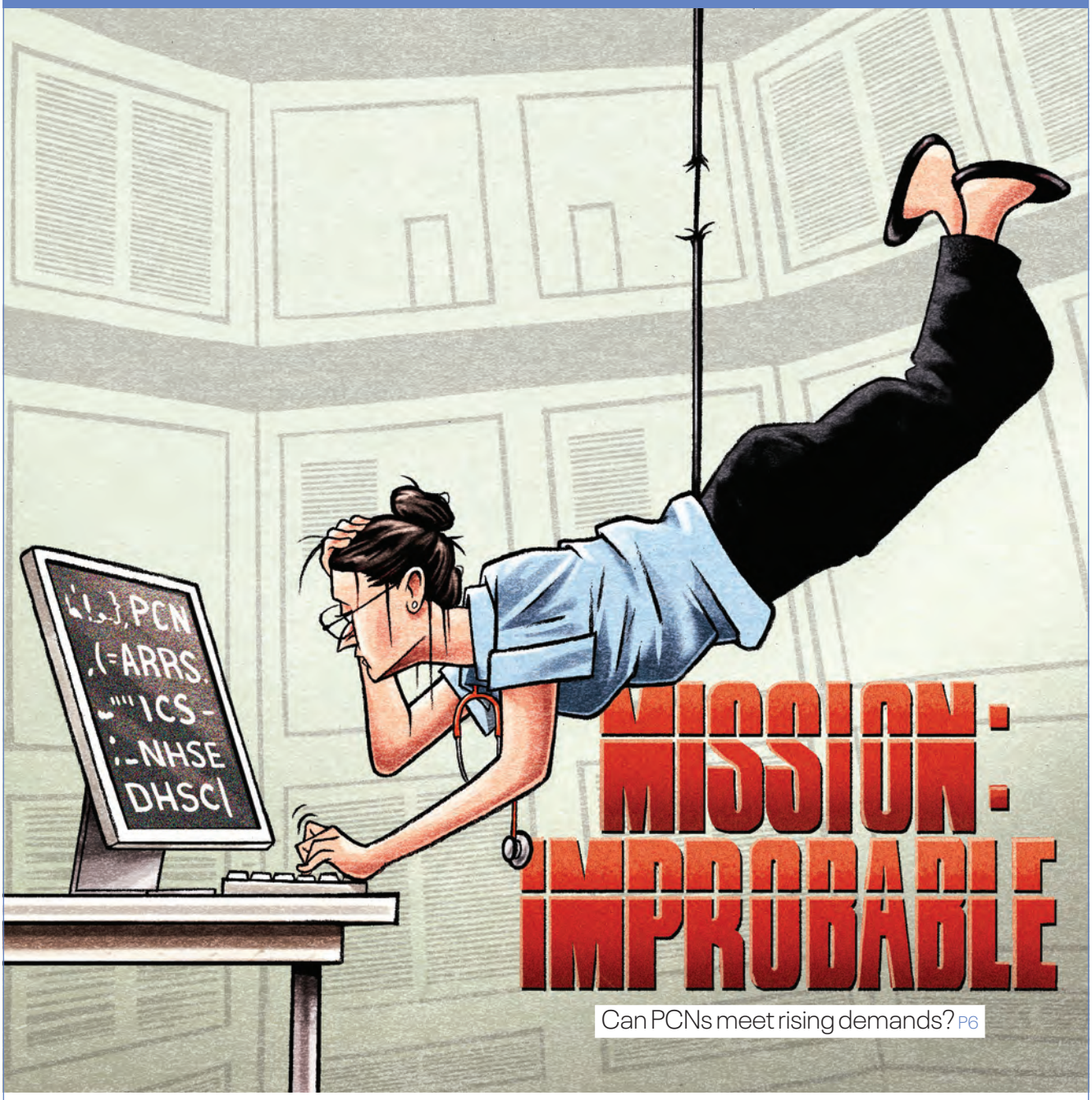
LAUNCH ISSUE

PULSE PCN

CONNECTING PRIMARY CARE NETWORKS
SPRING 2021



MISSION: IMPROBABLE

Can PCNs meet rising demands? P6

INSIDE

SPRING 2021

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STRUCTURED OPIOID AND GABAPENTINOID REVIEWS BECOME COMPULSORY FOR PCNs

PCNs are now required to offer structured medication reviews (SMRs) to patients taking opioids and gabapentinoids, it was confirmed last month.

NHS England published a suite of documents in April relating to the network DES for 2021/22, including 'minor updates' to the SMR requirements that 'reflect evolving clinical policy'.

A new FAQ document says: 'From April 2021, SMRs should be offered to all patients identified and prioritised within the groups listed in the DES service requirements, using appropriate tools.

'This explicitly includes patients on any opioid, gabapentinoid, benzodiazepine or z-drug.'

Accompanying SMR guidance lists other eligible patients, which 'must include' care home residents, those with severe frailty, those taking 10 or more medications and those on medicines 'commonly associated' with errors.

The FAQs reiterate that although reviews should be offered to 'all' eligible patients 'identified and prioritised', the 'actual number of SMRs offered will be determined and limited' by clinical pharmacist capacity.

However, it is also specified that PCNs must 'demonstrate all reasonable ongoing efforts to maximise that capacity'.

And the guidance says: 'PCNs and commissioners must discuss and agree a reasonable volume of SMRs... if a PCN has not been able to secure sufficient clinical pharmacist capacity to offer initial, follow-up and reactive SMRs to all identified patients in the required cohorts.

'In estimating available capacity, CCGs and PCNs should acknowledge that clinical pharmacists have a variety of responsibilities and not all of their hours should be spent on SMRs.'

The reviews, which could take 'considerably longer than an average GP appointment', can be done remotely 'where clinically appropriate'.

PCNs SET UP DROP-IN CLINICS TO CATCH COVID VACCINE STRAGGLERS

Primary care networks took to holding drop-in Covid vaccination clinics to reach their remaining unvaccinated patients in the first nine priority cohorts.

Patients usually require an appointment to be vaccinated after receiving an invitation to book, but many patients failed to respond to their invitation.

In Bolton, the local GP federation decided to make the process more convenient for patients and to minimise any obstacles to accessing the vaccines by holding a walk-in vaccination service.

The GP-led clinic, which took place on 28 March at a community hall, saw attendance from 378 people to receive their first dose of the vaccine.

Bolton GP Federation performance and programme manager Dawn Lythgoe told Pulse PCN that it had developed the clinic in response to evidence showing that the appointment booking procedure had been a 'potential barrier' to some people getting vaccinated.

She said: 'Not everybody has got access to a mobile phone, to receive a text or go online. It's about saying, actually you don't need to do any of that – just come along if you meet the criteria.'

South London GP Dr Nick Merrifield told Pulse PCN that his practice – the lead for his PCN – had put a poster on a local Facebook group, inviting over-50s to 'turn up' for a jab on 20 March.

He said: 'It's interesting that we spent hours all week ringing people who didn't want it, and yet one post on Facebook resulted in 150 people who did.'

Other local organisations have also held drop-in vaccination clinics to maximise uptake.

Leicestershire Partnership Trust, with the help of the local CCGs, held drop-in clinics on Sunday 28 and Monday 29 March for all eligible patients at a local centre, and saw 450 walk-ins on the first day alone.

QOF FLU PAYMENTS MOVE TO PCN FUND

Four flu-related QOF indicators, totaling 18 QOF points, were retired in April 2021 and replaced with new incentives in the Investment and Impact Fund (IIF).

NHS England QOF guidance for 2021/22 said the rationale was for 'incentives to support seasonal influenza vaccination coverage' to be at PCN level via the IIF.

The IIF is an incentive scheme introduced in September 2020 and focuses on areas where PCNs can contribute towards the 'triple aim' of 'improving health and saving lives', 'improving the quality of care for people with multiple morbidities' and 'helping to make the NHS more sustainable'.

The eight IIF indicators included in 2020/21 relate to seasonal flu vaccination, health checks for people with a learning disability, social prescribing referrals and prescribing.

Under the flu indicators, PCNs will be measured on the percentage of over-65s receiving the seasonal flu vaccination. They will be worth £6,400 to the average PCN.

However, Swindon GP and QOF expert Dr Gavin Jamie told Pulse PCN: 'To my mind, it reduces the incentive to invest in flu uptake. There is still the item-of-service fee but this year, staff came in on a Saturday and we paid overtime and there's going to be less return on that.'

ALAMY X2

MISSION IMPROBABLE

There is mission creep in every area of the NHS but PCN work is spreading way beyond the original plan of bringing practices together to provide more care locally. Are the new demands now making their mission improbable? *Emma Wilkinson* reports

Since the ambitions for PCNs were first set out in the NHS long-term plan, the requirements placed on them have been substantial, not least with NHS England's recent publication of Enhanced Care in Care Homes, bringing a collaborative approach to serve individual needs, in care homes and structured medication reviews.

The pandemic galvanised PCNs to get online services going and provide support at the network level. They then showed just what primary care was capable of by setting up a world-leading Covid-19 vaccination programme at phenomenal speed.

NHS leaders have agreed to hit the pause button on the rollout of further planned specifications, with the BMA saying now is not the time for major contractual changes. Yet there is growing concern among PCNs that they are being asked to take on more and more that they don't have the capacity, resources or training for.

Dr Sarit Ghosh, clinical director (CD) at Enfield Unity PCN in north London, said once the network DES was in place, everyone suddenly saw the PCNs as the first port of call.

