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SUMMER 2021

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INSIDE

SUMMER 2021

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QUARTER OF GPs SAY PCN OPTED OUT OF PHASE 2 OF COVID VACCINATIONS, CITING WORKLOAD

Almost a quarter of GP partners in England say their PCN decided to opt out of phase 2 of the Covid vaccination campaign, with the main reason being intense workload pressures.

In a Pulse survey carried out in May, 95% of around 400 GP partners said their PCN took part in phase 1 of the Covid vaccination programme, while just 4% said their network never signed up.

However, only 72% of the 400 GPs said their PCN is participating in phase 2, with 24% stating their network had opted out.

Eight in 10 (79%) of those who said their PCN is not taking part in phase 2, and who stated a reason, put this decision down to 'workload pressures' in general practice, while 5% said they left because individual practices were unable to administer vaccines themselves, and 16% gave other reasons.

This included a handful of respondents who said the level of pay for vaccinations was not 'adequate' or that their PCNs didn't take part in phase 1 and were sticking with their decision.

Of those who have taken part in the Covid vaccination programme – either personally, or through the practice or PCN – 83% said it had made carrying out core GP work 'significantly' or 'slightly' more difficult, while only 14% said it had no impact.

Dr Cagdas Calisir, a GP partner in Hertfordshire, told Pulse that her PCN, during phase 1 of the programme, allocated GP, nurse and clinical pharmacist time away from surgeries to provide the Covid vaccine clinics.

She said: 'We saw phase 1 as our duty as we knew these patients needed us and our flexibility in primary care, whereas phase 2 patients were young and mobile. We will be back for flu and possible Covid vaccine boosters in autumn.'

Suffolk GP Dr Louise Beale told Pulse: 'We did our best to protect the at-risk groups, but to continue the vaccination programme down the

further cohorts would be to the severe detriment of our day-to-day care of patients and management of caseload, which is ramping up week by week, not to mention our own physical and mental health.'

An NHS England spokesperson said: 'PCNs are playing a vital role in the rollout of the life-saving Covid vaccine programme and the number of vaccination sites changes in line with the needs of local communities and is actually increasing with even more sites offering jabs this month, compared with last month.'

GERADA: GP PATIENT LISTS SHOULD BE 'POOLED' ACROSS PCNs

GP patient lists should be pooled across PCNs as part of measures to address the GP workload crisis, former RCGP chair Professor Dame Clare Gerada has said.

In a *British Journal of General Practice* editorial, published last month, Professor Gerada reiterated that she has 'never seen things so bad' in general practice.

She set out a series of recommendations that must now be 'put into action' to protect GPs, including a 'new service model' to prevent 'piecemeal' care of complex patients.

She said: 'Now more than ever the management of complex patients (including, I would suggest, those in nursing homes, frail elderly, those with complex comorbidities, and those with serious mental illness) must be moved outside the remit of day-to-day care of the GP and instead cared for through intermediate multidisciplinary teams, bridging the gap between hospital, general practice and home, each adding complementary skills providing enhanced care to patients.'

Professor Gerada added that the partnership model is 'outdated and holds us back', instead advocating for the pooling of patient lists across networks alongside digital triage to direct patients appropriately.

She said: 'The pandemic has shown the value of GPs working together — within PCNs. Patients and staff have benefited from the greater flexibility size gives.

'We should build on this and pool patient lists across PCNs; allowing for continuity provided through personal lists (adjusted in size to address numbers of clinical sessions GPs undertake).'

PCNs CAN RECORD COVID VACCINATIONS IN SYSTMONE FROM THIS MONTH

PCNs will be able to use IT systems other than Pinnacle to record Covid vaccinations, including SystmOne, from mid-July, NHS Digital has announced.

Currently, the pharmacy IT system Pinnacle is the only point of care (PoC) system available for recording Covid vaccinations, but NHS Digital has announced that more will become available over the coming months to provide 'greater choice' in primary care and 'reduce reliance on any one supplier'.

This includes TPP (SystmOne), which has passed NHS Digital assurance, and will become available to PCNs from 'mid-July', as well as EVA health (eVacc), which is ready this week.

Meanwhile, other suppliers, including EMIS (EMIS Covid Vaccs PCN hub) are still going through the assurance process, with NHS Digital stating that several systems will finish this evaluation process in the 'coming weeks'.

NHS Digital has assured PCNs that the new systems will ensure vaccination data will flow into the GP record within 48 hours, as is the case currently.

