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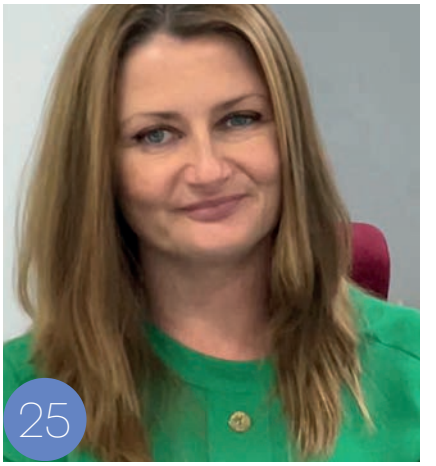

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PULSEPCN

Pulse PCN, Cogora,
1 Giltspur Street, London
EC1A 9DD

Email
pulsepcn@pulsetoday.co.uk

Editor
Victoria Vaughan
victoriavaughan@cogora.com

Commercial director
Edward Burkle

Art director
James Depree

Reporter
Jess Hacker
jesshacker@cogora.com

Editorial enquiries
020 7214 0552

Display advertising
benguynan@cogora.com

Delivery and subscription
subscriptions@cogora.com

NO RISK TO PCNs, SAYS NHS PRIMARY CARE BOSS

By Victoria Vaughan

Uncertainty about the future of PCNs has been quashed by the NHS head of primary care in an exclusive interview with our sister magazine Pulse.

Dr Amanda Doyle (pictured) reiterated that the funding for the additional roles reimbursement scheme (ARRS) will be rolled forward, adding: 'There is absolutely no risk to PCNs'.

'[PCNs] should recruit using [ARRS] funding this year. And they will have the money, it will come in future years for them to pay their staff. There's no concern at all that the money will suddenly be withdrawn and practices will be left with responsibilities,' she said.

Dr Doyle also clarified that PCNs would not be replaced by integrated neighbourhood teams (INTs), a structure first mentioned in the *Next Steps for Integrating Primary Care: Fuller Stocktake*, which was published in May last year and endorsed by all integrated care system (ICS) leaders as the direction of travel for primary care.

'I think [INTs] are something completely different. At the moment, an INT describes the way all the teams offering services to a defined community in a neighbourhood work together to make that as seamless as possible.

'I think PCNs are the general practice component of those INTs, but there are community services, there are end-of-life services and social care services, mental health services and a whole range of other teams who need to work in an integrated way with PCNs and general practice to deliver seamless services to our population,' she said. She added that the Fuller Stocktake was a 'vision, not a plan' which would not 'necessarily' be implemented 'just via a contract'.

The Fuller Stocktake stated that INTs need to evolve from PCNs, be rooted in a sense of shared ownership for improving the health and wellbeing of the population and build relationships and trust between primary care and other system partners and communities and have a blended generalist and specialist workforce drawn from all sectors.

INTs are currently running in Cambridgeshire, Surrey, Suffolk and Leicestershire, with staff drawn from social care, mental health and the voluntary sector working together in a locally devised way. Elsewhere, plans are in varying states, with many PCN leaders still defining what an INT is (see cover story, page 6).

Dr Doyle also said there was 'no plan at the moment to remove urgent services from primary care' but that there could be benefits if PCNs operate a slightly higher scale to help deal with surges in demand.

GOVERNMENT MAY FURTHER EXPAND PROFESSIONALS WHO CAN SIGN FIT NOTES

By Anna Colivicchi

GPs are being asked for their opinion on further extending the pool of professionals who can sign fit notes as part of a government consultation.

The Government is currently refreshing its guidance as part of recent legislative changes to fit notes.

Last year, changes to the legislation enabled nurses, occupational therapists, pharmacists and physiotherapists to legally certify fit notes, marking the greatest change to the rules for fit notes since they were introduced in 2010.

Now the Government says it is exploring ways to 'better promote the fit note as a means of having a work and health conversation that supports those who are at risk' of falling out of employment.

It is asking GPs, employers and other health professionals to take part in a consultation open until 12 October, giving their views on who should be able to sign fit notes.

The consultation said: 'This represents a significant step in the longer-term fit note policy journey by drawing on the skills and experience of other healthcare professions working as part of multi-disciplinary teams that can support the fit note to be a more effective tool in sickness absence management.

'As part of the move to a more multidisciplinary workforce to deliver work and health conversations, should we consider further extension of the professionals who can sign fit notes? And if yes, which professionals should we consider?'

GOVERNMENT PROPOSES TO EXTEND PANDEMIC VACCINATION REGULATIONS

By Anna Colivicchi

The Government has launched a consultation on proposals to extend vaccination regulations adopted in the Covid-19 pandemic.

It said it wanted to provide 'greater flexibilities for the movement and supply of certain type of vaccines'.

Ministers want to extend the regulations until 1 April 2026 to support the supply, distribution and administration of Covid and flu vaccines as the country transitions out of the pandemic.

These regulations have:

- Enabled trained healthcare professionals to conduct the final stage of assembly, preparation and labelling of Covid vaccines without additional marketing authorisations or manufacturers' licences.
- Allowed Covid and flu vaccines to be moved between premises at the end of the supply chain, by providers operating under NHS arrangements and the medical services of His Majesty's Forces, that do not hold wholesale dealer licences.
- Enabled the use of an extended workforce who are legally and safely able to administer a Covid or flu vaccine without the input of a prescriber, using an approved protocol.

The Government said the proposals 'aim to maximise patient and public health benefits' of these vaccines by ensuring their widespread availability, and that patient safety is 'at the heart of any public health vaccination programme'.

NHS England is working on aligning payments for flu and Covid vaccinations paid to GP practices.

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EVERYBODY NEEDS GOOD... Neighbourhoods

There is a commitment from the top to integrated neighbourhood teams but as there is no set plan and a wide definition of what they are, how do PCNs start to create a perfect blend of care for their neighbourhoods? *Emma Wilkinson and Jess Hacker* report

Since the publication of the Fuller Stocktake in May last year, the new NHS structure on everyone's lips has been integrated neighbourhood teams (INTs). In her report, Professor Claire Fuller, chief executive at Surrey Heartlands integrated care system (ICS) outlined her view that this was the direction of travel for PCNs.

Across the country, all 42 ICSs have 'accepted the mandate' set out in her report to develop INTs, 'which ultimately will provide more proactive, personalised and co-ordinated care to the most vulnerable in our communities', she says.

Underpinning this new model of care are multi-organisational teams, based on defined populations, who are tasked with two objectives: to improve access to integrated urgent care and take a proactive approach for those with chronic conditions who have more complex needs, Professor Fuller explains.

These integrated teams will be 'wrapped around practices' and will be pivotal in stepping up action on health inequalities, she adds.

'Understandably, different systems are at different stages of development with this, and that's due to a multitude of factors such as relationships on the ground, different ways of working, how much integration has already taken place and so on,' she says.

It will take time, Professor Fuller notes, but 'progress is being made with patients up and down the country starting to reap the benefits'.

Cambridgeshire, Surrey, Suffolk and Leicestershire are among the places that already have staff from areas such as social care, mental health and the voluntary sector working together under this banner.

Efforts are under way in Leicester, Leicestershire and Rutland (LLR) integrated care board (ICB) to transform its PCNs into neighbourhood teams – but the move is led by the system, rather than those in the PCN.

'We looked at what PCNs were doing, and how we could build on that to develop them into INTs,' says the ICB's deputy clinical director (CD), Dr Sulaxni Nainani. 'When we started, a lot of PCNs felt this was something new but it's really building on the work they are already delivering.'

She adds: 'We weren't looking much beyond the GP when we joined practices up with PCNs, but now within our surgeries we have different roles that are already linked to the wider community: social prescribers working with care navigators who are connected to the voluntary sector.'

The logical next step, she says, is to bring in local authorities, community providers and health and wellbeing boards.

In practice, this looks like a major merge of PCNs. Leicester, the ICB's largest city, currently has around 10 PCNs that will soon become one INT, with up to 11 more INTs currently in development alongside it.

An LLR PCN may be large enough to become its own INT or it might be merged with others. That depends on its population and their needs.