'For anything that needed primary care input, whether strategy or operations, there was an assumption PCNs would step forward. That put a lot of pressure on CDs,' he says.

'When the pandemic happened, people immediately came to the PCNs and CDs to deliver. In an emergency situation everyone stepped up as clinical leaders. But it does show that PCNs are seen as the solution to everything,' Dr Ghosh adds.

'Most PCNs are not equipped to deal with a lot of things that are coming their way, but are not in a position to say no either,' he says.

Dr Colin Garnham, CD at Beverley PCN, one of the largest networks in the East Riding area of Yorkshire, says the Covid-19 vaccine programme shone a spotlight on PCNs. All of a sudden everyone knows they're there.

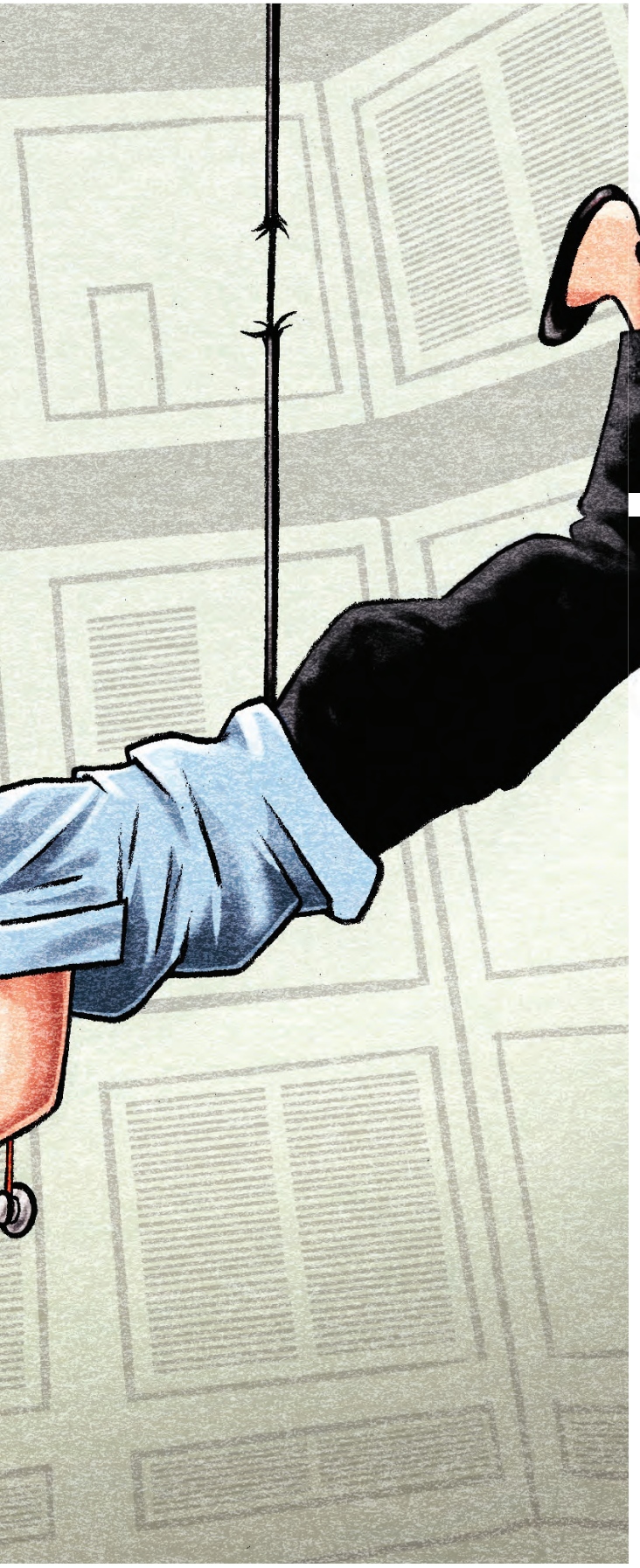
There is a 'huge disparity' between what he expected as a CD and how the role has turned out, he says. They hit the ground running with an incredibly successful programme to have paramedics doing care-home visits but are now struggling to keep up with the demands being placed on them.

'When the care home DES started, our neighbouring PCN couldn't cope with all the care homes so we went into an arrangement where we took on an extra two. It's snowballed to the point where the weak structure of PCN is taking the strain.'

That is in addition to the huge amount of work co-ordinating the vaccination programme including staffing, he adds, explaining that a large amount of his time is spent dealing with bureaucracy.

'The CCG and the powers-that-be are sending ridiculous emails and requests. I came into this thinking I was a CD and I'd be working with the practices to help direct what we're going to do with monies, but the CCG seems to think that everything should be sent to us. I spend half my time, if not more, in batting stuff away or dealing with it.'

BEN JENNINGS



It is a picture that Dr Geetha Chandrasekaran, CD of North Halifax PCN in West Yorkshire, recognises.

Even before the pandemic there was a sense that lots of organisations – CCGs, practices themselves or care homes – saw the PCN as a central place to go to with queries or requests.

'They do not understand that the PCN is there for some very defined DES stuff. We get quite a lot from CCGs because it is easier for them to deal with five CDs than 20 practices.'

There is a risk, agrees Ruth Rankine, PCN network director at the NHS Confederation, that PCNs will be asked to take on too much and will not be adequately resourced to do it.

'The Covid vaccination programme has shown that general practice working at scale has significant advantages and that multidisciplinary team working has significant benefits.'

But she adds: 'There has been an awful lot put onto the leadership of PCNs during Covid.'

In terms of what PCNs should be doing, a careful balance between national specifications and local flexibility is needed, she says.

'Our view is that they've got the balance wrong at the moment. If you go back to the NHS long-term plan, the purpose of PCNs was to respond to the needs of your population and reduce health inequalities. With the current contract, it's one size fits all – this is what you will do, irrespective of your population or your demographic, or deprivation levels or your system. We've lost the golden thread back to the purpose of PCNs.'

"The powers-that-be are sending ridiculous emails and requests

Dr Colin Garnham

Of course, because this has been such a pressured year for GPs, some new service specifications have been delayed. There is the question of when they will come in, what they will look like and how onerous they will be.

In addition, there are questions about how PCNs will be involved in the integrated care systems (ICS) agenda.

At the moment, Ms Rankine says, some are already involved in system-level discussions and others don't even know they should be involved, even though PCNs will have an important part to play.

The Government's white paper on NHS and social care reform after the pandemic, published in February, sets out proposals for ICSs underpinned by legislation that will make ICSs accountable for outcomes of the health of the population.

The white paper alluded to what would be expected of PCNs, but there was not enough detail of how PCNs are involved in system →

level design, says Dr Ghosh. 'The ICS white paper underlines that PCNs should have a key role, so there needs to be investment and infrastructure in PCN senior management to be able to do that.

'The personality of most doctors is to just get on and get things done, but that means running a lot on goodwill. That will run out if people over-commit themselves. If you want a sustainable model, you need to invest.'

Dr Rebecca Rosen, a GP in south east London and a senior fellow at the Nuffield Trust, says an ICS has been operating in her area for more than a year. It sets the strategic plan and PCNs are involved in the implementation.

'CDs are being drawn into this kind of development and they're having to invest a lot of time, probably more than they ever thought they'd have to, as well as being asked to be the voice of general practice,' she says.

Working to strengthen general practice is already a big ask and CDs are already finding they need more time for that, she adds. 'If the expectation is that they are going to be the representative of general practice in service redesign and integrated pathways, that is impossible to do on half a day a week. The expectations are growing and growing.'

Within 10 years there is exciting potential for PCNs to do amazing things rooted in the community, but that's not going to happen within the next year, she says. 'If you have patience and resources, maybe the expectations are realistic. But as ever in the NHS it becomes about expecting too much too quickly.'

The renewed focus on ICSs could produce a scenario where all these pathways are being redesigned and everyone will be giving tasks to PCNs. 'Every plan coming out of an ICS will have expectations of PCNs but the ICS leadership will have to be realistic about what PCNs are able to do at the same time as doing the DES. It may be that just doing care homes is enough,' Dr Rosen says.

There is variation in what PCNs are able to manage. Some have really flourished and others have struggled to get off the ground, says Beccy Baird, senior fellow at the King's Fund think-tank. There are multiple reasons for this, including whether they were formed from existing networks and what operational and managerial support they have. That is very patchy, says Ms Baird.

In order to carry out population health management, PCNs 'will need a lot of operational, managerial and analytical support, otherwise there is a limit to what they can do,' she says.

Dr Farzana Hussain, CD for Newham Central 1 PCN in north-east London and co-chair of the NHS Confederation national CD PCN network, says it is vital to have a network manager. 'A CD should not be doing lots of management. You are not there to pick up CCG commissioning functions, you are a provider organisation.'

I'm concerned about winter 2021 because we can't keep on in crisis mode

Dr Farzana Hussain

Her PCN had to work quite hard to make that clear when it first set up, she explains. 'Our network was previously a commissioning cluster and for the first few months we had to be quite strict to say I know we're the same people, but we're not commissioning. We're not here to look at the dashboard. Our job is as a provider – and that is an important distinction. This is about delivery on the ground.

'A network manager is an essential role, as is having admin support, and that is where a lot of CDs are falling down. I don't think a network can survive unless they have a manager,' she says.

Dr Rosen agrees, pointing out that PCNs at the top of their game have this support in place. 'If you look at the trailblazers, such as Tower Hamlets in east London, they have a manager and somebody responsible for providing data analysis and that is what helped them to get off the ground.'

