-stage renal disease and use of sacubitril/valsartan is not recommended. Use of sacubitril/valsartan may be associated with decreased renal function, and down-titration should be considered in these patients. Hyperkalaemia: sacubitril/valsartan should not be initiated if the serum potassium level is >5.4 mmol/l. Monitoring of serum potassium is recommended, especially in patients who have risk factors such as renal impairment, diabetes mellitus or hypoaldosteronism or who are on a high potassium diet or on mineralocorticoid antagonists. If clinically significant hyperkalaemia occurs, consider adjustment of concomitant medicinal products or temporary down-titration or discontinuation of sacubitril/valsartan. If serum potassium level is >5.4 mmol/l discontinuation should be considered. Angioedema: Angioedema has been reported with sacubitril/valsartan. If angioedema occurs, discontinue sacubitril/valsartan immediately and provide appropriate therapy and monitoring until complete and sustained resolution of signs and symptoms has occurred. sacubitril/valsartan must not be re administered. Patients with a prior history of angioedema were not studied. As they may be at higher risk for angioedema, caution is recommended if sacubitril/valsartan is used in these patients. Black patients have an increased susceptibility to develop angioedema. Patients with renal artery stenosis: Caution is required and monitoring of renal function is recommended. Patients with NYHA functional classification IV: Caution should be exercised due to limited clinical experience in this population. Patients with hepatic impairment: There is limited clinical experience in patients with moderate hepatic impairment (Child Pugh B classification) or with AST/ALT values more than twice the upper limit of the normal range. Caution is therefore recommended in these patients. B-type natriuretic peptide (BNP): BNP is not a suitable biomarker of heart failure in patients treated with sacubitril/valsartan because it is a neprilysin substrate. Psychiatric disorders: Hallucinations, paranoia and sleep disorders, in the context of psychotic events, have been associated with sacubitril/valsartan use. If a patient experiences such events, discontinuation of sacubitril/valsartan treatment should be considered. **Interactions:** Contraindicated with ACE inhibitors, 36 hours washout is required. Use with aliskiren contraindicated in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 m^2). Should not be co-administered with another ARB. Use with caution when co-administering sacubitril/valsartan with statins or PDE5 inhibitors. Monitoring serum potassium is recommended if sacubitril/valsartan is co-administered with potassium-sparing diuretics or substances containing potassium (such as heparin). Monitoring renal function is recommended when initiating or modifying treatment in patients on sacubitril/valsartan who are taking NSAIDs concomitantly. Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with ACE inhibitors or angiotensin II receptor antagonists including sacubitril/valsartan. Therefore, this combination is not recommended. If the combination proves necessary, careful monitoring of serum lithium levels is recommended. If a diuretic is also used, the risk of lithium toxicity may be increased further. Co-administration of sacubitril/valsartan and furosemide reduced Cmax and AUC of furosemide by 50% and 28%, respectively, with reduced urinary excretion of sodium. Co-administration of nitroglycerin and sacubitril/valsartan was associated with a treatment difference of 5 bpm in heart rate compared to the administration of nitroglycerine alone, no dose adjustment is required. Co-administration of sacubitril/valsartan with inhibitors of OATP1B1, OATP1B3, OAT3 (e.g. rifampicin, ciclosporin), OAT1 (e.g. tenofovir, cidofovir) or MRP2 (e.g. ritonavir) may increase the systemic exposure of LBQ657 or valsartan. Appropriate care should be exercised. Co-administration of sacubitril/valsartan with metformin reduced both Cmax and AUC of metformin by 23%. When initiating therapy with sacubitril/valsartan in patients receiving metformin, the clinical status of the patient should be evaluated. **Fertility, pregnancy and lactation:** The use of sacubitril/valsartan is not recommended during the first trimester of pregnancy and is contraindicated during the second and third trimesters of pregnancy. It is not known whether sacubitril/valsartan is excreted in human milk, but components were excreted in the milk of rats. Sacubitril/valsartan is not recommended during breastfeeding. A decision should be made whether to abstain from breast feeding or to discontinue sacubitril/valsartan while breast feeding, taking into account the importance of sacubitril/valsartan to the mother. **Undesirable effects:** *Very common (≥1/10):* Hyperkalaemia, hypotension, renal impairment. *Common (≥1/100 to <1/10):* Anaemia, hypokalaemia, hypoglycaemia, dizziness, headache, syncope, vertigo, orthostatic hypotension, cough, diarrhoea, nausea, gastritis, renal failure, acute renal failure, fatigue, asthenia. *Uncommon (≥1/1,000 to <1/100):* Hypersensitivity, postural dizziness, pruritis, rash, angioedema. *Rare (≥1/10,000 to < 1/1,000)*: Hallucinations (including auditory and visual hallucinations), sleep disorders. *Very rare (<1/10,000):* Paranoia.