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SEAT AT THE TABLE

As the changes in the upcoming Health and Care Bill filter through the NHS, PCNs ready themselves to ensure they have a strong collective voice and can seize the opportunity to shape care for their populations by engaging with integrated care systems (ICSs). *Emma Wilkinson* reports

In less than a year, 42 ICSs will be fully formed legislative bodies tasked with helping NHS and social care sectors across England to 'connect, communicate and collaborate'. Each will comprise an ICS NHS body, responsible for the day-to-day running, and an ICS health and care partnership, bringing the NHS, local government and the third sector together to improve health and wellbeing outcomes for their population.

PCNs will have a seat at the table, but maybe no more than that. The *ICS: Design Framework*, published in June, calls for one GP provider to sit on the board as part of a core team of around 10, including one representative from social care and NHS trusts. All three of these 'partner members' are expected to be 'full members of the unitary board' but not act as 'delegates' of their sectors.

However, NHS England says that it expects every ICS board to establish roles 'above' the minimum level in order to 'carry out its functions effectively'.

And many ICSs are already starting those discussions about representation. Dr Minesh Patel, chair of the National Association for Primary Care (NAPC), says the relationship needs to be strong but will not be built overnight.

'PCNs and the ICSs in which they now operate are both very immature structures. We know that from other parts of the world where perhaps the integration of care has been more advanced, that journey takes 10-20 years, perhaps even longer,' he says.

REPORT ON THE ROLE OF PRIMARY CARE

The NHS Confederation, which represents NHS organisations including PCNs, published a report at the end of May looking at the issue of primary care engagement at system level.

***The Role Of Primary Care In Integrated Care Systems* calls for clarity to prevent a 'tokenistic offer'. The report, which involves a survey of more than 200 primary care leaders including PCN CDs and managers, highlights concerns that primary care is not being sufficiently engaged with or involved in ICS decision-making.**

Only 12% of primary care leaders who responded said they were always involved in discussions at system level and 50% stated that they were 'unclear' or 'very unclear' about the role of primary care networks in ICSs.

The report sets out five key requirements reflecting its members' views on what should be included in the development of ICS structures, governance and culture:

- **Collective voice and representation for primary care at system level.**
- **Processes and structures for primary care at place level.**
- **System priorities that reflect local neighbourhood needs.**
- **Systems that promote collaboration.**
- **Enablers – investment in primary care leadership capacity and capability and financial certainty.**

To read the full report visit: nhsconfed.org/resources/2021/05/the-role-of-primary-care--in-integrated-care-systems

Local relationships will provide the foundation of the ICS but there is no doubt this is a tough ask for PCN clinical directors who are also trying to build relationships within their network while the system develops around them, having just been through an extremely testing pandemic period, he adds.

'I think it is a tremendous challenge. I don't envy them. I don't think they've necessarily been given the resources required to do that.' And he says it should be remembered that the framework that will be in place in a year's time will not be the finished product.

One key question for PCNs is how to organise themselves to provide a unified voice at the scale of the ICS. Dr Tom Holdsworth, clinical director at the Townships PCN in Sheffield, South Yorkshire, has recently started working on this very problem.

'There's keenness and willingness but the relationship at the moment is in the early stages,' says Dr Holdsworth, who has been given protected time by the CCG to understand not only the 'nitty gritty' about who's on what committee but also how information and communication will move up and down the layers.

'One of the strengths of Sheffield is that the PCNs have quite a developed relationship so there are quite high levels of trust and understanding between the network directors,' he says. But he adds that there will need to be governance, although not overly bureaucratic.

'When things are all going smoothly, it's the relationships that carry you along and allow you to work effectively. If things get difficult, or you know there will be times when you don't all agree completely, that's when you need some governance to fall back on.'

The challenge for PCNs, he adds, is that in some ways they're at their most effective when engaged in local work but now the system is asking them to shift their perspective. 'How you manage that it is partly about the trust and the relationship, so we don't all have to do everything and be in every meeting. If we have the governance structures to facilitate that, then we can make it less burdensome for practices.'

In Dorset, one of the smaller ICS regions with a population of about 800,000 and 18 PCNs across two local authorities, the plan is for PCN representatives to sit on two health and wellbeing boards in the local authority 'places' as well being on the ICS statutory board.

Dr Simone Yule, GP and clinical director of the Vale PCN in North Dorset, says when it comes to representing 79 practices at a board level, the current thinking is to have some form of primary care alliance.

'It's really important that whatever form you take as PCNs, it's an agreed form. So if it's an alliance with terms of reference, you have a mechanism for giving the people that sit on the ICS board the mandate to be your voice. We have to agree that and it has to be recognised that that voice is in the greater interest of the PCN as a whole.'