PCNs still need to find their feet, not least to work out how to function together. If they are going to be the voice of primary care at ICS level, that becomes even more vital, says Dr Hussain.

'Collaborating is easier said than done,' she says. 'It's a different way of working. It requires a big piece of work and that needs to happen now, otherwise they're not going to be doing anything else.'

She is concerned about the growing pressures on PCNs, especially for winter 2021 'because you can only work in crisis mode for so long'.

'Everyone is going to be tired and there will be a backlog. And we're looking after all these patients. If I was designing a DES, it would be for the immense deluge of mental health work that will be managed in general practice.'

Some PCN CDs have already increased their role from one to two days a week.

Ms Rankine says that is probably what is needed as a minimum. Coming out of Covid, PCNs will need to take a step back and assess their new baseline. If they're 'expected to be all things to all people' we need to invest in that capability, she says.

Dr Chandrasekaran says her PCN already discusses what work it should and should not be doing at board meetings. They have planned meetings to discuss their priorities after Covid, including what their role with the ICS will be.

'There will need to be a reset and we need to look at what "normal" will be – because we can't carry on as we are.'

Mission creep is a problem in all parts of the NHS, points out Dr Ghosh, and PCNs are being looked at as a lot of the solution. But actually, he says the solution is to pin down the ICS strategy because the resource then follows.

'The scope of PCNs needs to be made more clear,' he says. 'PCNs have shown they can deliver, now it's time to really commit to the model. PCNs can deliver with adequate resources.'

GENERAL PRACTICE FOR ALL

In January, we saw more than two million online consultation requests and 155,000 video consultations

It's been more than a year since general practice introduced remote triage to keep patients and staff safe from Covid-19. I say 'introduced' but we've all been doing some form of triage for many years, whether remotely or face to face. Triage originated in the Napoleonic wars as a way to determine the gravity of wounds and prioritise treatment – today we use it to help patients quickly access the right treatment from the many healthcare professionals who now make up the general practice workforce.

Technology has supercharged the potential to do this. Online consultation tools enable patients to send a digital contact describing their symptoms, allowing the practice to triage the patient to the right person or service. In January, we saw more than two million online consultation requests and 155,000 video consultations, as well as big increases in the use of electronic prescribing services. This shift hasn't just offered safer care for patients and staff – it has allowed us all to work in different ways. Balancing home schooling or caring duties with work has become more manageable – if no easier – and for some, being able to offer an early telephone surgery before the school run has brought a new flexibility. These experiences will help us decide what to adopt more permanently and where to return to more traditional ways.

None of this takes away the importance of seeing patients in person; during the pandemic more than half of appointments have still been face to face. However, a recent Healthwatch report highlighted that the changes in access have been challenging for some, and we must ensure no one is excluded along the way. The Covid vaccination campaign has underlined the need to reach into our communities in a variety of ways; the experiences gained should help us adapt access to local primary care, reflecting on what have we learned and what can we build on in partnership with patients and communities.

Last summer, a separate Healthwatch report – in conjunction with healthcare charity coalition National Voices – shed light on the patient experience of remote and virtual consultations. They heard that this is a convenient option for many people, who appreciate quicker and more efficient access and the ability to fit the appointment around their lives. Most respondents felt they received appropriate care and a majority said they would be happy with remote consultations and a blended approach in the future.

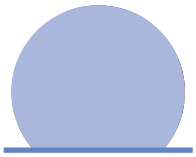
In-person collaboration is critical for staff too. Learning, development and teambuilding is hard to replicate remotely. A recent Kings Fund survey showed many GP trainees like the flexibility of remote working but want to be at the practice most of the time to ensure they feel part of the primary care team.

Recognising the different skills needed for remote working, our national clinical director for digital first primary care Dr Minal Bakhai worked with the RCGP to produce guidance on remote vs face to face. While general practice has proved its ability to transform, as our models evolve we must recognise one size does not fit all. Crucially, we must use the past year's experiences to increase access and help close the health inequality gap. As a practising GP, supporting patients will always be at the heart of what I do – technology offers options but that connection between clinician and patient will remain a priority.

ONLINE
Read more blogs by Dr Kanani online at pulsetoday.co.uk/pcn

Dr Nikki Kanani
is a GP in south London and medical director of primary care for NHS England

DELEGATES



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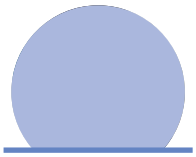

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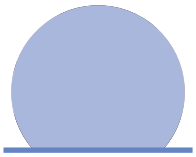

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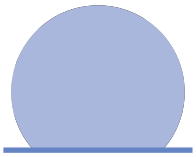

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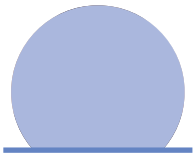

Dr Reshma Syed
Joint clinical director, Sittingbourne PCN, Kent

Dr Tom Holdsworth
Clinical director, Townships PCN, Sheffield, South Yorkshire

COVID VACCINE ROLLOUT

Eight PCN clinical directors joined Pulse editor *Jaimie Kaffash* for a remote round table in February to discuss how the Covid vaccination scheme has progressed

HOW MANY MORE VACCINATIONS COULD YOU HAVE DONE IF THERE HAD BEEN ENOUGH SUPPLY?

Jaimie Let's first discuss the problems with the vaccine rollout. How do you think things could've been done better?

Monica There could have been a lot more communication to start with. There could have been a lot more trust placed in the hands of the GPs... and more notice given. GPs have been doing [vaccines] for many years, we don't have any problems [with it].

We should be allowed to request vaccines as we need them. For instance, for Titan PCN in Luton, we had a delivery of vaccines in January and a month later we'd had no more.

Reshma Vaccine delivery is a major problem. We don't know when the vaccines are going to come to the various sites, deliveries are very erratic and there hasn't been the opportunity for other sorts of practices to get involved. So, PCNs have been given this cool contract but obviously there are separate contracts for other providers and individual practices have not been given the ability to also provide vaccinations. Vaccination could have been ramped up a fair bit if practices had been allowed to do it individually.

Helen In terms of vaccine supply, I think it's been split into too many different models of delivery. I suspect that primary care probably wasn't supposed to be involved in this programme from the offset. My cynical side thinks that there is still a strong push for mass vaccination sites to be delivering this but general practice has proved it has the means, expertise and the access to patients and relationships to deliver it and has far exceeded what any government expected us to do. Now there's a situation where there aren't enough vaccines to spread around all these different models of delivery. But there's a very successful service in primary care that can't easily be stopped.

Robin There were concerns about resilience, longer term. Yes, we've done this, and it's fantastic, but what services have we not delivered because we've been delivering vaccinations as a priority? Most of our staff have done [vaccinations] as additional hours – and yes, we've brought in volunteers to help support that - but still, that is additional work for our staff.

Jaimie When we talk about supply issues, is this simply a problem with lack of supply from the manufacturers or is it a problem with logistics in NHS England?

Tom H My honest feeling is we don't know. The transparency is really difficult. I'm not completely against mass vaccination centres. I think the issue is about the communication and the working together. At times, it feels the system's working in silos rather than working together. Sometimes the level of communication is that we [first] hear [about] things in the press and that's really bad. →

Dr Helen McAndrew
Clinical director, Abbey Health PCN, St Albans, Hertfordshire

Dr Sanjoy Kumar
Clinical director, North East London PCN, Waltham Forest, London

Chair
Jaimie Kaffash
Editor, Pulse

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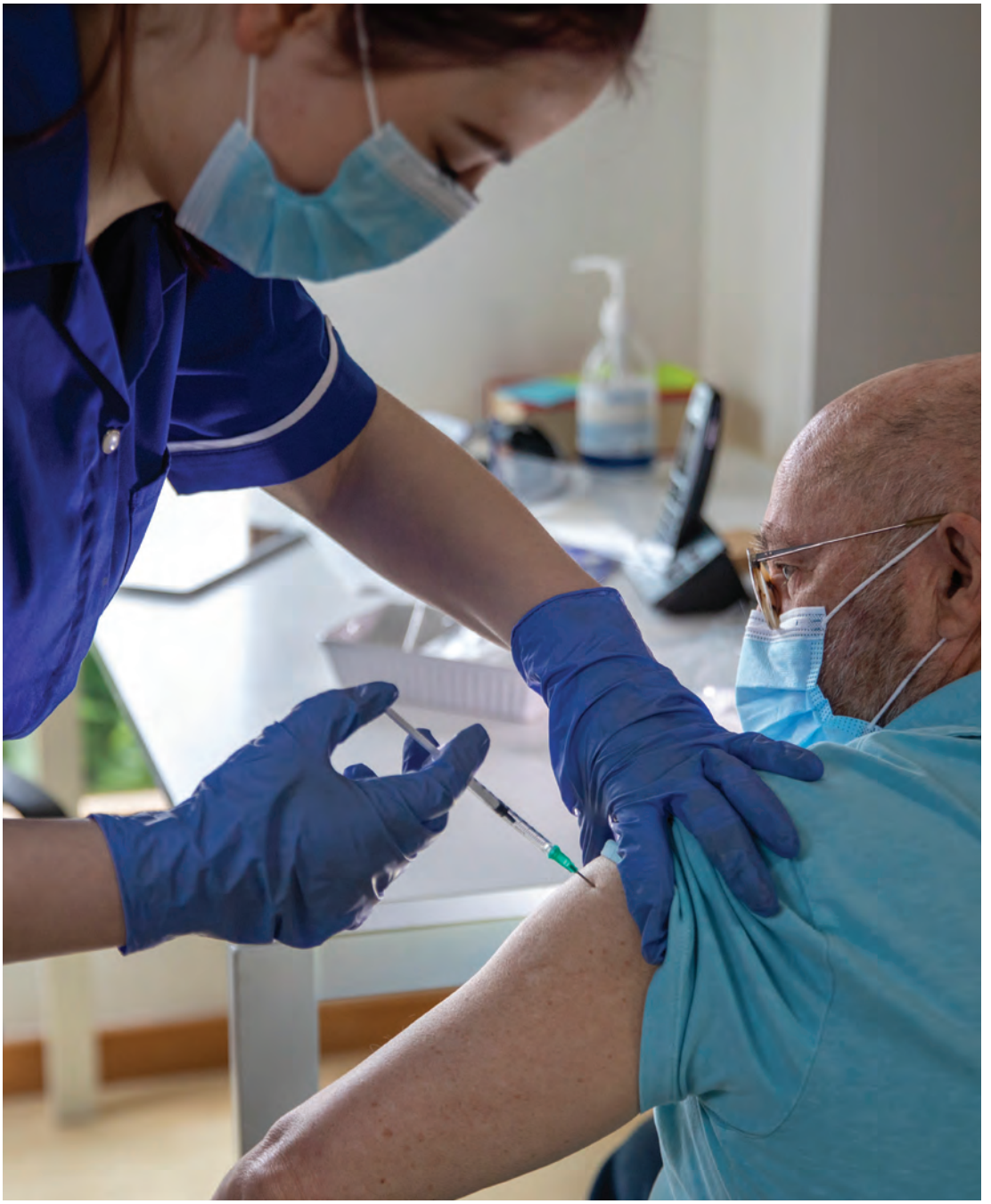