Legal classification: POM. **Marketing Authorisation Numbers, quantities and price**: Entresto 24 mg/26 mg film-coated tablets £45.78 per 28 tablet pack (EU/1/15/1058/001); Entresto 49 mg/51 mg film-coated tablets £45.78 per 28 tablet pack, £91.56 per 56 tablet pack (EU/1/15/1058/002-003); Entresto 97 mg/103 mg film-coated tablets £91.56 per 56 tablet pack (EU/1/15/1058/006). **Date of last revision of prescribing information: May 2021**. MLR ID: 129646. **Full prescribing information (SmPC) is available from:** Novartis Pharmaceuticals UK Ltd, 2nd Floor, The WestWorks Building, White City Place, 195 Wood Lane, London, W12 7FQ. Tel: 01276 692255.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Novartis via uk.patientsafety@novartis.com or online through the pharmacovigilance intake tool at www.report.novartis.com. If you have a question about the product, please contact Medical Information on 01276 698370 or by email at medinfo.uk@novartis.com

WAKE-UP CALL

We've come a long way since I wrote last time about the reorganisation in the NHS in the middle of a pandemic.

The booster programme is in full swing. There are proposals that under-40s will also have boosters, and by the time this magazine is published that process will probably have started.

So where does this stop? How long can general practice continue delivering the booster programme? How long can a profession on its knees continue propping up the NHS?

The staff are exhausted. Winter is in full swing. The flu season and RSV seem set to create unprecedented demand on general practice and Covid is still around.

To top it all, NHS England and sections of the media are hell-bent on blaming all the NHS's problems on GPs. Staff morale is at an all-time low and abuse from patients is rising.

We still have QOF to deliver, and we also have a shortage of the tubes used in blood tests, caused in part by increased demand in the pandemic. Then there are PCN targets.

I'm not going to discuss whether PCNs are a good or a bad thing for general practice. With a change of fortune and strong leadership from LMCs, the BMA General Practitioners Committee and the BMA itself, they will either not be here in the future or be significantly watered down, which should provide some hope for the Independent contractor model. But for now, they are here and we have the Investment and Impact Fund (IIF) targets to contend with.

Practices are stretched, clinical directors (CDs) are stretched, the PCN workforce, which is so varied across the country, is stretched.

No wonder any new targets in the IIF create a sense of desperation, however meaningless they might be in the middle of a national health emergency and NHS emergency.

I could go into the criteria in the IIF, the points and the funding, but to be honest, I can't be bothered at the moment.

Are these targets helping anyone? Especially patients? They're taking away valuable clinical time from front-line care.

I know practices and CDs will somehow pull this out of the bag. We always do. But it's coming to the stage where people have now started questioning the relevance and motives behind all this.

The motives couldn't be clearer than in the NHS England letter to practices on October 14, titled 'Our plan for improving access for patients and supporting general practice'. It outlines the requirements for the Winter Access Fund, intended to increase access and resilience, which have been roundly criticised by the profession for being punitive.