GETTY

'We have taken a very varied approach in LLR. In some areas the PCNs have been large enough to develop into an INT in their own right,' Dr Nainani says. 'It's about what is working already, what the population needs and how we can collectively deliver that.'

She adds that 'when you get too broken down into structures you lose the function' of what the INT is meant to be: services defined by a population, not a structure.

'When PCNs were formed it was about bringing your GPs together, but we need to understand the needs of the population beyond what a general practice can deliver. Your patients might have housing needs and we'll need to bring in the right people to support that,' she says.

Considering a population as a whole prevents clinicians looking at problems as either primary or secondary care issues, she says. 'We have now got secondary care clinicians doing clinics in primary care for chronic diseases because it is closer to the community. That is what you want with INTs.'

The lack of a national blueprint has raised a number of questions about exactly how and where PCNs fit in. LLR ICB is not looking at changes to additional roles reimbursement scheme (ARRS) employment via PCNs, for example and has set out its short-term plan for its INTs regardless.

Its first year has been dedicated to setting up boundaries. Year two will turn the focus to complex, frail and long-term condition management through wellbeing hubs and same-day access to non-acute urgent care.

Frailty hubs are the focus of INTs in Professor Fuller's Surrey Heartlands ICS. East Surrey's Care Collaborative PCN CD Dr Pramit Patel explains that the origins of INTs in his patch came from looking at data. In a population of 200,000 in East Surrey, 62,400 people were identified as high users of healthcare services and, of those, 1% or 624 had 1,900 A&E attendances, 500 ED attendances, 500 outpatient appointments and admissions, and 54,000 primary care contacts in the past year.

'Further analysis found that 75% of that cohort were frail so we thought about how to start reducing all that activity and get the care each person really needs,' said Dr Patel, who is also the primary care representative on the ICB.

Adding to work done with The King's Fund, using the primary care home model, East Surrey has set up an anticipatory care hub in each PCN. These are built around a lead GP, care co-ordinators, physician associates and pharmacists from the ARRS, along with a geriatrician, hospice representatives and community matrons working with a multidisciplinary team (MDT), including social care and dental surgeons.

This was initially financed by £300,000 of seed money from transformation funding secured in 2019 from the ICS, then still a clinical commissioning group. This paid for a GP in each of East Surrey's five PCNs for three days a week (£60,000).

Dr Patel says: 'If you're an elderly patient and you're moderately to severely frail, you will be identified and a physician associate or community matron will go out and do a comprehensive geriatric assessment. They'll go to your home and spend a good hour and a half with you, then do proactive, anticipatory care work and bring in the right agency.'

Through this way of working there has been a 'massive' drop in A&E attendances of 17% and a cut in admissions of 13% in this cohort of patients.

Surrey's Banstead INT has both an acute and proactive focus. On the urgent care side, the integrated team provides on-the-day support for patients at risk of hospital admission or needing urgent assessment at home. It consolidates GP home visiting, care home support and district nursing functions into a single acute home visiting service, also linking with the local place-based urgent community response team and virtual ward.

For proactive care, the team has a known caseload of patients with chronic conditions and can access population health management tools to identify those who may not be known to them and provide anticipatory care with MDTs. The initial focus is on people living with frailty and it will expand to other care groups.

Through links with other local services, the team has been able to get involved in a number of new initiatives, for example in care homes, with young people on the local housing estate and with the community, 'demonstrating exactly what the new model is able to achieve over time,' adds Professor Fuller.

But for many other corners of the country, the work on INTs is still in its infancy. Perhaps the team is there but not yet integrated with general practice.

Dr Tom Holdsworth, chair of Sheffield PCN CDs primary care services subcommittee, says one of the challenges is that there is no 'off-the-shelf blueprint' for an INT.

'You can't just look up a framework document that says "you need to do this".' He says that in Sheffield there have been a lot of discussions and some events to get the ball rolling but he is still getting to grips with defining an INT.

'In my mind some of it looks a bit like a primary care home model where we think about GPs as one part of a wider team and our job is to try to direct the patient to the right part of the team first time.'

He adds that there is also a need to consider 'softer boundaries' between services instead of endless referral forms and bureaucracy.

'If a patient comes in with a leg ulcer, I don't do a referral form to the nurse down the corridor. I knock on the door and say "can you see this patient". We should work in that way across a number of services that don't just include health, such as housing, social care, mental health services, voluntary sector, district nursing, occupational therapy, physiotherapy – the whole broad patch that is working in an area.'

Dr Tom Rustom is joint CD of Healthy Horley PCN in Professor Fuller's neck of the woods. He has been able to view the conversations on INTs from the perspective of a GP, PCN, ICS and place – as he is also CD in East Surrey.

He explains that there has been a lot of enthusiasm from the system leaders about neighbourhoods and really good engagement from the PCNs, the trust, community services and others and a willingness to make it work.

But they are aware there is still a tendency to work in the traditional siloed manner, which is difficult to overcome. 'In the current climate, there's probably a propensity for people to become very protectionist and cling to what they've got, rather than looking at this very different way of working.'

He adds: 'If I was looking at it as a normal GP, I'd say, I don't know what neighbourhood teams are yet. I don't think we're at the point where we can properly describe that to our coalface workforce.'

Dr Holdsworth agrees: 'There is a job to communicate because everyone's got a different vision of what an INT is.'

Initial focus

Starting small and building up seems the way to go. Greater Manchester ICB has written a blueprint for primary care with a chapter on neighbourhood teams.

The year one priority is to wrap care around the high users of health services, which could be small numbers of patients, says Dr Tracey Vell, medical executive lead for primary care at NHS Greater Manchester. 'What [those groups] lack is a personal relationship with somebody that helps them access the system. I think that's the start, and we'll move on from there.'

Greater Manchester perhaps had a head start because it was structured around neighbourhoods before the PCN DES came in and had fully integrated social care with community nursing. But in general Dr Vell tries to avoid the term integration because it 'smacks of organisational change', which is both distracting and pushes people back into silos.

Instead, Dr Vell and her team are focusing on what they want to deliver and who is accountable – which might be place, provider or ICB or another body. 'You look at the outcome and blend the team you need to reach the outcome. So the integration that's required for, say, homelessness is totally different from the integration required for CVD or obesity,' she explains.

To achieve this, practices will have to be connected digitally, sharing workload, and moving it around practices that make a neighbourhood, she says. They will also be pushed to move beyond their practice, for example, to deliver outside an NHS space once a month.

'That could be mobile or in a different site or a public place or →

library or whatever, so we are pushing to work with a wider MDT all the time,' says Dr Vell.

Down the line, they may do work on pulling some specialists into the community, such as dermatology, gynaecology, frailty and elderly medicine, she adds. From year two onwards the plan is to think more radically about supporting the population.

In Sheffield PCN they will most likely also start with high intensity users, says Dr Holdsworth. Sheffield PCN already has an MDT that includes housing, social care, social prescribing and a wide range of other professionals.

'At the moment we discuss cases we're stuck with but that's a reactive approach. We could flip this and take a more proactive approach,' he adds.

But another of his goals for the coming months is to work with local pharmacies on out-of-stock medicine issues.

'The pharmacists have really struggled to find time to engage with the network and they're under a lot of pressure. But if we pick the thing that's a stone in everyone's shoe it's something we could all start to engage on,' he says.

Dentistry and optometry also need to be brought into the fold, he adds.

Dr Saul Kaufman, CD for St John's Wood and Maida Vale PCN, says in Westminster one of the focuses has been housing. The PCN had been forming connections between health, the local authority and the voluntary sector in the Central London federation long before the NHS started talking about neighbourhoods. The PCN calls it the Octopus, with three hearts and eight legs being the connector roles – all working independently for the good of the whole.

'A lot of health problems are not really health problems but social problems,' he says. 'If a patient comes to a GP and says "can I have a letter to move to a different council flat because I'm depressed and I have diabetes and high blood pressure", that's not good for the GP because it's a waste of time.'

The data also tell them they have huge levels of deprivation and the biggest homeless population so prevention can be done in that group, making use of connector roles, he says, and 'investing in the fabric of communities'.