What services have we not delivered because we had to prioritise vaccines?
Dr Robin Harlow

Mass vaccination sites have led to patient distrust
Dr Reshma Syed

Helen Our CCG on the surface seemed to be really supportive of the fact that we would have a mass vaccination site imposed [on us]. They openly admit that there are thousands of vaccines in the fridges of our local pharmacists and our local mass vaccination sites and that people aren't currently going to them because of the cohorts they've [set up].

Yet we have more than 10,000 people in cohort six that I can't vaccinate because I haven't got any supply. We've tried the mutual aid route of asking for that vaccine to be moved to us, [which would] also let us go out and get some of the health inequality and vulnerable groups. Last night I vaccinated 20 homeless people. But I couldn't vaccinate the other 50-60 because I didn't have enough vaccine.

Jaimie Why do you think the mass vaccination centres are being pushed instead of the PCN groupings?

Helen Using this area – St Albans – as an example, GPs could successfully deliver 15,000 [doses] a week. We've proved this by doing 2,000 in a day – easily – on the odd occasion that we've had vaccines. But a mass vaccination site is still going to be put in the city, even though there is not the vaccine capacity. I think you've got to question why. We suspect it's to do with the May elections and the headlines that [might result from] mass vaccination sites.

Partha We actually have written to our integrated care system (ICS) vaccine team [saying] that we don't need the confusion created by mass vaccination and whatever workforce they are planning to use, asking them to give it to us to run the service much better. That was turned down. [The reply was]: 'We want to preserve your working capacity'. We are going beyond our capacity to do the job and at the end of the day I think our uptake is much better than uptake at a mass vaccination site.

Tom R I think that PCNs are really showing their worth with all of this because they've shown that they're the right size of footprint to be able to deliver a vaccination programme like this. So it would be a real shame if [vaccinations] did move out of PCNs from local sites to mass sites. We've got clinical directors who have built relationships with their practices over the last two and a half years. I think in most places the clinical directors are taking a lead with the vaccination sites. And we've proved that it's working.

Sanjoy The work streams to set up mass vaccination sites are completely separate [from PCNs]. We weren't told about the mass sites originally and how they would affect our area or that they'd be within half a mile of a PCN centre that's doing particularly well. We weren't told about the fact that someone else would be given the easiest cohorts which are in and out in three seconds.

We weren't told about the supply problems. We weren't told about the fact that if you do particularly well, NHS England will take your vaccine supply and give it to somewhere else that is perhaps making more noise about not having the supply.

We're all being treated like children here, but we all have a significant amount of experience in general practice. We give 20 vaccinations to every child in our practice from the time they are born to the time they go to school. We are the experts at giving vaccinations. It should be a ground-up [service]. This is actually a top-down service – the exact opposite of the way you should set up a service.

Jaimie Does anyone here think that mass vaccination sites have been a support at all in your task of vaccinating your populations?

Partha Before we divided up the cohorts 65 to 70 and cohort six, in our network we and our CCG got in touch with our local mass vaccination provider – which is the acute trust. They were quite supportive of us. We wanted to involve the pharmacists to divvy up the patient group because there is no point in fishing in the same pond. We decided we would aim for one cohort and they would aim for another. But we weren't told at the time that we could go down to [cohort] six. And then, some of [the patients] shared the link with patients who are quite young… younger than 50. Nobody is checking at the mass vaccination site which group anyone is in. By contrast, we are being monitored so closely, with distrust.

Reshma We're getting a lot of complaints from patients who have noticed other cohorts or lower cohorts have had their vaccinations done at these mass vaccination sites. We've heard this constant argument: 'I should be getting my vaccination before that person', and so on. [This inequality] between patients causes a bit of distrust and a contradiction between what's put out in the press and what we're doing.

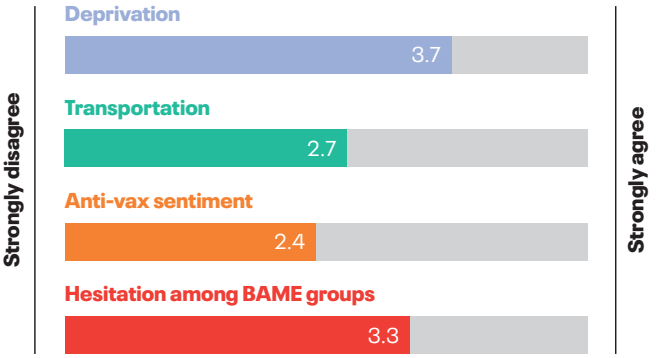
Robin Letters were being sent out to the public that weren't clear about their offer. We were part way through the campaign and patients were being offered an option [of where to get a vaccine], but it wasn't clear it was an option. So [this] increased the workload that we had in practices. That goes back to problems with communications. I also don't think there was clarity at the start about process – [or the] trust in GPs to undertake this.

Jaimie Do you feel the mass vaccination sites have been allowed to be more flexible with cohorts than PCNs have?

Monica The way it's being carried out is not right and they definitely have more flexibility. NHS England is gentler with them.

Reshma The cynical side of me thinks that basically the mass vaccination sites had this plan all along to do the easy cohorts of patients and leave GPs to do all the difficult ones, like care homes and patients who were housebound.

ON A SCALE OF 1-5, HOW MUCH HAVE THE FOLLOWING FACTORS AFFECTED UPTAKE?



Jaimie In our quick poll, deprivation seems to be the biggest barrier to patients getting the vaccine. What are the reasons behind that?

Tom R We can't underestimate, actually, the damage this whole pandemic has done to the worst off in society. I don't think we can talk about it enough, really, because we've seen domestic violence go up, we've seen job losses. If somebody gets invited for a vaccine but they're a single parent and their kids aren't at school and they haven't got enough money for a taxi or they haven't got a car, how are we supposed to vaccinate them? I think that those people get lost.

That's where the local vaccination sites can be quite useful. →

ALAMY

Speakers of Urdu, Punjabi or Bengali didn't have information
Dr Partha Ganguli

Initiatives like [the vaccination bus in Sussex] don't happen because someone's told us we have to do it, they happen because we're GPs and we care about our patients and it's the right thing to do. Local vaccination sites are best placed to pick up these pockets of deprivation. We know about the guy that sleeps outside the supermarket across the road from the practice. We know about the families that struggle, the child safeguarding families.

Tom H One of the things that needs to be thought about more is matching vaccine supply with areas of greatest deprivation. NHS England has done a particularly bad job of that in Sheffield, which has caused a lot of upset.

They should recognise some of the problems deprived populations will have [such as] very large cohorts like cohort six, and the huge amount of multi-morbidity. Understand that we have to have translated consultations, that some people are not going to be able to use the technology to book in. Also we must flip this idea of hard-to-reach populations. Actually, a lot of these populations are not hard to reach, they're underserved and that's been built in over the years.

Partha When you're looking at anti-vax campaigns, [they] sort of come together with [health inequalities] where there is not enough information given to these people. Also, there is a significant inequality in these groups. We work in a city centre area and there are people who don't have a phone. Some of them only come in to see us in person. These things are not being taken care of, and there is no extra effort put in for these groups of people separately to approach them. There needs to be flexibility. In terms of the BAME issue, I personally had to phone a lot of patients who speak Punjabi, Bengali or Urdu and convince them, because they didn't have the information. They all agreed to the vaccination. That's something we need to look at, it's GPs' time but I think it's worth spending.

Helen Last night I and my fellow clinical director personally did our local open door homeless shelter after hours, when [everyone was] there. No one else was going to do it. And there was a proportion of [people] who had been told by a local pharmacy that the vaccine wasn't safe. So that made our job harder. We had to convince [people] without having relationships and they did actually all come round. There is no recognition that that is what primary care brings. That is a significant funding issue and we're just all going above and beyond as we normally do. →

WHAT HAVE BEEN THE MAIN CHALLENGES IN DELIVERING THE PROGRAMME?