Put everything together, reflect and ask yourself, what will end first? The useless targets, the vaccination programme, the media and government rhetoric, this never-ending erosion of general practice or general practice itself?

I have a fair idea which it will be if we don't wake up.

Where does this stop? How long can general practice keep delivering the booster programme?

ONLINE
Read more clinical director blogs online at pulsetoday.co.uk/pcn

Dr Manu Agrawal
is clinical director for Cannock North PCN, Staffordshire, senior partner managing three practices in three PCNs and chair of South Staffordshire LMC

LEADING QUESTIONS

***Andi Orlowski*, director of the Health Economic Unit at Midlands and Lancashire Commissioning Support Unit and senior adviser to NHS England on population health management, shares his insights**

What's the current status of population health management (PHM) in England?
I started working on PHM at NHS England as part of the New Care Models programme more than five years ago and over the last three years it has become a critical building block for ICSs. PHM is a technique for local health and care partnerships, including PCNs, to design new models of proactive care, delivering improvements in health and wellbeing and making best use of collective resources. The challenge for PHM is using data to identify which interventions are most likely to succeed for an individual based on their wider circumstances and how interventions can be delivered in a way that is most likely to achieve a positive outcome. PCNs and organisations that really understand their populations are best placed to help tailor care to the best effect. We know that getting lots of organisations to work together – some with differing priorities, goals and ways of measuring success – is a real challenge. But we also know that better partnership working using PHM and giving the right person the right care considerably improves outcomes, uses resources more effectively and reduces duplication.

What impact does it have on patients?
PHM is affecting patients right now. I have seen bespoke approaches to delivering flu and Covid vaccines for different populations in an ICS, and diabetes care being tailored to address variations in outcomes.

PCNs are critical to successful PHM – they understand their local populations
Andy Orlowski

Who is responsible for PHM?
The responsibility lies with all of us. PCNs are critical, not only in the delivery of care but also in providing a deep understanding of local populations. PCNs can shape the care provided by local authorities, NHS providers, public health and beyond. If we are to address 'health' and not just healthcare, a wider understanding of what the population needs can only come from a local level. My advice for PCNs is not to wait for the ICS to come knocking but to actively engage with them now. This is the time to act and represent your population.

How will PHM change and shape the way primary care is done?
PHM ensures the right care is given at the right time by the right person. It allows primary care a greater opportunity to partner with other organisations to help address the health of the population. Also, PCNs and general practices may change the way they deliver their care, being liberated and resourced to design and deliver it according to the needs of their population.

What impact will it have on PCNs, GP practices and patients?
PHM, if done well, should have a profoundly positive effect on patients and primary care staff. Health and care professionals will be empowered to take a more proactive and tailored approach to supporting their population to live healthier lives. This is a key way to address health inequalities.

What is expected of PCNs in terms of PHM?
PCNs should be helping to direct care and support, ensuring the correct interventions are used and addressing unwarranted or harmful variation. PCNs are the engine room of PHM. Their insight and focus on populations will make all the difference.

What support and funding will they get to reach these aims?
There are numerous routes to funding for PCNs and for ICSs to develop as a system. The FutureNHS website has details and ICSs will know more. Organisations such as the Health Economics Unit, the Strategy Unit and the Midlands Decision Support Network all provide support and guidance on PHM.

Is there a timescale for PHM goals and outcomes?
This is a key question. If we want to address the wider determinants of health, we have to be prepared to wait a little longer for our return on investment. Paying out on 'lag' markers like outcomes may not be conducive to reallocating resources. We could instead pay out on 'lead' markers for success, for example:

- Individuals being prescribed and adhering to certain drug regimens.
- People attending and completing education courses.
- More exercise at schools.
- More efficient boilers being fitted, helping people to heat their homes more cheaply.