In Dorset, the data indicate that elderly people are the place to start, says Dr Simone Yule, CD of The Vale (BVP) Network, but Dorset is also grappling with the concept because the term 'neighbourhood' has different meanings for each group involved.

'We're going to be looking at healthy ageing in our over-65s population because it's such a large part of our workload,' she says. 'Just in my practice, we have 27,000 patients and nearly 8,000 are 65 and over. We're going to need a wider offer than primary care to support the older age community, or PCNs can never cope by themselves.'

Leadership

Dr Yule's view is that there is absolutely a place for PCN leadership in INTs but it should not be solely about health. And there should be more than one leader.

'That's why I see this is a real fundamental change in how we operate as primary care and PCNs. It's positive because it gives us permission to work more closely with the organisations in our community to support those populations.'

But it will take courage and there is an issue with permissions. 'Every part of the system has set targets and performance indicators. We need permission from NHS England to work differently in that neighbourhood constraint, and I'm not sure we've got it yet,' she says.

This can be exemplified by a piece of work Dorset is doing with the National Association for Primary Care on an out-of-hospital model. But the three organisations in involved – community care, the ICB and the GP Alliance – are all very medical when really the aim is to keep people well.

'The piece of work is the right thing to be doing but cultures and governance are very different between organisations. How do we get to that point where we're all signed up to working together for one or two shared outcomes?' she asks. 'Will NHS England give ICBs permission to grant autonomy lower down the food chain to neighbourhoods to get on and do things?'

Dr Holdsworth points out that while the contract is up for negotiation and the future of PCNs and funding streams is uncertain, there is a lot that neighbourhoods can get on with anyway because it's about relationships. At the same time, the responsibility should not solely be placed on PCNs. 'At the moment the PCN contract is the lever to support general practice to deliver its part of INTs. But if ICBs start to think they don't need to do anything about INTs and the Fuller Stocktake because PCNs will do it, that's a huge mistake.'

First you agree the vision, then you agree your part in delivering it, he adds. 'To be fair there is a lot of work being done on this and people understand that. We're currently in the process of writing a strategy for the ICB about how to support delivery of INTs, both for Sheffield and South Yorkshire.'

Decisions will need to be made on what can be done at regional level, at place level and at individual PCN level, he adds. For example, data sharing and information governance are broader issues and currently one of their biggest challenges.

PCNs have to be involved but they're not the be-all-and-end-all, says Dr Vell. 'There's got to be a strong [concept of] the registered patient. We need strong GP leadership and strong primary care leadership and we're developing those, but they need to be collaborative.'

The question is, she says, how you make a system accountable rather than individual organisations? Also, they need to better understand what financial reform is required.

'This is a five-year thing,' says Dr Rustom. 'This is not going to change overnight. Just think about PCNs four years ago, compared with now.'

The leadership of neighbourhood teams is going to be crucial, he adds, and initially that may be the PCN. 'Just as the CDs have been crucial in driving PCNs forward, neighbourhoods will need a leadership model, but with other organisations, not just health.'

When INTs first came on the scene, he thought the PCN would evolve into them. But he's changed his view. 'From the conversations we're having now, it's more like the PCN will dock into the INT. It's a part of the INT, but still its own entity.'

Looking to the future

Opinions vary on how INTs and PCNs will fit together in the future. Dr Kaufman notes that making or even predicting national policy is difficult because everyone is in such different places.

'My guess is PCNs will go and INTs will come, but for us it doesn't matter because we have the federation and PCNs will work together and INTs will work together because that is what we have been doing for three or four years.'

In addition to the work on high-intensity users with neighbourhood MDTs, Dr Holdsworth hopes that in a year from now his PCN will be on a better footing with information sharing and information governance, and that the ICN will be building relationships on a wider and wider scale. Local services, including adult social care, are in the process of aligning boundaries, which will help, he adds. 'I would also like to have dismantled barriers to services that require GP referral so our social prescribers and other team members can refer directly,' he says.

INTs don't themselves have the ability to change the fact that 80% of health is socially determined, notes Dr Vell, but she feels that this time they really do need to do things differently.

'We have to get public opinion on side first to understand what we're trying to build, which is where we've been going in Greater Manchester. But NHS England is still old school, in our opinion,' she says.

It is the time to be brave, says Dr Yule. 'This could be a really positive fundamental change to care and wellbeing but the risk is that we carry on in that same narrow health focus, just doing a redesign of services rather than thinking about the whole community.'

It's clear that the ambition set out in the Fuller Stocktake for INTs is very much in the early stages in most places, a stage of definition rather than action. CDs see PCNs as a core team player but have questions about how it works practically in terms of leadership and funding.

But as PCNs wait for details about their future it's clear that everybody is on board with the idea that good neighbourhood working is needed to find the perfect blend of professions to provide good care for patients and that there is no need to wait.

Funding for cloud-based telephony is coming.. Are you ready for it?

Paul Bensley, the managing director of X-on Health, says PCNs need to take a strategic approach to the roll-out of cloud-based telephony to realise the full benefits for healthcare communities, surgeries, and patients this winter and in the future.

A critical moment in the roll-out of modern telephony systems across primary care is approaching, PCNs and their surgeries need to be ready to make the most of it.

The government signalled its support for cloud-based telephony very clearly in May, when Health and Social Care Secretary Steve Barclay made it the centrepiece of his plan to "make it easier for patients to contact their GP and end the 8 am rush for appointments."

The Delivery Plan for Recovering Access to Primary Care promised that £240 million would be invested in helping practices to move away from analogue phones and adopt new care navigation and triage solutions.

NHS England backed this up with a Better Purchasing Framework for Advanced Cloud-based Telephony, to help practices pick from a list of suppliers with the capabilities required.

ICS, PCNs and surgeries are now faced with making the most of the imminent roll-out, aimed at addressing a variety of day-to-day pressures, whilst also laying solid foundations for the future.

Proven benefits for surgeries

For individual surgeries, cloud-based telephony can significantly improve patient-to-practice communications while accessing the administrative control and features needed to improve practice performance.

X-on Health's flagship product, Surgery Connect creates positive patient habits with self-serve features. Patients can be given options to carry out common transactions, such as accessing test results, or requesting a 'call back' to reduce the length of call queues.

Peel Hall Medical Practice recorded a 54.4% reduction in inbound calls and a 77.3% reduction in call length with Surgery Connect

Surgery Connect also generates data that can be used to pinpoint and address bottlenecks that help allocate resources effectively.

The clinical integration provides staff one-click access to view and record patient information during a call. The Surgery Connect Phonebar enables clinicians to seamlessly switch between patient records to call, send SMS, request photo or video call.

X-on Health an SCG company

SURGERY CONNECT

Delivering coordinated care at scale

For PCNs, the additional consideration is scale; clinical leaders need to develop a strategy to deliver more coordinated, proactive, and personalised care to the widest audience.

PCNs will find it much easier to do that if they work with a consistent set of suppliers. Or, if they want to avoid a lot of inter-vendor negotiation and integration, one supplier that really understands the needs of primary care and has good partnerships in place.

Many PCNs use EMIS Community to share records and information between practices, and Surgery Connect integrates seamlessly with it. Making it much easier to transfer calls from busy surgeries to practices with more capacity, or to set up a hub to handle initiatives like the annual flu vaccination and COVID booster drive.

For winter, and the digitally-enabled care of the future

NHS England has just issued its winter planning guidance, placing a significant focus on using health technology to plan capacity, reduce pressure, avoid hospital admissions, speed up discharge, and give patients 'digital front door' options for accessing care and information.

Surveys show many patients still want to use the phone to contact their GP. Careful deployment of cloud-based telephony means that surgeries can improve patient-to-practice communications by reducing call volumes and improving patient care navigation.

A strategic, PCN-led roll-out of new technologies in primary care, will bring all kinds of automation that will enable patients to book more services directly, to machine learning and AI to guide them while they are doing it.

The role of trusted advisors in technology has never been more vital and with the choice of vendors being so broad. The ultimate test for decision-makers will come down to those that have truly listened and delivered proven results.