Jaimie Is there anyone here who feels this should have been delivered on a practice basis from the very start and not at PCN level?

Monica We decided to have a hybrid model because we are in a deprived area and many of our patients said they will not under any circumstances go to the main [vaccination] site. We were able to get support from NHS England, support from our LMC although our CCG was very cross about it. And now all we do is we deliver AstraZeneca vaccines from the practice for our most deprived patients and Pfizers when we get them from the main vaccination site. But that option and that flexibility should have been built in and that should have been organised via the PCNs.

Tom R I think there were practical issues that would have made delivering [the vaccinations] from individual practices very difficult. Not everybody's got the same access to estates. [Also] we've got other patients coming in for other problems, [who would mix] with the most vulnerable people who are coming in for their vaccinations. We've potentially got heart patients coming into practices so I think there would be a lot of complications about trying to deliver [vaccinations] at practice level only. Also, I think the Pfizer vaccine would have been particularly difficult to deliver from smaller practices. But it would be nice, as we have now, to have [had] the flexibility to take a few vaccines from the [main vaccination] site to the practices to deliver them.

Jaimie At the start of the programme, vaccinating vulnerable groups was probably costing more than you made. Did you expect to claw some of this money back once you started vaccinating younger, healthier patients, and has this happened?

DO THE ITEM-OF-SERVICE FEES FOR PROVIDING THE VACCINATIONS DELIVER A PROFIT?

Provide a minor profit

0

Provide a major profit

0

Allow us to break even

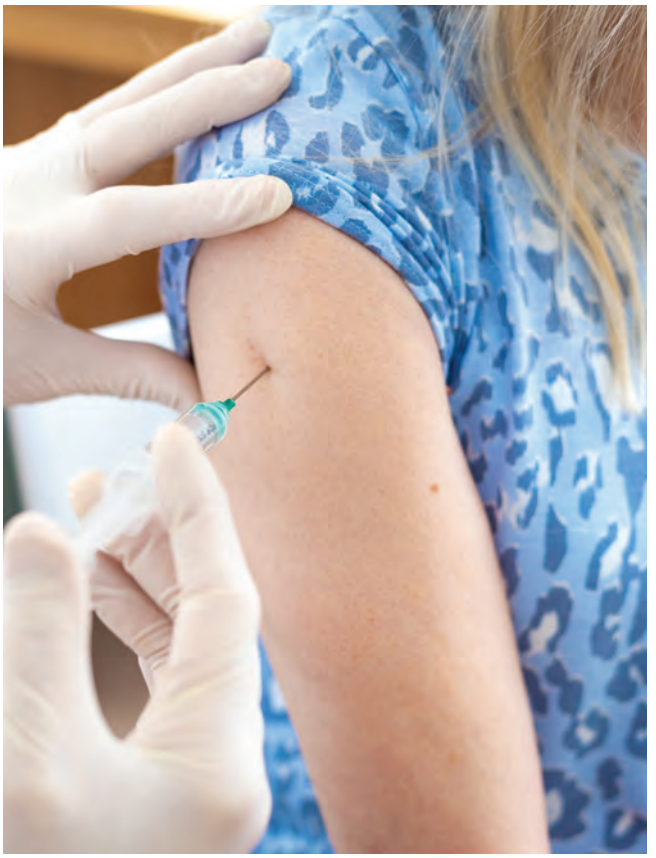
5

Cause a minor loss

2

Cause a major loss

0



Sanjoy All of our set-up was cost neutral. We hoped that when we started doing the 16- 60-year-olds, we would then pay off some of the things [we purchased]. Now, though, GPs will be left out of pocket because now it's payback time, we are not getting those [patient] cohorts. So it is unfortunately going to leave some GPs out of pocket.

This is a huge funding issue. GPs are not supported by the NHS England model and again, as my colleagues have said, they haven't joined up the thinking with the pharmacy model. So there are so many people getting vaccinated at sites that will [result in] a complete financial loss to certain groups.

Partha When we are talking about loss and profit, we need to think about the time and effort the PCN group clinical directors have given. I don't think that that's being evaluated or valued at all. As a whole, we don't expect to make a profit, which we should as a business. We are all worrying now that we might have a loss if we are actually taking into account the time we have spent.

Helen When you bring up the argument of not having access to the lower cohorts we'd financially accounted for, it's been used against us as a reason why general practice [shouldn't] continue to deliver the service.

Tom H Sometimes we're stuck because we're trying to operate like a business but at the same time we've got to do the right thing and that makes it really difficult.

And yet again, it comes back to transparency and communication. The initial question was 'Can you deliver a vaccine service? But you're not going to have any of the details of it or [only] very bare bones. Can you say yes or no by next week?' What would you need, if you were a proper business moving forward? Well I'd like to know how long this would go on for. What's the funding? Yes, there's extra funding for management up until March, what happens after that? Without these details it's so difficult.

So, yes partly [the problem is] the model but also it's the lack of clarity and the difficulty with the communication.

A UNIFIED VOICE

Now that PCNs have proved their mettle with the Covid response, what do they need to lead primary care safely into the future?

Having reported on the NHS for more than a decade, I am not surprised to see a new cycle of reorganisation. However, no one could have foreseen the emergence and impact of Covid-19.

Forged in this fire, clinical directors (CDs), leading the charge for PCNs, came together at unprecedented speed. In just months, they accomplished work that would have taken years. Practices swiftly set up their red/blue, hot/cold, Covid/non-Covid sites, working together to stop the spread – aided by the links already made in the PCN.

Now they are running vaccination sites and finding these are preferred by some patients. They are visiting homeless shelters to vaccinate underserved populations. They are on the phones, reaching out to hesitant, vulnerable and deprived patients. All alongside their daily GP and PCN business.

Much of the thanks should go to PCNs – which are making waves, even though they are drowning in demands (see our cover feature, page 6).

The inspiration for this supplement was the report I wrote for Cogora, our publisher: *Primary Care Networks: Controversy, Covid and Collective Working*, on the state of PCNs after their first 18 months. Through the interviews, I saw recurring concerns: the size and scale of the task; the restrictive nature of the additional roles reimbursement scheme; and how PCNs fit into the system.

In fact, the publication of the white paper, *Integration and Innovation: Working Together to Improve Health and Social Care for All*, signifies the increased importance of PCNs with the wider NHS. The 80-page precursor to the Health and Care Bill sets out the stall for the NHS, public health and social care system to 'connect, communicate and collaborate'.

But contrast this aim with the Covid vaccine rollout – the disconnect between expectations and supply at mass vaccination sites, PCN sites and pharmacies – which PCN CDs discuss in our roundtable (page 10).

The white paper mentions PCNs twice. The first is when it allows the formation of joint committees between commissioners and providers, which 'could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector'. The second mention restates a commitment to the 'primacy of place', with 'shared priorities' and 'place' as a primary focus for PCNs.

PCNs will have a vital role in shaping the agenda – if their voices are heard. Therein lies the challenge – working together across a single PCN is already difficult in some areas. Combining roughly 10 PCNs to create a unified primary care voice across the ICS board, while keeping local focus, will be no easy task.

ICS leaders I spoke to recognised the value of PCNs, which allowed them to manage the pandemic more effectively. The first two years of PCNs were defined by setting up and Covid. But as they come into their third year they can embed the work they've done and focus on their future priorities to deliver agile and responsive care. But they must be supported and listened to – and I hope this supplement will help.

Victoria Vaughan is editor of PCN

JUST SAY NO

Our worried friend in the Midlands, *Dr Manu Agrawal*, sets out his concerns for traditional practice as demands on PCNs grow

I am both excited and nervous about the future of PCNs. I'm excited about the role that general practice and PCNs have played in the mammoth task of vaccinating our population. Despite years of underfunding, vilification by the media and constant contractual threats, general practice has shown again why it is the most reliable, trustworthy bedrock of the NHS.

However, I am nervous because traditional general practice, the cornershop model, which actually looks after 85-year-old Joe Bloggs, is under a threat like never before. That threat is from integrated care systems (ICS) and PCNs.

This is evident if you read the NHS England *Long-Term View*. You can count on one hand the number of times general practice is mentioned. Well, it is only a small part of the NHS delivering just 90% of the activity for a mammoth 10% of the budget. Contrast this to the focus on PCNs. Is general practice going to be represented in the future NHS by a DES? A group of geographically co-located, often conflicting practices, which signed up to an 'optional' DES because our leaders in the BMA General Practitioners Committee linked it to contractual uplifts?

Don't get me wrong. PCNs have brought practices together. They've delivered the vaccination programme while recruiting for the additional roles reimbursement (ARRS) scheme. But compare the funding diverted to ARRS and PCNs with the investment going into core contracts – £11 per patient this year and £15 next year. If this PCN funding had been given to practices it could have prevented incomes being reduced. It would have made general practice a desirable specialty again. It would have given practices freedom to employ who they want as per their needs.

PCN clinical directors are the most underfunded and overstretched people in NHS employment. We do it for the sake of our practices and patients. But it is a huge ask. I'm not sure how a jobbing GP suddenly gets the knowledge to deal with corporate people on ICSs, who have protected salaries and bonuses at the end. One mistake from a PCN clinical director could wipe out our budgets.

And I'm sure the system leaders' solutions are to incorporate PCNs, start holding GP contracts through PCNs and create larger partnerships, ticking the box of saving the independent contractor model, and making the whole profession, barring a few, salaried.