Are PCNs important for PHM and do you think that is recognised at a system level?
PCNs are critical to successful PHM. Any ICS that does not engage with its PCNs will struggle to have a real understanding of its populations and will miss the key element of tailoring care – after all, how can anyone really understand all the differences in a population of 2-3 million patients? This is not a time to be passive. PCNs must make sure they are heard. If you are in a PCN, do you know who at the ICS you should be contacting? If not, find out.

How important is PHM for the future of the NHS?
It's been 50 years since GP Dr Julian Tudor Hart showed the inequalities in our healthcare system with the 'inverse care law'. Then 11 years ago, Professor Sir Michael Marmot of the Institute of Health Equity showed that inequalities had increased. Now, Covid-19 has demonstrated that those who most need support haven't received it. PHM allows us to address the wider determinants of health and inequalities. PHM is here to stay. I hope you join me in rallying to support it.

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EMPLOY A DIETITIAN

GP principal and PCN clinical director *Dr Anil Shah* shares advice and experience from employing a dietitian under the additional roles reimbursement scheme

We are a network of five GP practices in the London borough of Newham, part of the recently formed North East London CCG. Our network serves nearly 40,000 patients. The population is relatively young and highly diverse, with more than 100 languages spoken, and is the third most deprived borough in London. Obesity, diabetes, asthma and hypertension are the predominant long-term conditions, along with very high mental health needs.

GETTY

Why did we employ a dietitian?
Our aim was to offer a bespoke and holistic service to our patients in primary care. We also saw this as a real opportunity to focus on addressing root causes and patient education, and to prevent some health conditions relating to diet and nutrition – in particular diabetes, hypertension, high cholesterol, coronary heart disease, stroke, gallbladder disease and osteoarthritis.

What do we hope to achieve through the new role?
We have identified a number of key proposed outcome measures where we hope to see a significant impact. These are:
- A reduction in GP clinical appointments and hospital admissions.
- A reduction in HbA1c levels (over a three-to-six-month period).
- An improvement in clinical risk factors – blood glucose, blood cholesterol, blood pressure and weight.
- An improvement in malnutrition risk, as measured by Malnutrition Universal Screening Tool (MUST) scores.
- An improvement in eating patterns, habits and food choices.
- To transition patients off supplements and onto food-first nutritional support.
- A reduction in the number of oral nutritional supplement (ONS) prescriptions.
- An improvement in patient behaviour change.
- An improvement in self-care and self-responsibility for health.

How we hired a dietitian
Guidance in the network contract DES is clear on the qualification requirements for employing a primary care dietitian under the additional roles reimbursement scheme (ARRS).[1] We chose to hire a dietitian at Band 7 on the NHS Agenda for Change scale.

As the role in PCNs is so new, we only received applications from secondary care dietitians, but their skill set is completely transferable. With some coaching on primary care pathways our dietitian was embedded in the primary care team within a few weeks.

What does the dietitian do for the PCN?
During the past 12 months, the role has evolved, with an emphasis on proactive care. Our dietitian runs a weekly clinic, following up on referrals from other members of our clinical team. The dietitian has consulted with nearly 2,000 patients across our network, which is around 5% of our population.

The working week includes:
- Supporting diabetes patients with high HbA1c.
- Supporting housebound and care home patients.
- Supporting patients on ONSs.
- General dietetic clinic.
- Attending administration and wellbeing team meetings, and practice clinical meetings.

What support does the role require?
As the CD I work closely with our dietitian. I conduct monthly consultation audits on the dietitian's documentation, provide clinical support as needed and have regular catch-up meetings to provide support and suggestions for improving consultations. The clinical leads and GP partners of all our PCN practices are available for support when required.

Supervision is crucial as the dietitian is largely working alone, and needs GP time to be able to check clinical information.

Overall, the benefits we have seen outweigh the time taken.

How has the dietitian helped practices so far?
We have received fantastic patient feedback about having access to a dietitian. Also, our GPs have welcomed the access to an in-house referral service – so patients can be seen quicker and offered a more tailored service to meet their needs.