X-on Health was founded 24 years ago and has focused almost exclusively on healthcare since 2015. Today, we are working in over 2,400 general practice sites, including those that have adopted Surgery Connect because of region-wide or PCN-wide roll-outs.

For more information about Surgery Connect visit www.surgeryconnect.co.uk

NEIGHBOURHOOD WATCH

Integrated neighbourhood teams (INTs) won't replace PCNs, but PCNs do play a key role in an INT

Professor Clare Fuller's *Next Step for Integrating Primary Care: Fuller Stocktake Report*, published more than a year ago, set out a direction of travel for primary care and an idea of how to get there – by setting up integrated neighbourhood teams (INTs) – but it definitely wasn't prescriptive.

What an INT is, and how it links to PCNs is undefined but by degrees it's becoming increasingly clear.

INTs won't replace PCNs, as national director for primary care Dr Amanda Doyle, told our sister publication Pulse (page 4), but PCNs do play a key role in an INT. While this may not be as cast iron as a contract, it is reassuring to hear.

Our cover feature (page 6) looks at examples in Surrey and Leicester, Leicestershire and Rutland (LLR). In Surrey, the INTs have focused on a group of high intensity users across a place. They have been tackling admission rates by catering to the patient in a more holistic and personalised way through PCN frailty hubs.

In LLR, the work is being led by the integrated care board (ICB) and involves bringing PCNs together in localities and merging them into INTs, while retaining them as organisations that employ additional roles reimbursement scheme (ARRS) staff.

A couple of things are worth noting. First, LLR sees this work as a natural extension to what's already being done. ARRS staff have moved care beyond the NHS as care co-ordinators and social prescribers (see page 25) engage more widely with services that are better suited to certain patients' needs (see page 27) and, where successful, they remove some of the burden from GPs. This should assure PCNs that the work they have done will not be scrapped but extended.

Second, in Surrey the plan benefitted from seed funding from the ICB. It is crucial to understand that funding will be needed to support new ways of working. This should give PCN leaders pause for thought as they will have to help articulate the need for, and direct that funding.

INTs are coming but the form they take will vary massively. They need a vision, strategy and leadership. PCNs need to be at the heart of this to remain relevant and ensure there is a focus on the priorities for patients in their locality.

The Fuller Stocktake states: 'The role of PCN clinical directors (CDs) in the future will be essential to the leadership of INTs.' It called for more support for leadership development and 'local provision of sufficient protected time to be able to meet the leadership challenge in INTs' beyond the current contract.

CDs could think about the role they wish to play in their area's INTs and what they would need to take up that role, or how they could support a fellow PCN CD to represent them in this space. Could it be more time or more training? If so, they should make the case for that to the ICB, if it's not happening already.

And PCN leaders can find out and articulate what their network and component practices would like to achieve from being part of an INT. The time for watching and waiting is drawing to a close.

Victoria Vaughan is editor of PCN

FLUX CAPACITY

Professor Aruna Garcea says primary care must make maximum use of the breadth of its roles to cope with the coming winter

Primary care has been at the forefront of care delivery through multidisciplinary teams (MDTs). Nowhere is this more evident than in PCNs, which have seen a rapid increase of the MDT with the recruitment of more than 29,000 primary care and additional roles reimbursement scheme (ARRS) posts since 2019; exceeding targets. Two critical papers, both of which have a direct impact on primary care, were recently published: the delivery plan for primary care access recovery and the long-awaited workforce plan. Both of these recognised the success of MDTs in primary care and describe measures to build on that achievement.

While we appreciate the benefits of MDTs with a wider set of skills to deliver a broader range of services, as identified by the PCN DES, PCNs' capacity to translate the full potential has varied. As we prepare for another challenging winter, how can we ensure we are fully using MDTs to fulfil patient needs while realising potential for resilience and transformation in primary care?

We must now understand what more we can do to work as effectively as possible, not least because enhanced access means there are more appointments available at the PCN scale. Care navigation, integration, collaboration and population health management will all be important here.

To ensure all this is done successfully, integrated care boards (ICBs) and national policy must facilitate the enormous organisation development support that a transformation initiative like this requires, especially when the GP workforce is under significant strain.

The right infrastructure is also vital, as is capital investment so that primary care estates can house these diverse MDT roles.

Primary care will also need support from ICBs with their digital implementation projects, as outlined in the recovery plan. This includes support for population health management, ensuring primary care can tailor services to local needs.

Meanwhile, further additional winter funding needs to be released sooner rather than later. Releasing extra investment to ICBs means they can then fully engage primary care to co-create solutions, instead of scrambling to make ends meet during the colder months.

Recognising and supporting GPs' evolution as 'consultants' in primary care is a critical acknowledgement of us – as a profession and as key players in the system. It will allow us to deliver effective clinical supervision and dynamic support to our teams, as these demands can place significant pressures on GPs and clinical directors (CDs). Clinical supervision and organisation development are critical issues that help us to maintain clinical quality and demonstrate continuity of patient care across MDTs, while improving capabilities for current and future demands.

We have fewer full-time GPs than before the pandemic, who are delivering 12% more appointments. It is vital that we make the best use of the breadth of primary care to have the best chance of meeting winter pressures. We must recognise the importance of collaborating with other systems and ensure primary care is supported to deliver for patients in the months ahead.

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

Professor Aruna Garcea
is clinical director for Leicester City and Universities PCN and chair of the NHS Confederation's PCN advisory group

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PCN ROUNDTABLE

ENHANCED HEALTH IN CARE HOMES REVISITED

Clinical directors and care home leads joined editor *Victoria Vaughan to* discuss the progress made during the past year through the enhanced health in care homes service

ALAMY

DELEGATES

Dr Amit Bhardwaj
Care home lead GP, Harpenden PCN, Hertfordshire

Dr Binodh Chathanath
Clinical director for Bexhill PCN, East Sussex

Dr Katharine Bhatt
Enhanced health in care homes and frailty clinical facilitator, Torbay and South Devon Foundation Trust

Dr Dan Bunstone
Clinical director, Warrington Innovation Network PCN, Cheshire

Dr Zoe Archer
Care home lead, Hastings and St Leonard's PCN, East Sussex

Sam Johnson
Care home programme manager, Central and West London

Victoria Pulse PCN first discussed this service in the spring 2021 roundtable. Then the challenges were how to link the service with work already happening. There was a disconnect between the service demands and patient care. More than two years on, how is it now working in your areas?

Katharine In Torbay, we have a relatively aged population and there are about 87 care homes and almost 2,000 care home beds. Three PCNs have collaborated and deliver enhanced health in care homes (EHCH) through one team using staff from all three PCNs so GPs work on a rotational basis. And we have pharmacy cover, paramedic support and a nurse as well.

We had an acute care visiting service in place before and we have bolted on to that existing service. Doing it at scale has given us some benefits in terms of economies. We have access to wider hours of support than before. We do weekly home rounds and signpost to the most appropriate member of the clinical team.

From a system perspective, I was previously the clinical lead for three PCNs, but we have eight PCNs in South Devon and all are doing things slightly differently. But we have got reasonably good data from across our whole trust about a significantly sustained reduction in care home acute admissions. Obviously, that's going to be multifactorial, but it's nice to see the positive impact of EHCH work now that we're a couple of years into it, not just on individual patients but our system as well.

Zoe It was great to have the DES because before we had so many different practices, managing different patients in different care homes.

The first thing we did was align everybody. That has made a huge difference. We've opened up communication between the 10 practices in our PCN's 65 care homes.

Each practice is aligned to a clinical lead who is a district nurse. They can go in and see new patients and patients who have recently been discharged from hospital. They do a comprehensive geriatric assessment, if needed. They write a summary to the GP if there's anything that needs actioning, but most things they can do such as making referrals to dietitians.

My next thing is to try to work with the clinical leads to improve training.

We've had a number of issues with death verification. In one case the patient was left for 14 hours. You don't need to be a clinician to verify death, you just need adequate training and so I've been looking into that. Unfortunately, I'm getting a lot of backlash from the managers of care home saying that, if [a death] happens at nighttime, they would worry that their staff would not be competent to [verify] it. So we're looking into that. We're looking into getting ear syringing and dentists into the care homes as well.