This is where I believe PCN clinical directors, LMCs and local GP leaders should start saying 'no'. This is the most powerful word, which you don't hear in the NHS. We should say no – to when the ICS wants to move traditional GP-led services into PCNs, to when QOF will be moved into PCNs, to when we will be forced to merge our contracts, and to when the whole commissioning role becomes the responsibility of PCN clinical directors.

But there is also a 'yes'. Yes to developing new services and pathways, with new funding, moved from secondary care into primary care. And this is where PCNs give us an advantage.

We can be proud of what we have achieved in this pandemic. We have stayed open, looked after our patients, picked up secondary care's work, and we are the cornerstone of the biggest vaccination programme in our lifetime.

PCNs have brought practices together but we should be careful what we let them do

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 treasurer for South Staffordshire LMC

LEADING QUESTIONS

***Dr Monica Alabi*, clinical director of Titan PCN in Luton and former government adviser, shares her insights**

What motivated you to become a clinical director?
I like to be involved in not only making policy but translating policy into action – into strategy and operations.

When the PCNs were created, I had the experience to set up our structure and help make it successful in terms of outcomes for patients. We were able to provide social prescribing services to our most vulnerable patients across the network.

The added pharmacist capabilities meant we could tackle polypharmacy and manage patients with chronic conditions better. We intend to employ a paramedic so that patients can get emergency care in the community and unnecessary admissions can be prevented. I was pleased that my peers trusted me enough to vote for me and allow me set up our operations.

What's been the best moment of being a PCN clinical director?
I have had many 'best' moments. I think employing a dedicated manager early on, when such a move was not popular, really helped our PCN get a head start as we had that key person to keep a focus on PCN work. Other highlights include successfully recruiting into our additional roles and seamlessly delivering the vaccination plan for our PCN population.

And the worst?
Changing the lead practice as it found the workload too great. This was challenging and could have been avoided but was done successfully.

What has the experience taught you so far?
The experience of being a clinical director has continued to reinforce what I already know as a leader. Leadership is very much about relationships.

You cannot have success without building relationships, mainly by effective communication. Focus on the big picture – you have to be able to predict what is coming on the horizon and prepare your organisation for it adequately. Also, listen and observe effectively. Keeping a focus on these three important facets of leadership has helped me throughout my career, particularly as a clinical director.

Do you have any tips or hacks that help you get through the workload more efficiently?
Delegate. Use the best person for the job. You have a team for this reason. Prioritise your physical and mental health so that you are at peak performance. Schedule important jobs for the times of day when you are most effective.

Do you have a goal in mind for your PCN?
To successfully deliver our population health project and also the vaccination plan. To seamlessly hand over leadership at the end of my tenure. I will be leaving in June as my strengths and interests are innovating, shaping and delivering a plan so that it can continue successfully.

Who or what inspires you?
My mentor Dr Yinka George. She is no longer with us but she was a medical doctor and entrepreneur who I met when I was 15.

My not-for-profit organisation, Beyond Wealth, is in honour of Dr George. It focuses on giving back to causes that benefit the community.

We launched a programme to support black students in years 11 and 12 to gain access to the 24 Russell Group universities in the UK.

Where do you turn for support?
My mother and my family.

What do you do to relax?
I run, which helps clear my head. Also, I spend time with my family.

Name
Dr Monica Simisola Alabi

Practice
Wheatfield Surgery, Luton, Bedfordshire

PCN
Clinical director, Titan, Bedfordshire

Number of practices in PCN
Three

Number of patients in PCN
About 32,000

PCN roles hired
PCN manager, two pharmacists, one pharmacy technician, two social prescribers

PCN roles to fill
Seeking a care co-ordinator, pharmacy technician, community paramedic and a physician associate

Career to date
- **2000** Medical student, Lagos University Teaching Hospital.
- **2003-05** Senior house officer, obstetrics and gynaecology. Northwick Park, Central Middlesex, Royal Free and Watford General hospitals.
- **2006** GP registrar, Halesworth Medical Centre, Halesworth, Suffolk.
- **2007 to present** GP partner, Wheatfield Surgery, Luton, Bedfordshire.
- **2011-16** Clinical director, maternities, children and families. Luton CCG.
- **2015-16** Clinical director, long-term conditions. Luton CCG.
- **2013-16** Assistant clinical chair. Luton CCG.
- **2016-18** Adviser to the health secretary on primary care as part of non-partisan informal group.
- **2017 to present** Central Bedfordshire LMC representative.
- **2019 to present** Clinical lead for population health Bedfordshire, Luton and Milton Keynes integrated care system.
- **Current** Founder, Vine Health private wellbeing company.

Founder, Beyond Wealth equal opportunities education charity.

DEAR EDITOR...

I've been reflecting on the lessons learned about communication, particularly for those co-ordinating the network response to the pandemic. As GPs we have slowly mastered the art of communication with our patients. Most GPs involved in teaching will have watched a student explain a difficult diagnosis badly or fall into well-worn pitfalls like overly technical language. Gently explaining how to improve this is rewarding as a teacher. This humbling and infuriating pandemic has been a masterclass in communication.

Over a period of weeks, many of us have gone from novices in video conferencing to, as one colleague put it, 'black belts' in Skype and Microsoft Teams. We have been challenged to communicate with colleagues we have never met, in the middle of a crisis, by Whatsapp, Microsoft Teams chat and video.

There has been a huge challenge in developing a relationship quickly and effectively under pressure to achieve complex goals. I visited our network's planned vaccination hub in December to meet a manager, a CCG representative and someone from IT. After 15 minutes we were in a stand-off of frustration. We had failed to recognise this needed a crisis management approach. I kicked myself afterwards, sure that a member of an NGO in a global health crisis would have taken the first two minutes to clarify names, roles, expectations of the visit and time available. We should have done this and saved time and heartache.

There have been numerous other challenges. How do you communicate with a large population? How do you keep people up to date but not overwhelmed? How do you frame problems so that people work constructively with hope? How do you tell your staff difficult news? And of course how do you take all that learning of patient consultations and apply it to phone calls and video?

It has been a difficult year. The 'command and control' style of national communication has been especially hard. But the learning has been huge. Even when things haven't gone as planned, I think they have added greatly to what we know and how we communicate.

Dr Tom Holdsworth GP, Mosborough Health Centre; clinical director, Townships Neighbourhood PCN, Sheffield, South Yorkshire

I have cautious optimism about February's health and social care white paper. The sentiment is positive, setting the framework to enable the health and social care system to build on our work.

The response to Covid-19 has seen many examples of collaboration and integrated care provision, delivering excellent results, but even before this, there were many areas developing it up and down the country.

The question is whether legislative change alone will deliver tangible improved and expanded collaboration and integration. This change itself will come from people and organisations collaborating, and this requires behavioural change, and the existence of the necessary facilitative organisational cultures. Whatever shape the new landscape takes, general practice and PCNs, as the fundamental building blocks for place-based care, should be a central voice in future collaborative and integrated developments.

Dr Jeremy Carter executive partner, Park Surgery, Herne Bay; clinical director, Herne Bay PCN, Kent

GET IN TOUCH
Send your letters to pulsepcn@pulsetoday.co.uk

I want to reflect on the last 18 months as a PCN clinical director (CD). Casting my mind back to 2019, the new GP contract, the introduction of PCNs and the CD role is distant memory.

I am not sure what I expected but I remember wondering what I would do for two sessions a week. Then I was asking myself where and how can I fit this in?

I am sure a lot of CDs recognise the phrase 'this can be taken back to the PCN by CDs' and the numerous emails inviting us to meetings with people and organisations who suddenly seemed very interested in primary care.

I get asked about phlebotomy, GP mentoring, diabetic clinics and many other practice-based dilemmas as the CD. Sometimes I reply that this isn't PCN territory, but at other times we try to solve it as a PCN. Even though it may not be part of the DES, it is sharing good practice and enhancing our collaborative working.

The PCNs have shown what we can achieve for our population by working together as practices and engaging with other organisations. We have successfully started new services, created a North Halifax central wellbeing partnership, set up Covid clinics and now are in the midst of running a Covid vaccination programme, like many others.

The real success of the PCNs is in making sure the health and care needs for the population they serve are the best they can be. We will need continued investment in the programme and in the leadership that drives this change.

The very fact that the CD has been recognised as a full-time role (albeit just for three months) is progress in the system's understanding of our valuable input and the time commitments required.

Despite hurdles along the way, I remain enthusiastic and passionate about my role and our PCN. I am confident we will continue to achieve great things as a team. But I feel that general practice thrives on its independence, identity, ability to implement change at pace and its personalised continuing care. My aim is to make sure this is not lost as we continue as a PCN on this exciting journey.

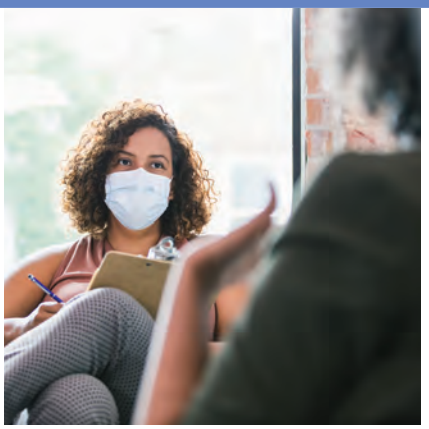
Dr Geetha Chandrasekaran GP partner, Plane Trees Group Practice; clinical director, North Halifax PCN, West Yorkshire

MAKE THE MOST OF YOUR MENTAL HEALTH HIRE

GP partner and federation lead *Dr Kamal Sidhu* offers tips on how your network can make the best use of the new mental health practitioner role available through the additional roles scheme

Since April, each PCN has had access to a full-time mental health practitioner, employed by the local community mental health provider and funded equally by the PCN and local provider.[1]

Our GP federation South Durham Health has had practice-based mental health link workers – all trained community psychiatric nurses – for the past few years. In partnership with Tees, Esk and Wear Valleys mental health trust (TEWV) and with funding from the CCG, we deployed a team of mental health link workers to provide a practice-based service offering advice, assessment, short-term counselling, de-escalation, crisis prevention and referral to secondary care and the voluntary sector. This has given us useful insights and I believe the new mental health practitioner role funded through the Additional Roles Reimbursement Scheme (ARRS) is a good opportunity for PCNs, if managed optimally.