We have already seen a number of improvements. For example, we have seen some significant reductions in HbA1c levels, with a number of patients achieving reductions of 20-30mmol/l after two or three interactions over a six-month period.

We have also seen nutritional supplement prescribing streamlined and reduced by about 10%, due to better compliance and ordering. In addition, our dietitian has brought a focus on reducing obesity in the local population and recently supported a project to help patients with sickle cell disease.

Based on our experience so far, my advice would be that every PCN needs a dietitian – we are certainly looking to develop the service for the future.

Dr Anil Shah is a GP principal in east London and CD at Newham North West 2 PCN

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NHS X

EXPAND YOUR PCN ESTATE

GP partner and PCN clinical director *Dr Sarit Ghosh* offers strategic advice on acquiring extra premises space to suit your PCN needs

Notwithstanding the pandemic, the network DES has presented a significant challenge for practices over the past two years.

Taking on additional roles reimbursement scheme (ARRS) staff has been resource intensive for PCNs, further complicated by the shortage of adequate primary care estate.

Treasury constraints have prohibited any funded expansion of estate and the nascent ICSs are still catching up to address this gap. Meanwhile an update to the premises cost directions (PCDs), making provision for up to 100% capital grants, has yet to be published.

The process for assessment and approval of estate proposals is opaque and varies between regions. Criteria for successful practice expansion still seem largely to be centred around Health Building Note 11-01 guidance, which models space based on core primary care activity only, with outdated assumptions on list size and activity.[1] More recent guidance from Community Health Partnerships (CHP) in partnership with the National Association of Primary Care (NAPC)[2] is helpful, but only touches on how to take a business case forward and access any available funding.

With all this in mind, here are some tips for acquiring new estate based on my PCN's experience of planning and securing funding to provide a dedicated shared space for our ARRS staff in north London to deliver services.

GETTY

1 Take ownership of your estates review

First, it is crucial to undertake a comprehensive review of the available estate. This is often done in conjunction with local estates teams, but practice partners or managers should take ownership of the process, as assumptions may not reflect the reality. For example, the modelling used for average contacts and patient attendances underestimates current levels of activity.

2 Allow for supervision and face-to-face contact

Be prepared to challenge any assertion that significant numbers of staff can work from home. We find most ARRS staff need constant supervision, and this requires them to be in the same location as their supervisors. In addition, some patients need face-to-face consultations. Also, there has been general feedback that staff want to work as part of larger teams rather than be isolated at home, so remote working arrangements are not always suitable.

3 Match your estate expansion to the delivery model

Once the workforce gap analysis is completed and reconciled with the PCN's recruitment plans, you will need to consider how these staff will fit into an effective clinical service delivery model.

In my large network, with over 160,000 patients, we soon realised that it would not be possible to expand each of our 21 individual premises to meet staffing targets for 2024, with staff allocated on a weighted list size basis.

We already had a progressive estates strategy in motion, with a super-practice of 15 sites in the process of consolidating and merging into nine premises, on a completely cost-neutral basis to commissioners. As part of this, we decided that building remote consultation hubs at several of our sites to house groups of ARRS staff, supervised by GPs, would allow us to accommodate the necessary teams. Staff can then rotate between these 'e-suites' and also hold face-to-face consultations at the practice sites.

4 Consider self-funding to get the estate you want

The next step is to create and submit proposals to the local commissioning team. In our case these were only approved on the basis that the PCN would take on all capital and revenue implications for these expansions.

The system reported that it could not support us financially in any way in view of the current PCDs. However, our member practices and landlords have agreed to self-fund, the former out of shared PCN income streams, with the hope that legislation may change down the line with respect to funding of PCN space.

5 Seek out alternative funding options now

Other PCNs may not be willing to take this approach, so you may need to explore other innovative options – for example, capital funding options through Section 106 (Town and Country Planning Act 1990) monies from the local authority, use of void space in the ICS footprint or an arrangement with a local trust.