In terms of primary care representation in the important ICS work streams, business managers, practice managers, nurse practitioners and other parts of the wider primary care team should also be involved, she says. 'We are a key player here and we've never had the opportunity really to be a key player.'

Dorset ICS lead Tim Goodson says collaboration is always far more difficult than competition because it involves trying to get people to support decisions that are not necessarily in their best interests. →

BEN JENNINGS

'And if you've got a couple of PCNs represented, they've got to go back and explain to the rest of their colleagues. That communication on some of the decisions I think can be difficult, not just for PCNs but for any partner.'

Yet he sees no reason, with investment in time and support, why PCNs shouldn't be able to provide that unified voice. The most important bit to get right is the ability to do things at different levels – place, PCN or practice level, and not always at the top.

'I don't want to get bogged down in whether we do this at this level or this level. We need to take the right decision at the right step,' he adds.

The ICS in West Yorkshire, which covers five local authorities with 52 PCNs and six acute trusts, is also building on relationships that were in place before PCNs were formed. The key principle they are working from is subsidiarity – dealing with an issue as close to the person as possible, explains ICS lead Rob Webster.

'We've adopted the subsidiarity principle that starts with the practice unit – strong primary care with a strong PCN in a strong system. It's important to get this right.'

We need to do things at different levels, not always at the top

Tim Goodson

The ICS is working with the concept of neighbourhoods – essentially PCNs – within five local authority 'places'. While most of the 'work' happens at neighbourhood or place level, when decisions are needed at a West Yorkshire level – such as on mental health or health inequalities – PCNs will have input, he says.

'As we move towards statutory basis, we're looking at the role of the CDs within a PCN, and how they are represented at that senior level. We're setting up a CDs' forum for the 52 PCNs and appointing a clinical lead to support our approach,' he adds.

His understanding of the white paper and draft legislation is that it will be clear about the statutory role and functions of an ICS body, but will not be prescriptive about the governance in a place. Local models are being proposed – which relates to the maturity of the networks, he says.

He echoes the view from Dorset that not everything should happen at an ICS level and he doesn't expect the PCNs to solve the problems of the whole area. What is essential is that they can operate effectively at the ICS, PCN and local place level.

The larger ICSs arguably have a harder job in creating a truly integrated system, not least because they are working across boundaries that people rarely travel across for healthcare.

In Cheshire and Merseyside, the current leaders, Jackie Bene and Alan Yates, recently announced their intention to quit because the task had become 'significantly different'.

Ms Bene, chief officer at Cheshire and Merseyside ICS, which covers a population of 2.6 million, confirmed to Pulse PCN that she would not continue in her role after April 2022. She described the relationship between the 57 PCNs and the ICS as very good and improving.

A new primary care provider leadership forum includes a PCN CD from each of the nine 'places' in the system as well as LMC and GP Federation members. In what she describes as a 'significant step', two members of the forum will be elected to sit on the partnership board. Further down the ladder, PCN forums have been created in most of the nine localities.

'We believe that the structures we have put in place provide a democratic and transparent process for the primary care voice to be heard at ICS level,' she says.

Dr Dan Bunstone, clinical director of Warrington Innovation Network PCN in Cheshire, says PCNs are ready and waiting to be involved with the ICS but it will not be an easy task. 'The local variation and control is going to be tricky as the regions coalesce. The sheer change in size is huge and the timing short, as PCNs are still in the developing stage after Covid.'

There also needs to be flexibility in where decisions are made, he adds. 'We need to return to the localism of PCNs. Our job is to deliver strategies fed down from the ICS and I'm not sure how that will work.'

The resignation of the current leadership is a fairly seismic move, he says. 'We are at a critical point in the development of Cheshire and Merseyside ICS, so to lose two very experienced and respected leaders who have been deeply embedded will cause ripples and concerns.'

Dr Paul Bowen, medical director at the Middlewood Partnership in East Cheshire, agrees that it is daunting to lose a leadership that inspired confidence in the task of transformation just nine months before ICSs become statutory bodies in April 2022, subject to the passage of the health and care bill through parliament. 'It is a concern that we are losing, late in the day, two supporters of localism and pragmatism.'

In his view, there was not enough focus in the ICS white paper on the potential of PCNs, which leaves ICSs to ensure primary care is properly embedded. Yet at the moment, the focus is either on recovery from the pandemic or reorganisation.

'It would have been better to have an intermediate step for a year or two. Providers should be focused on restoring normal NHS work at this time and it's a lot to ask of people who are pretty exhausted.'