Amit We've got three practices in Harpenden. Each practice has a named clinical lead GP for the care home. We currently cover three but we've got another two additional care homes being developed. We haven't been told much about them so our clinical director (CD) is having discussions with the council saying, resources wise, how are we going to look after these additional two big care homes?

Chair Victoria Vaughan
Pulse PCN editor

ALAMY

We have a regular multi disciplinary teams (MDT) meetings. We try something quarterly and invite all the care managers. We've got a team of pharmacists and physician associates that do the weekly contacts and GPs do the monthly reviews.

Sam We've got about six PCNs operating between central and west London. There are 14 older people homes and seven learning disability homes that are key drivers. In terms of the EHCH governance framework, we've split it so we've got the enhanced primary care support. This will look at everything about the weekly home rounds, [and] the MDTs, which are co-ordinated by the community matrons. Also, some of our key services such as hydration, nutrition and falls. We've also got palliative and end-of-life care, mental health and dementia care. That's working in close collaboration with all the case-based partners in our area and to facilitate conversations between home managers and GPs. We have an open forum so we're all in the same room together. Also we have digital [services] as well – that's key for access to health and social care datasets.

"We've split the governance framework so we have support
Sam Johnson

Binodh We've got three big practices and around 30 care homes. This is a mixture of nursing homes, care homes and elderly mentally infirm (EMI). Unfortunately the learning disability homes are not included.

When Covid struck, we started by employing the care co-ordinators and then assigned 10 homes to each practice.

We have employed an advanced care practitioner as a paramedic practitioner, who is the main lead of the care home work. She's supported by three care co-ordinators, and we work closely with the care home leads.

We are going to introduce a new system, Enact, a form to be filled in by the care home team to raise concerns. These forms are passed to the care co-ordinators. They don't go to the GP practice any more. It's like a triage. It asks have you done this? Have you done that? It makes [the care home team] think before they pick up the phone and ask for help for something simple. Once that [is up and running], we plan to have a meeting every morning at 8.30am, [when] the teams sit down and look at it all.

We're working with a digital team, Plexus, which integrates primary care and health and social care records. We also did proxy prescribing requests – managers can request prescriptions. We've agreed that our PCN pharmacists will take an hour each every day [on presciptions for] the care home.

Dan Broadly, we've aligned the care homes – one care home to one GP surgery. We have a similar thing to Plexus but the care homes have access so they can request prescriptions directly from the surgery as if they were a patient. →

We trained care home staff to get some observations before they bring the GP in – and now we get fewer calls

Dr Binodh Chathanath

That's a practical thing we've done with our data sharing to enable the care holders to register as surrogates on behalf of their patients.

We've also got pharmacists aligned to the care homes. Their remit is to de-prescribe. It's difficult because you've got to do so much Sherlock Holmes work. But while they're doing the reviews, they're doing that – their broad remit is [to stop] medication rather than start it. My hope is that I will be able to search the numbers of polypharmacy and that number will go down. It's crude, but it'll give us some impact numbers.

Victoria You've mentioned training of care home staff. Do you see an increased confidence in care home staff to manage things before they pick up the phone to the GP?

Binodh Training does work. Just before the pandemic started, we gave training on chronic diseases and foot care. We helped staff to make sure that they get some observations first before they bring us in. They use a score to step up or step down. [They] don't get in the routine of making calls. And we have fewer calls now.

We did a measurement to look at unnecessary admissions to hospitals last year. We looked at 15 care homes, five at each practice. At the beginning of the second quarter, we had about 15 unnecessary admissions. At the end of the second quarter, this number was down to one.

This is partly because of training and partly because our approach is practical. The main thing is the recommended summary plan for emergency care and treatment (Respect) form and how we interpret that – and it's not easy. We can teach but [much comes down to] how we interpret it and how it's put into place. It's about things like [taking] fewer urine samples because there is proper hydration and hygiene maintenance and therefore we reduce the amount of unnecessary antibiotic prescribing.

From a training point of view, we've done a few sessions. One key thing was wound care management. We trained caregivers to offer the first basic wound care while residents wait for results for other things. Each home has a wound care box. That's been well received. We just ran a programme on dementia and managing people with diabetes.

Zoe I've found over the last couple of years that I've worked with the same people and their confidence and clinical knowledge have increased so much.

I'm on call at the weekend for them as our locally commissioned service. The number of calls I receive now has reduced dramatically over the two years. Quite often [the caller] just wants to discuss their patient. It's really positive and gives the staff more job satisfaction, which means there is less staff turnover.

Actually, I think a lot of senior carers would do more if they were allowed. That's where the problem lies at the moment. I get told, we can't do that; head office said no.

Katharine Yes, training is key. There's formal trainings, [such as] verification of death training. There's also the informal training that we are all doing and our care co-ordinators are doing week in week out. It's relationship building, and narrowing the divide between health and social care.

Underpinning the success of training and advanced care planning is the relationship and the [knowledge] that your care co-ordinator is going to ring your home the next day, and you're not going to have your ear chewed off by a grumpy GP [if you] escalate, [because you do it] appropriately and are able to evidence that.

Some of the challenge in the training is staff turnover in care homes. Maintaining any learning is challenging in this environment. But if you've got an established relationship, [the care home can] say, we've lost a member of the team that you trained to do insulin. Can I ask for this new member please?

It's not by ticking boxes that we sustain the benefits we have achieved, it's about doing the stuff that makes it work – that's relationship building and training. And, without wanting to be too negative, the challenge is that neither of those is in the DES.

If I do this from a frailty GP perspective, the evidence-based intervention for our moderately severe patient group is comprehensive geriatric assessment. That's loosely what the personalised care support plan is based on – you can only deliver comprehensive geriatric assessment with an MDT in primary care. If we didn't have our additional roles reimbursement scheme (ARRS) team, our care co-ordinators, would we be able to deliver in an effective way? [Especially] when we're acknowledging that a key part of that is knowing who to call with non medical problems that currently would go to medics who are totally the wrong people to sort this out. You need good care co-ordination. You need good social prescribers, understanding of the voluntary sector and understanding of your community teams.

Victoria New arrangements can sometimes mean a difficult transition. How has that been for care homes and patients? Have you had any feedback on how this different way of co-ordinating care is working for them?

Amit Initially, it was a challenge because patients are used to being with the practice for years. So, building that trust is probably the difficult step initially and the main challenge. But from a care home perspective, it's more efficient. I expect it to make things a lot easier.

I feel like it's going well. We've had really good feedback from the care homes because they feel supported. Obviously these meetings are good in terms [of] discussing cases, if there are any difficult patients. We're trying to incorporate training elements to cover anything that other care homes can benefit from.

Binodh When we assigned care homes to a practice, we did a lot of work to raise awareness among care home managers and residents. And their family members and our staff.

A positive thing from patients and relatives is knowing what's happening. Continuity of care is important. I think that's a key thing for everybody. And as long as there is clear instruction, they're happy. We had really positive comments about the way things have been done in our areas. We have not had any negative comments at all. We are trying to develop a system where there is a lot of input from our team such as dietitians who visit care homes regularly. They train the caregivers about food, hydration and food care, and they also help with the chronic disease management.

Zoe The biggest challenge has been getting each individual practice to do the same thing. We've been meeting with the care co-ordinators for each practice and will set up the teams group to address that.

We had chat with 10 care managers way back at the beginning to ask what would be helpful for them as we didn't want to do a tick-box exercise. So we tend to only discuss the very complex cases. We can be more focused on the complex patients and we have the integrated care manager who can co-ordinate and invite different members depending on the case that's being discussed.

Most of them said that with the new working – the way every care home has a dedicated phone number, email and so on – means that things are dealt with very quickly. It's usually within a week, especially with the ward round.

ALAMY

Dan We have an associated care co-ordinator. Our care co-ordinator picks up the non clinical stuff – [for instance] if the care homes have got a problem with dressings. That's been really good because it's helped the homes in a very practical way.

Victoria How do you see the EHCH evolving this year and beyond?

Dan I don't think this sort of thing can proceed without PCNs because you need an MDT to manage it. I deeply disagree with the BMA's point that PCNs have failed thus far.