It is likely that if they have not already, networks will run into real consulting space issues in the next year and it is important to raise this early, as most estates projects take years to get off the ground.

Dr Sarit Ghosh is a GP partner at the Medicus practice in north London and CD at Enfield Unity PCN

ONLINE For a full list of references, visit pulsetoday.co.uk/pcn

SAFE HARBOUR

When the call came to provide a warm welcome to refugees from Afghanistan, to support families who had fled their homes under extreme circumstances, health and social care services in East Devon banded together. *Victoria Vaughan* reports

Dr Barry Coakley was having lunch at his desk one Friday in early September when he received an email from Devon CCG announcing that the Home Office was placing 60 refugees from Afghanistan in Exmouth, Devon at 3pm that afternoon and he, as clinical director (CD) of the local PCN, was charged with creating a health record for them.

The terrors of the swift resurgence of the Taliban following the US withdrawal from Afghanistan were, for the majority of us, confined to news reports. But for one East Devon PCN it became a matter of urgent and immediate work.

As CD of Woodbury, Exmouth and Budleigh (WEB) PCN, Dr Coakley immediately put out the call for help to the seven practices in the area. The reply was just as swift. 'Sure, what do you need?'

There was no prior information about the refugees because they fled their homes in such haste – arriving in just the clothes they stood in. They left loved ones behind. Daily medication and glasses were not even an afterthought.

'They arrived with very little in the way of belongings. Our role was to provide them with all the things we take for granted,' says Dr Coakley, who worked in collaboration with Devon County Council, Devon CCG and a number of health and social care agencies to support the refugees.

A total of 12 families arrived by coach in the seaside town of Exmouth with 40 children between them, ranging in age from nine months to 18 years. They have been given accommodation in a coastal hotel until more permanent housing can be found – and this could be anywhere in the country.

Although all the PCN's practices offered to help, the location meant it made sense for the four Exmouth practices to take on the patients. The two larger practices took 20 patients each and the smaller two took 10.

The families were also divided by language groups. Although each family has an English speaker – which is why they have safe harbour here, because they were helping the UK Forces in Afghanistan – there are four different dialects among the other family members. Translators, of which there were few – were found and Language Line has been used during follow-up appointments.

The practice teams of GPs, practice nurses, advanced nurse practitioners, healthcare assistants, practice managers and administration staff worked to establish consultation rooms in the hotel. After three days, all the patients had been seen and a health record for each had been built.

'It became clear that each patient needed an NHS number. This unlocks the rest of the system,' says Dr Coakley, who is now sharing what he's learnt with Exeter City PCN as more refugees are due to arrive there. 'We've fed back that filling in the registration forms to get this number should be started as soon as the people get off the plane.'

'We started by seeing family groups together as it seemed to be the most time-efficient way of doing things. However we've learned, both from the families and the interpreters who were native Afghans, that culturally the entire family likes to stay strong for each other rather than to discuss any concerns. This made the process of gathering the necessary history challenging. In hindsight, seeing patients individually might have made more sense and saved time in the end.

'If we had more time, I would recommend initially just chatting to the patients. Knocking on the door and saying "Hi, I'm the local doctor, how can I help?" and having that initial conversation is the best way to start the caring relationship and I think we would have saved time later if we could have done this first,' says Dr Coakley.

What the team didn't expect was the initial euphoria of the refugees. 'The outpouring of gratitude from the families for their safety meant that conversations about healthcare were low on the list of priorities when their lives and those of their children had likely been saved,' says Dr Coakley, who is visibly moved by his new patients . He says he – and his whole team – have 'taken them to their hearts'.

Although the families are generally in good health, there were a number of challenges for the PCN team. The children's immunisations had to be started and brought into line with the NHS vaccine programme. People's regular medication needs had to be determined.

'It seems while initial diagnosis of a problem may have happened, the ongoing management hasn't so much. Dentistry is another area they need help with as dental pain is just something they live with. So we worked with local services to ensure they were added to the waiting list, but access to NHS dentistry is a challenge in this area for everyone.