Here are my 10 tips for making the best of this scheme.

1 Relationships are key

The joint funding with your local mental health provider means you need to forge an open and equal partnership, underpinned by mutual trust. These local providers want to work with PCNs to ensure that they can meet demand, which is only possible with early intervention and by investing in the promotion of positive mental health.

2 Enhance access and provision

Make sure your mental health practitioners are delivering an additional service. The ARRS roles are designed to increase capacity in primary care in recognition of the immense pressures on access. The role should be practice based, backed by joint funding and collaboration with the trust. Otherwise, it might end up as a reorganisation of services or extension of local referral teams, causing further confusion for patients.

3 Make 'first contact' a priority

Ensure patients can be booked in to see the mental health practitioner directly. This is of utmost importance for those who 'suffer in silence' or are experiencing suboptimal care and helps to overcome the stigma of seeking help for mental illness.

4 Promote the new role

Publicise the mental health practitioners on the practice website, newsletter, new patient leaflet, patient participation groups and social media page to help raise awareness and engagement among your population. Consider using the mental health practitioner role in promoting the self-help resources and prevention available in the wider community through social prescribing.

5 Make the mental health practitioner essential to your MDT

It is vital to have seamless links and genuine integration with the wider primary care team, in particular social prescribing, wellbeing and IAPT services, to ensure a good patient experience and optimum engagement.

6 Have a named lead in the practice and PCN

Having support from a named clinical lead in each practice and PCN, for example to discuss challenging or complex cases as well as ironing out any issues with case mix, will help improve patient outcomes and experience. The lead could be a GP or a nurse practitioner with a special interest.

7 Agree no referral is 'inappropriate'

The practice and partner organisations need to agree how appropriate patients will be directed to see mental health practitioners. Clear criteria for referral agreed in the team and shared with the reception staff and care navigation templates can help ensure the right people benefit.

All services should take responsibility for any referral through any source, to ensure patients do not have to navigate complex (and often fragmented) services themselves. Have a clear policy that no referral will be deemed 'inappropriate' or bounced back to the practice or mental health practitioner. PCNs should use the opportunity and discussions about the mental health practitioner role to reduce bureaucracy around referral processes and forms as supported by NHS England.

8 Offer regular training and peer support

The mental health practitioner role has a high risk of staff burnout. Make regular times to debrief and discuss cases so that staff can cope with the stress of challenging cases and feel valued. Your partner trust has probably established processes for this and you will benefit from their insights as well as governance and support network.

9 Involve mental health practitioners in improving care for serious mental illness

Your mental health practitioners may be able to improve engagement with these patients. They can help monitoring of antipsychotic medications, and supporting QOF work, such as ensuring patients are captured on disease registers and have timely and effective reviews.

10 Consider working with like-minded PCNs

This will give a larger pool of practitioners and help with annual leave, sickness cover and training.

Dr Kamal Sidhu is a GP partner and trainer with a special interest in mental health, and chair of South Durham Health CIC, a GP federation that provides practice-based mental health link workers

Reference 1 NHS England Letter. Supporting General Practice in 2021/22. 21 January 2021. england.nhs.uk/publication/supporting-general-practice-in-2021-22

HOW TO FORM A COMPANY

Specialist medical accountant *James Gransby* explains why PCNs might want to consider switching to a limited company business model

As the third year of the PCN DES approaches, now may be the time to consider if the present form allows a network to function at its best.

Most PCNs adopted either a lead or flat practice model to set up their network. However, these models can be problematic, particularly in terms of sharing staff.

There are two key reasons why PCNs are considering a possible move to a limited company (corporate) business model: the PCN workforce is now increasing with more funding available from the additional roles reimbursement scheme (ARRS); and a recent change in legislation means that limited companies can now access the NHS pension.

PCNs that are operating as a super-partnership or as a federation were equipped from the outset to deal with these legal and employment issues, and generally appear to be robust and fit for purpose.

What key problems can a company model overcome?

VAT

While healthcare services are often classed as VAT exempt, the sharing of staff around the network (including medical staff) is usually subject to 20% VAT (unless a practice is operating below the £85,000 registration threshold). This is a complex issue, but essentially a PCN operating a limited company can be structured to benefit from a separate VAT relief, called the cost sharing exemption, by operating a cost sharing group.

Liability

A network operating under a lead practice or with a flat practice structure is not a separate legal entity in its own right. It is a group of practices that are jointly and severally liable for what happens in the network. This means all practices – and therefore all the partners – are trusting each other to share the network's legal and financial responsibilities.

The main concern here is that if a PCN needs to make staff redundant, the cost will fall on individual member practices. However, if a company is employing the workforce the costs will come out of the assets of the company – which lessens the risk of destabilising the individual practices.

Legal framework

A PCN operating without a formal framework relies only on the guidelines set out in the network agreement. A limited company is governed by the Companies Act 2006, which sets out strict regulations on the company's obligations. Having this formal framework makes the people involved accountable for their actions.

Tax on PCN surplus

If a PCN is not a legal entity it has no mechanism to report its taxes, except through its member practices, with each practice needing to report its share of the surplus through their own accounts.

With a company, the profits can be sheltered at lower tax rates, and in some circumstances without tax being applicable until profit is distributed to practices. This is far more attractive than the exposed route that lead and flat practice models need to adopt.

Why is TUPE important?

When moving the workforce into a corporate vehicle, such as a limited company, companies must follow the Transfer of Undertakings (Protection of Employment) – or TUPE – Regulations.

These ensure employees retain their terms and conditions and keep continuity of employment in the event of a change of employer. As a consequence of TUPE regulations, a number of PCNs, despite operating below the VAT registration threshold, have formed a company to avoid needing to transfer a larger number of staff (requiring time and resources) at a later date.

What about pensions?

PCNs operating as limited companies can now apply for staff to access the NHS pension under a temporary direction/determination order, available until March 2023, and expected to be written into legislation.

How can PCNs weigh up their options?

A quick way to assess if something needs to be done, particularly those using the lead practice model, is a VAT review to highlight if you are close to the £85,000 VAT threshold. Also, look at the likely scale of the PCN in coming years. Can the practices in the PCN accept circa £1m of income flowing through an unincorporated entity with only the network agreement to fall back on?

Next steps

Once a PCN decides to form a corporate entity the practicalities, for which specialist advice will usually be needed, to consider are:

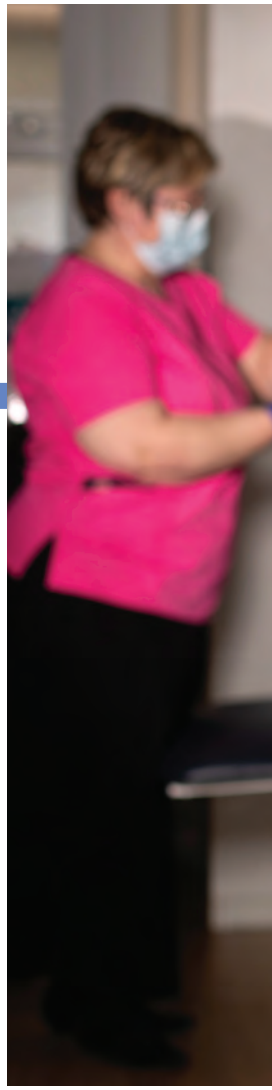
- Forming the company, ensuring the underlying legal structure and paperwork are correct.
- Transferring any staff from the PCN (in accordance with TUPE regulations and after necessary consultation).
- Obtaining access to the NHS pension scheme.
- Other steps such as opening a bank account, arranging contracts of employment, exploring CQC registration and many other aspects.

Although there is a 'pain barrier', for many PCNs the long-term benefits of operating in this structure will outweigh the initial short-term effort.

James Gransby is vice-chair of the Association of Independent Specialist Medical Accountants and a partner at RSM UK Tax and Accounting

Abridged. First published for Pulse Intelligence. Is it time for primary care networks to think about forming a company? 3 March 2021

FORGED UNDER PRESSURE



Dr Partha Ganguli, clinical director (CD) in Preston, Lancashire, describes how his 'diamond' of a PCN has been brought together by the intense pressure of Covid

Name
Dr Partha Sarathi Ganguli

Practice
Fishergate Hill Surgery, Preston

PCN
South Ribble Primary Care Network (Ribble Medical Group)

Location
Preston, Lancashire

Number of practices in PCN
Seven

Number of patients in PCN
About 38,500

PCN hires
Four pharmacists, two social prescribers (through third-party organisation), one first contact physiotherapist (through third party)

Recruiting
Still looking for a physician associate

Preston hit the headlines in early August last year as cases of Covid put the city under increased restrictions, which banned separate households from meeting. In mid September, the city, along with much of Lancashire, was placed under fresh lockdown restrictions. Combine that with November's lockdown and the third lockdown, triggered in January, and the people of Preston have felt the full impact of this pandemic. Fortunately, before this crisis hit work had begun to create a resilient primary care service that could work together to face these unanticipated demands.