Dr Patel says it is realistic to set up the basic framework for next April, but they also have to create the space for people to collaborate differently. 'Representation is not the answer alone,' he says. 'We need representation with a depth of engagement. A lot of developments happen just because people are able to communicate with each other. How do we generate a system with a space, and the resource to make that happen?'

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GROUP PROACTIVITY

In no other sector would an organisation have a chief officer that works just half a day a week

Throughout the Covid-19 pandemic, the huge value of PCNs has been evident in the provision of primary care at scale, using data-driven approaches to deliver better outcomes for their populations.

The next 12 months provide us with the opportunity to build on this in an exciting and innovative way. However, PCNs will need to be given the right support and opportunities to help drive system-level decision-making.

In no other sector would we set up an organisation with a large budget and workforce, delivering services for large populations with a chief officer that works just half a day a week and a part-time manager.

Primary care is an anchor in the community. PCNs have the opportunity to be integral to systems, making sure population health is understood at all levels and that resources are allocated and distributed to support the need of the communities they serve.

During the June 2021 annual NHS Confederation conference, I hosted a session on this topic with three PCN leaders: Dr Sunaina Khanna, CD of GPS Healthcare PCN in Solihull, West Midlands; Kat Dalby-Welsh, a nurse CD of Yeovil PCN in Somerset; and Sheinaz Stansfield, PCN transformation lead at Oxford Terrace and Rawling Road Medical Group in Gateshead, Tyne and Wear.

We reflected on the past two years – and particularly the challenges of Covid-19 – and agreed that the vision for PCNs has become much wider than it was at the start.

The pandemic has accelerated relationship and trust-building and, while it may have exacerbated inequalities, in primary care we have seen a galvanised sense of purpose. PCNs now have a real opportunity to think proactively about their whole population's health, rather than just being reactive.

For many, PCNs came along at just the right time as the challenges in primary care were growing more pronounced and they have been invaluable during the Covid-19 crisis, allowing practices and others at neighbourhood level to work together, increasing their collective capacity, and have worked deftly to deploy the new workforce roles.

These benefits and the confidence in PCNs are now vital as we begin to look beyond Covid-19.

Over the next year and beyond, PCNs are keen to build on new ways of working and delivering care differently to meet needs rather than just manage them. Their focus will be on continuing to make connections, using data to take a true population health approach and harnessing the new skills in their workforce to ensure that patients get the most appropriate response to their need.

According to Dr Khanna, if we are going to build on what we have done during the pandemic, we have got to be brave and courageous in pushing ahead with new relationships and collaborative working to build new pathways of care for the patients we serve.

Yet to turn this into a reality we will need more time, sufficient funding and proper support for PCN management.

ONLINE
Read more columns online at pulsetoday.co.uk/pcn

Ruth Rankine
is director of the networks for PCNs and Primary Care Federations at the NHS Confederation

DELEGATES

Dr Katharine Bhatt
Care home lead covering Baywide, Paington and Brixham and Torquay PCNs. Care home beds: 2,100

Dr Paul Bowen
Clinical director Middlewood PCN, Cheshire. Care home beds: 600

Dr Geetha Chandrasekaran
Clinical director for North Halifax PCN, West Yorkshire. Care home beds: 240

Dr Brigid Joughin
Clinical director Outer West Newcastle PCN. Care home beds: 240

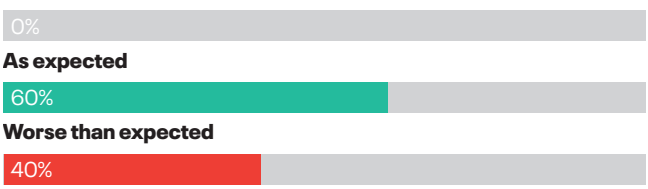
Dr Rajiv Mansingh
Clinical director North Easington PCN, Durham. Care home beds: 400

Victoria Vaughan
Roundtable chair, Pulse PCN editor

ENHANCED CARE IN CARE HOMES

Five PCN clinical directors joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss how the enhanced care in care homes DES is working in their regions

HAS THE IMPLEMENTATION OF THE ENHANCED CARE HOME SERVICE BEEN



Victoria Katharine, as you're responsible for the largest care home population, how has the implementation of the Enhanced care in care homes (EHCH) DES proceeded in Torbay?

Katharine We had an existing care home service prior to the EHCH DES, which was more focused on acute and proactive care in a handful of our care homes with the highest use of healthcare. We have adapted and enhanced that to deliver the DES, but one challenge is to not take away from the existing pathways that worked very well, while also delivering on the DES because it's not the same work stream. [We are] trying to deliver that using the additional roles reimbursement scheme (ARRS) and a whole multidisciplinary team (MDT) approach.