'Sometimes we'd be struggling to deduce the cause of headaches and blurred vision only to discover, with further questioning, that the patient wears glasses – which have been left behind,' says Dr Coakley. And this gives rise to another challenge – navigating the healthcare system.

'We've had to explain a lot about our healthcare system; how you go

Clinical director
Dr Barry Coakley

Practice
Claremont, Exmouth, Devon

PCN
Woodbury, Exmouth and Budleigh (WEB)

Location
South East Devon

Number of practices in PCN
7

Number of patients in PCN
52,000

PCN hires through additional roles reimbursement scheme (ARRS)
3 clinical pharmacists, first contact physios (linked with Royal Devon & Exeter NHS Foundation Trust), occupational therapist, young people's mental healthcare co-ordinator, 2 health coaches and mental health link worker.

Recruiting (ARRS roles still to fill)
Band 6 occupational therapist, frailty care co-ordinator, dietitian

Tips from the WEB PCN experience of receiving refugees
1 Obtain NHS numbers as a priority – this unlocks NHS services for new patients
2 Start the caring relationship with an informal conversation rather than a formal appointment. This saves time later
3 Be prepared to educate and explain the health system and how to pick up medication
4 Work closely with colleagues across all services and communicate regularly

From left: practice manager Zoe Newey, PCN CD Dr Barry Coakley, practice manager Chris Ladbrook

> **Looking after the families has been a story of extraordinary teamwork for this seaside PCN'**
> Dr Barry Coakley

from a GP to a specialist at a hospital. You can give someone a prescription and it means absolutely nothing. You have to show them where to take it and how to get medication. The health system can be complicated enough for people that have lived here all their lives,' says Dr Coakley.

Now, after the initial euphoria, the refugees are starting to process their circumstances, what they have been through and the fact that they have left loved ones behind – grown-up children in some cases.

'Things start to come to the surface,' says Dr Coakley. He is supported by the local mental health teams, who help these patients as needed. This is new territory for the team.

'We've treated people for PTSD before,' he says. 'Lympstone Commando – the Royal Marine training centre – is just up the road and we have many ex-servicemen and women in our community. However, these people are civilians. We haven't had any specific training in how to deal with the trauma that refugees might have experienced, but we have been supported by Devon County Council and our mental health teams. The National Refugee Council also offered support and guidance,' he says.

Dr Coakley is adamant that the PCN structure has been invaluable in enabling him to co-ordinate effective care for the families.

"It's been a team effort and we've been there to support each other as we have been at the height of the pandemic. Having a PCN meant that there was a single point of contact for Devon CCG, the Home Office and the county council and locally those relationships were in place so that people were ready and willing to help and work together to support these families.'

Of course this kind of work costs. Extra funding was given to Devon by the Home Office as part of the Afghan Relocations and Assistance Policy (ARAP), which made £3m of additional NHS funding available so that Afghans arriving under the scheme can access healthcare and register with a GP.

Exmouth is not the final destination for these families. They are on the waiting list for council housing which, when it becomes available, could be anywhere in the UK.

A home office spokesman said: 'We do not want to see families remain in hotel accommodation for prolonged periods, and there is a huge effort under way to get families into permanent homes so they can settle and rebuild their lives.'

When they are moved, Dr Coakley will endeavour to communicate a handover with the new PCNs.

However, as the time frame for this is unknown, thoughts are turning to getting the children into education to give them a purpose, friends and a future.

'The teenagers in particular want to get back into education. They want to learn the language and start planning their futures here. Even though it's temporary, we're looking at getting the children into the schools which would be great for them and for the area.'

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

CLARIFYING THE FACE-TO-FACE ADVICE

Hi there! It's Penny here, with more news from the Primary Care Support Team at the System Integration Unit.