Before the primary care networks were in place, our PCN practices shared a close informal relationship. We had discussed working together but we lacked a common goal. There was also a lack of trust among us and this posed a big challenge.

Another limiting factor was time. Getting the time needed in our busy day-to-day schedule is never easy. We were not ready to integrate services in the neighbourhood.

But eventually we all started realising that the way we were going on was not sustainable and that gave us the impetus to work officially together.

However, moving on to becoming a PCN was a big step. Initially we were not sure what we could achieve. Working together in this way was new territory to us and so was the concept of individual businesses trusting each other. The different population sizes of the practices and our working patterns posed an immediate challenge. Sharing staff over seven practices was also something that had never happened before. Increased communication, a transparent way of working and trying to get all practices involved actively in decision-making was the key to developing trust.

The formation of the PCN helped us to know each other better, and gave us the opportunity to work together on different projects such as a population health project on frailty and mental health and improved management in perimenopausal women in community.

Since then, we have come a long way, especially last year when the Covid-19 pandemic compelled us to work together. We are now delivering our PCN vaccination programme, sharing our workforce, helping each other, trusting each other and becoming an integrated team while also preserving our own entities. This has undoubtedly been a very positive experience for us. We are learning from each other and now we look forward to working on new projects in the network to improve patient care and provide better service to our patients.

Finding our feet

Once the process of setting up the PCN started, the main limiting factor was the time and funding for backfill. As we are a smaller PCN the funding was limited but there was a lot of work in the setup process. We were also unsure of what we were establishing initially. I reluctantly took up the role of clinical director (CD), without knowing what I was getting into. Now, I'm passionate about the job and believe we can achieve the intended goals with hard work and collaboration.

Currently our main challenge is the Covid vaccination programme. Alongside this, the administration and my role as CD take way more time than the funding allows.

Finding time to organise regular meetings and integration between practices, community providers, councils and voluntary and faith organisations is another challenge. We have been able to improve communication and integration but there is a lot more to achieve.

As an organisation, it is always important to get time and space to integrate. But we sometimes feel the PCN is seen as the solution to all problems in the healthcare system. We are asked to take up new projects by the CCG, for example, such as diabetic care in the community as it is not working in the present model.

At times, it feels like we are spreading ourselves thinly and perhaps beyond our capacity.

Still, now there's a feeling that all primary care funding is going to be siphoned into PCNs rather than the GMS contract and this can generate mistrust. To overcome this, we must endeavour to adapt to new ways of working.

Recruiting for additional roles in the PCN is another challenge as there is a shortage of good quality applicants, but we have been fortunate enough to fill the roles in the end, although we have a significant underspend as there were lots of constraints that made the funding inflexible during our Covid vaccination work.

Before we started working as a PCN, all the communication and integrated working was informal. But now we have been able to cover each other and share staff in an organised way, so our practices have not been short staffed. For example, a singlehanded GP was not able to see patients face to face because of health issues, but another network GP stepped in to help on the days the locum was not available.

Our workforce has expanded with the creation of additional roles in

the network, which helps share the workload and improve patient care.

We have undertaken a population health project to address inequality in providing patient care and improving access for the vulnerable patient group. We have focused on frailty and mental health, incontinence awareness and improved management of perimenopausal women in the community. It is easier to deliver the project as a PCN rather than as an individual practice as we are now able to share and learn from each other and aim for a positive outcome.

All this is happening alongside our Covid vaccination project, which we are currently delivering from our centralised PCN site. We are managing to cover our target population. Staff members have worked hard to make the project successful. We all agree our efforts have been a result of spontaneous team building and have paved the way for greater integrated work.

All of this calls to mind a quote I used to see on the staircase of the Royal Preston Hospital where I undertook my GP training: 'Diamonds are made under lots of pressure'.

I cannot think of a better way to explain the benefit we gained in the first phase of PCNs. This may sound a bit strange, but I feel Covid has fast-tracked the development and teamworking in the PCN. We have achieved it in a few months. Otherwise, it possibly would have taken two to three years.

The success of the vaccine delivery programme is a fine example and cannot be overemphasised.

One important point we've all learned is that changes can't be forced but need to be adapted to with mutual agreement and understanding. Quite often it may seem that a person or an organisation is not willing to change. In such scenarios it is appropriate to explore and discuss issues and adapt accordingly, keeping in mind that the outcome should be mutually beneficial for all.

Looking to the future

It is also important to inform all the team members about any changes as communication is at the heart of any successful collaboration.

We all feel that the commitment to the network will increase every year and more funding will be mobilised to PCNs in future. We need to have a system so that we are not overwhelmed with the commitments, which might lead to burnout.

I would like to think our short-term goal is to integrate as an organisation and develop further relationships between practices so that we can increase trust and collaborative working. Delivering the Covid vaccine has paved the way for this and we need to build on this further.

As a mid-term goal we are looking at working with the wider organisations in the community, council and in secondary care to integrate services further for improved patient care. We are also looking at reducing the work pressure and avoiding duplication of work in primary care services.

As a long-term goal, it may seem far-fetched but we are looking at the integration of health and social care, to work with different organisations to deliver the highest level of care to our patients. This is perhaps the aim of all PCNs. This would also put more emphasis on a preventive approach, rather than a reactive approach, to health issues.

NEIL O'CONNOR

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

KNOW YOUR ARRS!

Hello everyone!

I'm Penny Stint from Primary Care Support and Strategic Integration Unit at the Sackwell & Binthorpe CCG Alliance, the shadow form of what will soon be the S&B Integrated Care System.

This is the first of my Team's regular newsletters for PCN Leaders. We'll be aiming to provide timely, up-to-the minute information and guidance on an approximately monthly basis to keep you 'up to speed'.

As many of you know, I was a Practice Manager until 2003, before going off to work in a number of exciting contracting roles in the PCT (remember them!) and then the CCG. So, I'm completely up to speed with the issues and challenges facing Primary Care and very much 'on your side'. Not literally, of course.

My role is to work strategically and collaboratively with Clinical Directors and other PCN Leaders to ensure that the emerging S&B ICS is fully integrated and completely collaborative at neighbourhood, place and system level.

Why another newsletter? Well, we've listened to your feedback that you sometimes feel overwhelmed with work and the sheer volume of information you receive. As commissioners it's our job to cut through that and support you in any way we can. We also heard what you had to say about the amount of jargon in 'official' documents. There won't be any of that here!

The Bulletin will feature the latest must-dos, should-dos, can-dos, may-dos and nice-to-haves for PCNs as well as top tips, handy hints, bite-size guides, quick guides (for those who don't have time to stop for a bite) and backgrounders for those who want to find out more.
At the end of every issue, you'll find a couple of pages of useful weblinks to documents that should be read in conjunction with this Bulletin and all the other newsletters, updates and reporting requests we send you, including the fabulous output from the Head Honchos at Skipton House!

Strategic aims for the Bulletin

- Spread learning – we gather together the Best Practice examples nationally and throughout the Sackwell & Binthorpe area and e-send them to you in the hope that you'll find the time to aim to e-read them.
- Promote sharing – the more time we spend sharing, the less we waste on unproductive clinical and administrative tasks.
- Enable collaboration – thanks to the new Duty to Collaborate, collaboration is now mandatory. We look forward to working with you to embed collaboration in everything you do. We call it our 'Collaborating to Prepare to Collaborate' Programme. More details in the next newsletter.
- Use Capitals to emphasise whatever seems important, whether it's a proper noun or not – Primary Care, Doctor, Guidance, Quality, Patient and Carer are all great examples of words that we're passionate about.

Get to know your ARRS

As you know, the Additional Roles Reimbursement Scheme (ARRS) exists to fund new roles in PCNs. Many of you have fed back that we don't always cover ARRS as comprehensively as we could, so the Bulletin will regularly feature a profile of a real professional from the B&S PCN Collaborative. This time, I've asked Sally Plant from Eastpark PCN to talk about her role as a Social Prescriber.

My role – by Sally Plant

Hi there! I'm Sally and I'm delighted that Penny asked me to tell you something about my role at Eastpark. On day one, Dr Raman Khan, our Clinical Director, was clear that the Social Prescriber would be vital in the PCN. We started by demystifying the term, which he felt could alienate patients who, as he put it, 'come for medical care not bizarre knitwear'.

We agreed that Admin Link Worker (working title!) might convey the right level of approachability. I immediately set about 'getting to know' some of the patients in the PCN by helping Alan, the Group Managing Partner, with some strategic paperwork.

My next task will be to map all the local organisations providing mindfulness courses and older people's Pilates mornings – subject to easing of Covid restrictions. I was introduced to other local leaders at a virtual meeting of the PCN Collaborative where I outlined some of my ideas, including community litter picks, which improve social cohesion and wellbeing but are also great for the environment.

Some of the GPs seemed a bit dubious, but Dr Adams agreed with me and was very keen to get involved. I'm to run a trial scheme at her practice where we're going to transform the car park. It's a small step, but it's all about making a difference.

Dr Khan has already been quick to recognise the value of prescribing healthy living alternatives to medical interventions, such as walking groups. He's given me a list of patients living with conditions such as chronic hypochondria and agreed that I should work with the Reception team to tell them how to 'take a hike'. I'm so excited to get started!

I hope you've enjoyed Issue 1 of The Bulletin. Whether you have or not, please reply with a 'read receipt' so that we can meet our engagement targets. It's all about helping each other!

Penny
(As told to Julian Patterson)

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