"GPs are expert at holding risk in the community for frail patients"
Dr Katharine Bhatt

We've now got a GP with a specialist interest in frailty. They do the care homes proactively and reactively, and it's a definite skill set. They know the patients, they know the risks to take and they can push the boundaries based on previous conversations. I deeply believe in frailty as a service. Ultimately, I think it's a underserved part of our population for a whole variety of reasons.

Katharine If you look at the trajectory for our ageing population size, our frailty trajectories and also our geriatrician numbers, we're going to have an escalating number of severely frail people living in our communities with nobody to look after them. I realise it's a Marmite [concept] because some people hate it but GPs are expert at holding risk in the community for our frail patients. We can share expertise and knowledge with our wider MDTs to support that. It would be bonkers to leave this – we've got to think of how much progress has been made in that space over the last couple of years. [Yet] if no funding is attached, look at how stretched our workforce is and what other things are going to be put out for us to do. How are we going to [run this service]? I don't have an answer for that.

Sam We have used this as a starting point. There are local needs that can be looked at as well. The EHCH framework does provide focus and we're all signed up for it. The other two main work streams are workforce and personalisation. →

The next step is opening up communication between primary and secondary care, out-of-hours and the ambulance service

Dr Zoe Archer

At this point we're trying to standardise the London personalised care plan so it's standard across both boroughs, making sure the social ambitions of the resident are captured.

For workforce, we've got a pilot running from Imperial College [University of London]. We have a doctor who was undertaking a baseline activity on the early signs of deterioration and understanding where homes are, how they access services, how vital signs [are] taken. The plan would be to offer specialised training to those homes, to ensure the workforce is trained.

Binodh There are loads of streams of work happening across the system. They have to be streamlined into this, rather than [being] isolated pieces of work. This bit of work that we've done can help to bring care back into the centre to where the person is. It has evolved from there. That's what we're doing at the moment and I say this has to carry on. We need this support. We need to have these people in place to carry on this good work.

Zoe Ideally, the next step would be opening up communication between primary and secondary care, the ambulance service, out-of-hours and hospices. That's one of the biggest barriers in trying to manage patients and make significant change. Everyone has their own contracts and their own funding.

Amit Do we want to keep this service running? Yes, absolutely. And the demand will only go up. Where do I see it going?

I feel we need more resources to help us. We're trying to get an elder care consultant attached to us, but I think there is a contract issue. How are they employed in primary care? So it hasn't happened yet but we're trying to work out how to do it.

We're trying to get specialists to help us – to do a mini ward round to support GPs and the PCN staff, the physician associates and the pharmacists. It would be more efficient and give more confidence to the care team.

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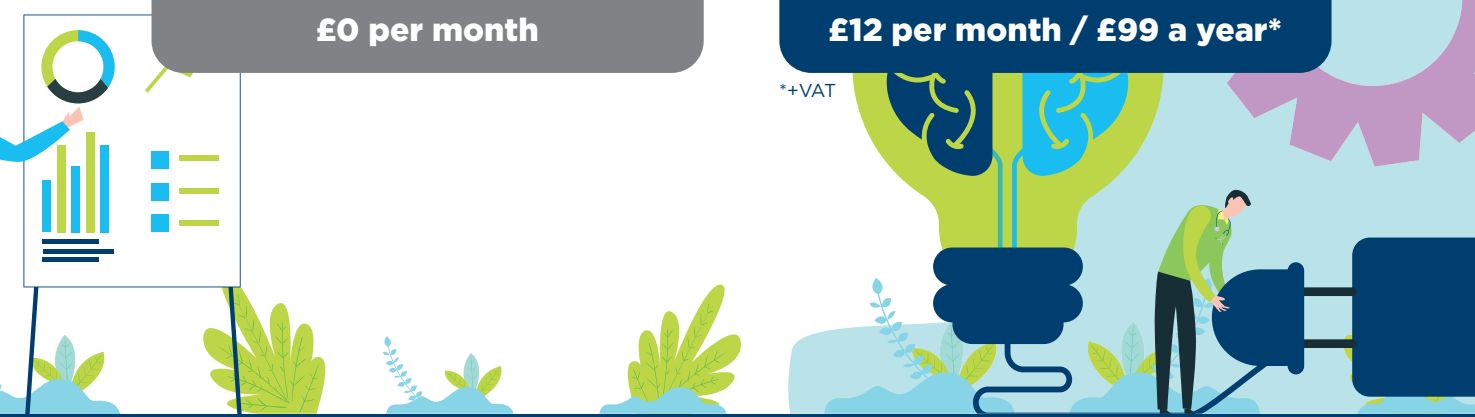

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PCNS, ME AND THE BMA

As the BMA withdraws its backing for PCNs, Dr Sian Stanley stands up for them

I am pro PCNs. Recently we have seen our whole PCN team doing incredible work in increasing awareness of cancer screening, culminating in a Sunday drop-in smear clinic where 45 women attended in one morning, some of whom were overdue or had never had a smear.

I am pro PCN because I have seen what primary care at scale can do, and because I cannot see how many of our projects could happen without it.

I know not all PCNs are equal and some are not functioning well. Perhaps this is due to poor leadership or practices not playing nicely. I am genuinely sorry and would love to see all areas unlock the potential from their PCN.

I cast my mind back to May 2019, when our PCN was set up, with very little organisational development money and a vague sense of purpose. This DES I believe was negotiated by the BMA on behalf of its members. The BMA had also negotiated a government indemnity scheme, and those of us who were paying sky-high indemnity costs were delighted to be freed of this enormous burden. I trusted the BMA General Practitioners Committee (GPC) and thought we could make a go of PCNs. They seemed a good idea, although it was clear we would need a lot of support.

I did question why this money was not going into core funding. I had robust debates with colleagues who said if it had, primary care would never change.

In June 2019 I went on a BMA masterclass for PCN clinical directors. We examined the network DES. Many people were worried about how this would work but we came away feeling supported and cared for by the BMA.

In February 2020 I was asked to speak at the BMA PCN conference. My session focused on working with partners. It was like I accidentally produced an integrated neighbourhood team (INT) without knowing what one was.

The GPC was delighted. It had just negotiated the 100% reimbursement for the additional roles reimbursement scheme (ARRS). It felt wonderful to have the expertise of HMRC, solicitors and the BMA helping us form our networks. Again, some people remained cynical but overall, the feeling was positive.

Fast forward two years. The BMA is trying to remove PCNs altogether. Why? I am not sure. The BMA has been very good to me and I am loyal to those who have helped me, but I am not sure it is representing me at the moment. For a while now it has felt that we are thriving despite the BMA, not because of it.

I would love to see a solution-focused stance on PCNs, where those that are not working are helped to mature and flourish. Those that have become paralysed need support and infrastructure with clearer governance and all the boring things that are necessary to make an organisation function.

There is no doubt that we need more core funding but is the abolition of PCNs the right way to get it? Should we not look into the art of the possible, with funding flowing into practices who work together and produce good outcomes rather than simply good processes?

My story with the BMA has not ended. But I want us to work together to build a brighter future for primary care rather than arguing among ourselves.

As one of my colleagues said to me, 'If not PCNs, what would we get instead?'

ONLINE
Read more blogs at pulsetoday.co.uk/pcn

Dr Sian Stanley
is clinical director of Stort Valley and Villages PCN, East of England CD Representative, NHS Confederation and a GP partner in Bishops Stortford, Hertfordshire

LEADING QUESTIONS

Charlotte Osborn-Forde, CEO of the National Academy for Social Prescribing, describes the evidence and benefits of social prescribing link workers in an interview with *Victoria Vaughan*

What advice do you have for clinical directors (CDs) for getting the most from their social prescribing link worker?
The first thing is to read the guidance and see what's possible with a link worker and make sure you understand what the role is.

It's a band five role. It is not about simple signposting. It's about enabling your practice to offer personalised care, and to have a part of your team that is able to unpick non-medical issues that are affecting patients' health.

It works really effectively where you have generic link workers and also specialisms. For example, a PCN could recruit a link worker with a background working with children and young people with mental health conditions.