PCNs carry can as ICS chief leads major review

What a busy few weeks it's been for me and my team! I expect you've all been quite busy too, but just a gentle reminder that we're nearing the deadline for your winter planning submissions.

If you can remember to get your provisional returns in no later than 5pm next Friday, we can finalise the data collection methodology, send out the survey form and give you plenty of time to work on your final Neighbourhood Winter Plans. We don't want a repeat of last year when some PCNs still hadn't contributed to the Pandemic Winter Pressures Data Collection by March.

You will notice that the section on stationery and consumables resource allocations has been streamlined in line with the ICS's commitment to reduce bureaucracy and grant greater autonomy to clinical directors (CDs). The smaller typeface means that it is now nearly three pages shorter. You said, we did.

My team will be in touch shortly to gather your ideas for new key metrics for the Local Improvement Matrix. We've already agreed the following important new schemes:

- Patient ratings for occasional celebratory enhancement of premises (culturally appropriate festival decorations, eg for Diwali, Christmas, Pride Week).
- Community engagement for the vegan healthy lifestyles programme .
- Post-pandemic practice book club and walking group re-registration.
- Improving quality of life for people with limited access to social media.

We are still in discussion with CDs and LMC representatives about the schemes for:

- Reduction in avoidable deaths from remote consultations.
- Enhanced access and productivity targets.
- Affordable referrals management performance incentives.

So we're making great progress, but as ever there is still more to do.

The big news in this issue is that the executive lead of the Sackwell & Binthorpe ICS, Dr Helen Crumb, has been asked to lead a national review to improve general practice and out-of-hospital care. We have invited Helen to set out her vision for the review, what she hopes to achieve, and what difference her report will make by the time it appears, which could be as soon as this time next year (those of you who have worked with Helen will know that she doesn't hang around!).

Statement by Dr Helen Crumb

'I am excited and honoured to have been asked by Amanda Pritchard to lead this vitally important work to accelerate the ambitions of the long-term plan and drive the integration of primary, community and social care aspirations at a local level.

'I was a GP for several years before moving into a full-time commissioning role in 2007, which makes me uniquely qualified to understand the pressures that my clinical colleagues are under today. And, of course, I see many of you at our PCN Congress meetings, which we hope to start running face to face again next year.

'As a GP, I'm all too aware of the critical determinants of ill-feeling in primary care, which is why I'll be talking about air quality, housing and the importance of daily exercise for children and not about contracts, service specifications, recruitment or workload.

'Like you, I understand that PCNs are crying out for examples of good practice and successful service models that demonstrate how PCNs can reduce pressure on primary care by reducing pressure on urgent and elective care services.

'I'd like to think that some of the inspiring examples we've already seen in Sackwell & Binthorpe might help systems across the rest of the country to emulate our success. I'm thinking particularly of our Barrier Triage scheme to divert traffic from hospitals to more appropriate primary care settings. By stationing GPs at the entrance to hospital car parks, we were able to reduce admissions, free up essential spaces and save patients the expense of avoidable parking charges.

'As a GP, I don't want to anticipate the results of my review before all the evidence has been gathered, but I fully expect my proposals to include steps towards further integration, a call for increased collaboration, a renewed focus on relationship development and team working, a collective commitment to change, and better use of the latest IT innovations to share learning and spread good practice. I'm sure you're as excited as I am to read the final report.

'I have been particularly encouraged to see PCNs start to consider how population health management approaches could potentially be discussed at local level, but this needs to be part of a wider, system-level conversation with the eventual aim of embedding population health management in everything we say.

'As Amanda said, in the email asking me to lead this work, this is too important to fail. It's a demonstration of the pivotal role played by PCNs that Amanda asked me, a GP, to "carry the can". I'll be asking all of you to carry it with me in the coming weeks and months.'

Penny Stint is primary care enablement lead for the Primary Care Support and Strategic Integration Unit (PCSSIU) at the Sackwell & Binthorpe ICS. As told to Julian Patterson

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