We are now seeing PCNs think about the biggest issues affecting their network, such as very long waiting lists for neurodevelopmental services and young adult mental health services. PCNs can work creatively with local partners and link workers to identify how to support people on those waiting lists through social prescribing.

We've seen PCNs recruiting quite diverse teams with specialists that are very targeted to their particular needs. For example, in Kent, patients with neurodevelopmental issues can be referred by GPs but link workers are also looking at GP coding for families that are on the waiting list. They proactively telephone them to ask, 'How is everything? Do you have any concerns? What more can be done?'

That came from a CD who said they'd made referrals into services that weren't being progressed because the information wasn't right on the referral form. They'd needed other bits of data and evidence, so a link worker was taking ownership of that process and also reducing demand on GPs.

We need NHS England and others to spread the message about the value of social prescribing
Charlotte Osborn-Forde

Is there any evidence that social prescribing works?
Social prescribing only became mainstream in 2019 with the additional roles reimbursement scheme (ARRS). And since then, we've had a pandemic. Before that there wasn't even an agreed definition for social prescribing. This meant there was no shared approach. So what would go into an evidence review?

Now, we've got the definition of social prescribing, and we start to invest in it and have it delivered in a standard way. Now we're starting to see evidence as a result of that. The National Academy for Social Prescribing (NASP) collates that evidence and publishes it. That includes looking at the positive impact social prescribing can have on a wide range of outcomes for patients, as well as economic value and reductions in GP appointments and acute secondary appointments.

We're now building up a robust picture of evidence and we can provide it for any part of the system.

Previously I was the CEO of Involve Kent, a charity providing social prescribing. We worked with 21 PCNs to provide social prescribing link workers. We were constantly evaluating the impact of that.

One study looked at around 1,000 patients who had accessed a social prescribing link worker, referred by their GP in a PCN. Then we were able to track their A&E usage and unplanned admissions. Depending on the demographic we saw up to 20% reduction in A&E admissions and an 8% reduction in unplanned admissions.

We did that by working with the integrated care board (ICB), pseudonymising their NHS numbers and running that data. That showed us those patients weren't frequent fliers at A&E, and they weren't necessarily patients with really complex health needs. They were just people that the GPs felt could benefit from social prescribing.

At the NASP our academic partners have looked at other examples and compiled evidence reviews that show how social prescribing can reduce pressure on primary care – including reducing GP appointments and A&E visits and saving costs. It can have a significant social return on investment as well.

What could help support social prescribing in primary care?
We probably need support from NHS England and the Royal College of General Practitioners and others to spread the message of how valuable social prescribing can be to GPs and PCNs, to help them develop their strategies and meet their requirements.

As I've said, there is flexibility in the guidance and in how the investment can be used. For example, we're publishing a guide to supporting children and young people's health priorities through social prescribing in PCNs, which looks at what they can do and what's available. But I think there should be more strategic development to help CDs understand the potential and possibilities.

Do you think PCNs realise the potential of social prescribing?
There is a huge range of understanding. Some really get it and some don't. Some of that is related to things outside PCNs' control. What we typically see is in very deprived areas, there's already a lot of demand on GP practices, and there isn't always headspace to look at something holistic. Often where we see it move forward, it's because the CD has always valued a biopsychosocial model. I would encourage PCNs to link up with the local voluntary sector, who can guide them on connecting with local services. For example, all ICBs now have an alliance of key voluntary sector providers in health and wellbeing. They know what might be available, and that expertise and support is valued.

Are PCNs crucial to the use of social prescribing?
I don't have strong views on the structure of GP practices and how they work together. But it is important that social prescribing teams are able to work across a number of practices.

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IS HELPING FISHERMEN OFFSHORE

An outreach pilot in Northumberland is offering GP appointments to fishermen who are often offshore when practices are open. *Karen Wood*, health inequalities lead for Well Up North PCN, explains

We have quite a lot of fishermen in our area. Well Up North PCN consists of nine practices stretching up along the coast north of Newcastle upon Tyne. Our PCN serves 77,477 patients, of whom we estimate around 80 are fishermen.

Being out at sea, often for stretches lasting several days, is much more of a lifestyle than a job. They're unpredictable too, depending on the weather. All this restricts fishermen's access to GP appointments. If they need an urgent same-day appointment, they might only be available when our surgeries are closed. Or if they book an appointment in advance, they might not be able to attend because of the weather.

Of course that means it's much harder to spot potential problems early on. And if they need to see one of our nurses to manage a long-term condition and they are ringing up on the day, the appointments aren't there.

We realised we needed to bring our services to the waterfront.

Methods

We relied on our practice to identify that this was an issue. We started by looking at the health inequalities in our patches: who can we see isn't coming in very much? It became very clear to us that we had a group of fishermen who were ringing up on the day and struggling to get seen.

We launched the pilot service for fishermen in January, based at Amble harbour building in Morpeth. It takes place on a Wednesday every eight weeks. Funding for the pilot comes from the health inequalities investment and impact fund (IIF).

Our target is to offer between eight and 10 appointments across the day. We know they will cover a wide range of health concerns, so we send a variety of staff – our first-contact physiotherapist, a GP, a nurse and a social link worker.

Our health inequalities care co-ordinator Karen Gibson spent time on the harbour, talking to the people we were trying to reach. We spoke with the harbourmaster to determine how our plans would be received, and if they aligned with the needs of those who work in the harbour.

We became aware of two common issues for this patient group – excessive alcohol intake and mental health problems. Also, the job can be isolating and loneliness is a problem for a lot of these people, so we included a mental health practitioner.

Outcomes and challenges

We're engaging with patients who haven't been coming into the surgery so the benefits are clear: we're picking up things that might have been missed. Monitoring of long-term conditions, especially cancer, is much better. We've been able to raise awareness of the symptoms of prostate cancer, which might affect a lot of people in this job. The health promotion aspect is another benefit.

In the launch session, 14 patients were seen. In the second session, eight came along. In the third, no one turned up and in the fourth, most recent, session we saw seven.

If we want the service to remain feasible we need more people to attend, particularly as we're sending staff out of practice for an extended period.

There are things we are doing to encourage that engagement, but a big factor is the unpredictability of the weather and the lifestyle that makes it hard for these patients to come in for health appointments. If the weather is terrible and they've had to come back to shore then we are there waiting for them. But if not, it isn't feasible to keep our staff down there.

But one of the important things we are doing is engaging with the families of the fishermen who are registered with us. Perhaps if a fisherman isn't too concerned about taking the time to come into a clinic, they might do so with a push from their partner. Then they know where we are and when.

If we are able to extend the programme beyond its pilot, we'll look at using extended hours to offer later evening appointments that suit their needs better.

Karen Wood is an advanced nurse practitioner and health inequalities lead for Well Up North PCN and an executive director for the PCN

ONLINE

Read more additional roles reimbursement scheme (ARRS) articles at

pulsetoday.co.uk/category/pulse-pcn/

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BROUGHT IN A HEALTH MODEL FROM BRAZIL

A community health worker model made impressive changes in Brazil, so a GP practice teamed up with public health to implement it in a deprived area of London. After only a year, the impact has been major. *Dr Cornelia Junghans-Minton*, *Dr Matthew Harris*, *Dr Saul Kaufmann* and *Dr Sheila Neogi* explain

The Churchill Gardens estate in Westminster is a community with a high chronic disease burden and low levels of vaccination and screening uptake. There is a 17-year life expectancy gap between men living in areas like Churchill Gardens and those living 10 minutes away in affluent Belgravia.

To address these issues from a new angle, public health at the local authority and a GP practice drew inspiration from the Brazilian Family Health Strategy.

The vision came from Imperial College London's reverse innovation research, which seeks to understand how ideas from lower income countries could be effectively translated to the UK. Community health workers (CHWs) exist in other countries, but it is the Brazilian model that holds the most promise.

Brazil's CHW system has led to significant uptake in screening and immunisations, reduced hospital admissions and increased equity. It has also led to a rise in breastfeeding, improved child development and demonstrable reductions in mortality. It is cost effective because CHWs are trained lay community members. They build trusted relationships with households across a small area in a universal, comprehensive and integrated way. It is different from any other role in the UK health system.

Community health and wellbeing workers

In Brazil, CHWs live in the community they serve. Every month, they visit all the households in their area to build a relationship with the residents. They address their needs in a personalised manner, signposting to and connecting to services as needed. There is no discharge from or referral to a CHW. If you live in a neighbourhood covered by a CHW, they will knock on your door once a month, or more frequently if needed, to see how things are going.

To mirror the Brazilian CHW role, we looked for patients registered with the practice who were in Churchill Gardens. Four community health and wellbeing workers (CHWWs) were recruited from a pool of local community champions with a focus on empathy, a non-judgmental attitude, cultural competence and problem-solving abilities.

They were employed by the local council, each holding an honorary contract with the GP practice. Their training included introductions to key local services such as health visitors, care navigators, family navigators and social prescribers.

Each CHWW was given around 120 households to look after. The practice sent letters and text messages to the households to let them know who would be knocking on their door and what the service was about. The CHWWs wear T-shirts and fleeces with the CHWW logo and lanyards, so residents can identify them easily.

Building relationships

One year in, about 60% of residents have engaged with the CHWWs and engagement continues to increase. Crucially, once a relationship has been established, nobody has disengaged with the CHWWs.

Several important insights have emerged, including the discovery of people with high medical needs who do not visit their GP or A&E. We have also been surprised at some of the people struggling to access services. Importantly, the pilot has shown that the intervention is possible and acceptable to residents.

The project has already delivered significant impact. A quantitative evaluation of uptake showed households visited by a CHWW were 47% more likely to receive a vaccination and 82% more likely to have cancer screening and NHS health checks compared with homes that have not yet been visited.

We also found a decrease of 7.3% in unscheduled GP consultations in visited households compared with the previous year, while unscheduled consultations only decreased by 1% in those not visited.

> **CHWWs can help resolve households' other problems so they can then give more attention to their health**

Bridging gaps

CHWWs act as 'glue', creating bridges between the local authority, health services and the voluntary sector, drawing on these services as required. Relationships between CHWWs and the residents are enduring and trusted. They become a first point of contact in times of crisis and the CHWWs know how to provide just-in-time support.

Households may require support at any time so regular light-touch engagement is a must. Targeted health campaigns often fail because people may require multiple conversations or because other issues – housing, worries about children, antisocial behaviour or employment – are more of a priority.

As CHWWs provide support across the health and social care spectrum, they can help resolve households' more pressing concerns, before returning to health conversations (see box, below right).

The trusting relationship also means they are well placed to learn

From left: health and wellbeing workers Nahima Begum and Comfort Idowu-Fearon, GP and clinical lead Dr Cornelia Junghans Minton, and health and wellbeing worker Maureen Katusabe

about misconceptions. For example, a CHWW discovered some Muslim women declined cervical screening because in the countries they came from this service needs to be paid for. There was also a belief that married women did not need to worry about cervical cancer. However, being Muslim herself, the CHWW was able to address this.

As a result, GPs see fewer patients seeking help for non-medical problems, such as requests for housing letters. But at the same time, they see more people presenting with issues that were previously unknown to the practice because the patients would not normally make an appointment.

A scalable model

In Westminster, the model will expand to up to 25 CHWWs in areas of high need. It has also inspired two more pilots in London as well as in Yorkshire and Norfolk. And it has attracted the attention of the National Association of Primary Care (NAPC), which is championing a national roll-out. There is a CHWW apprenticeship scheme to standardise training and professionalism.

However, challenges remain.

Integration takes time and the CHWWs are only as good as the relationships they can build with the professionals around them and the help available. Clinical and pastoral supervision is key, providing psychological safety for the CHWWs.

And a sustainable funding solution is still needed. An initiative like this needs long-term sustainable funding to work. The longer the CHWWs work in a locality, the better they will be at building relationships and the more knowledgeable and skilful they will become.

In terms of value for money, the pilot cost about £90,000 in the first year with the majority being salary costs. Previous modelling shows that it would cost about £2bn per annum for every household in England to have a CHWW. But if the programme focussed only on the areas of highest need, this would be around £300m.

By starting in deprived areas, the impact on health inequalities could be profound.

The next step will be to demonstrate measurable impact on prevention, community cohesion, health literacy and wellbeing among the residents and to safely scale and implement a truly collaborative model on the ICS footprint. Imperial College London is hoping to carry out a trial to assess this.

CHWW CASE NOTES

• During a monthly home visit, the CHWW noted that a 45-year-old man had not had an NHS health check. The resident listened to the information but wanted to talk about a housing issue. During a subsequent visit, he mentioned health issues and the CHWW encouraged him to see his GP. He ended up being investigated for prostate cancer. Months later, the resident asked about the health check because, following his cancer scare, he wanted to take better care of his health.

• The CHWW visited a family and learned that the 12-year-old daughter was missing a lot of school because she accompanied her mum to medical appointments to translate. The CHWW brought in help for the mother and met the daughter separately to talk about her mental wellbeing and support.

PCNs AND THE NHS LONG-TERM *WHAT*FORCE PLAN

Health journalist Andy Cowper says the new long-term workforce plan raises too many questions

One of the big bits of health policy and political news of recent times was the NHS long-term workforce plan (LTWP), published at the end of June.

It is an (inevitably) unfunded way of telling people 'don't worry – it'll all be absolutely fine in a couple of Parliaments' time, honest'.

So now we're all reassured. Except, perhaps for staff in PCNs, because they were not explicitly mentioned in the LTWP. Nor were they obviously covered in the 6% pay deal for NHS staff (of which only 3.5% is funded).

At a time when the rhetoric is about taking the pressure off primary care, this feels problematic. LibDem research released to *The Times* shows that in May, 1.3 million people waited over a month for a GP appointment (up from 912,000 in May 2022).

Knowing your ARRS from your elbow

In the LTWP, NHS England pledged to introduce more than 20,000 additional clinical staff to general practice by 2036/37, building on 'the success' of the additional roles reimbursement scheme (ARRS). The national quango plans on bringing in 15,000 non-GP direct patient care staff and more than 5,000 primary care nurses 'to extend the success' of the ARRS.

Alas! NHS England did not specify whether it would introduce new roles or add to the total available funding pot. This was later clarified – it will indeed uplift finding to cover this, but the detail will reward close attention, as 2.5% of the 6% pay rise is unfunded and is meant to be delivered by 'reprioritisation and greater efficiency', according to the Department for Health & Social Care.

Looking to new contract negotiations for 2024-25, the BMA's GP Committee (GPC) called for a unified new contract, with all funding coming through one route with sufficient resource to enable practices to deliver core services. It also called for QOF, Impact & Investment Fund (IIF) 'and all other micro-targets' to be scrapped along with the PCN direct enhanced service, as it has proven to be 'a failed project' to be replaced with a quality improvement-based contract. This also means removing general practice from the CQC's remit, if the GPC prevails. Lots of uncertainty.

What about the clinical director PCN workforce?

What does the future hold for the 1,250 clinical directors (CDs) in PCNs? Having asked GPs to care for practice populations differently, what are the plans for CDs now?

The LTWP raises another question for people trying to make PCNs and GP federations work: 'where's the money for me as an employer to hire these newly trained people?' It is worth noting that the entire promised increase in workforce training money is less than the NHS lost in real-terms funding in April when the Government failed to uprate the NHS budget by inflation.

There is also the issue of retention. How much point is there in having new trained staff, if there's no one left for them to work with beyond those who couldn't get a job elsewhere?

This feels like a lot of unanswered and important questions.

ONLINE
Read more PCN articles online at pulsetoday.co.uk/category/pulse-pcn/

Andy Cowper
is the editor of *Health Policy Insight* and a columnist for the *BMJ* and *Civil Service World*

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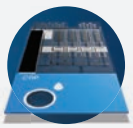

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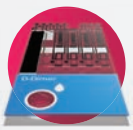

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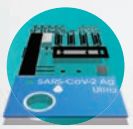

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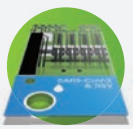

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