In Torbay, where we had an established care home team that was already running well, and the practices knew what we did and what value we added, we see a reduction in acute visit requests to practices, acute admissions to the hospital and contacts to out-of-hours services, for example. There was more buy-in from an earlier stage than we might have had otherwise. I can see in the South Devon area, where the PCNs haven't historically had a dedicated enhanced care home delivery service, it's been quite hard to get people on board.

We had already started doing an MDT meeting on a weekly basis. We found that the community teams, the dietitians, mental health, speech and language services, were really keen, because they struggled to access timely GP advice when they needed it.

And this was seen as a real enabler. Rather than waiting for the [GP to] call back or send an email and hoping to get something in a couple of weeks' time, we can make relatively nimble decisions that allowed us to progress the care for that patient. It's been a real strength of implementation that's persisted.

Victoria How is everyone managing the challenge of not losing what existed before the DES came in?

Geetha What we had before from the CCG was a 'Quest for Quality in Care Homes' programme, and that was set up quite a few years ago as a proactive service, probably similar to what the enhanced care home DES says. We've adapted it a little in line with the enhanced care home DES, and we're still trying to find how they both fit together. With Quest we soon found, because of the GP and practice workload, it turned into an acute service, so that the care homes started calling them for all the acute stuff, which they were okay with, and we do it as a Calderdale-wide project, which covers five PCNs.

So we've kept the care home DES arm, but we've also kept our acute arm. As part of that acute arm, there is already an MDT which includes a geriatrician, a pharmacist, a dietitian, and anybody else who is relevant. The Quest team is mainly led by quite senior community matrons and nursing staff, so they are well versed and experienced in what they're doing, but we then had to incorporate it with the care home DES requirements. So, we used our care co-ordinators and our clinical pharmacist teams from the ARRS because they are funded and that was the purpose of bringing more workforce in. →

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Community teams were really keen as we got timely GP advice

Dr Katharine Bhatt

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Rajiv We had a vulnerable adult wraparound service (VAWAS), which the CCG set up about eight years ago. It's a well-structured team working in all the care homes and the GPs are consulted for help when it's needed.

When this [DES] came, it was building on what already existed. We found that compared to before, the care home managers and staff felt more empowered and also more involved with the MDT and all that, so that's made a big difference. We were able to educate them to a higher level. There is a clinician who works very closely with the nurse practitioners who are working in the nursing home, and there's monthly training going on, and the aligned GP works with them in educating. So it all diffuses through to the care home manager and the care home nurses and healthcare assistants. Holistically the patients are getting better care.

Brigid We used to have a care home project in Newcastle for nursing homes, but it was voluntary and not all of them took part. That has now been merged with the new DES. We're struggling to work out where our specialist care home nursing team fits in with it all.

We're having a lot of discussions about acute versus planned care, because our specialist nursing team was very involved at peak Covid, going into homes when people were unwell, and managing the likely Covid symptoms, and sadly also managing a lot of deaths. Because they were all drawn into that, we had nothing extra for the DES. Now as the Covid crisis in care homes has lessened, they have carried on running an acute service, and most of the PCN leads would rather they put their specialist knowledge into doing more of the planning, and also into looking after the complex elderly patients which is where their skills lie.

I think a lot of the value of teams is that they are consistent. Your nurse knows those residents. When they're unwell they say 'This is Dolly, she's like this when she has a urine infection'. If you've got an acute service run by seven nurses who take it in turns, they don't know Dolly.

Katharine Fundamentally we're trying to fulfill quite a rigid black-and-white DES. But actually this is about establishing values, ethos and culture. The culture is that these are generally patients who are best cared for in a community setting, not an acute hospital. We need to encourage and nurture our clinical teams to be comfortable that they can do that, knowing that we have systems and processes to support a patient to safely remain in the community. We must enable our care homes to feel confident in holding that [risk], to then not put the phone down [after talking] to us and ring 999 because they're [still worried].

Victoria What do you think about the requirements of the DES?

"The DES covers the 'what' but not the 'why', which is vital

Dr Paul Bowen

Paul The DES goes into a huge amount of detail about what we should do, but it doesn't cover the 'why', which our original enhanced service pre-DES did. Why is it important for this population to receive this type of care? What is the focus?

We established an enhanced care in care homes service across east Cheshire back in 2010, which we've obviously adapted with the publication of the PCN contract as well. Our initial approach was all about outcomes. It was: 'You get on with it, practices; you do what you think is best for these individuals to achieve these outcomes.' The outcomes that we mutually agree on are: people should live a full, dignified, comfortable life in the care home; they should avoid unnecessary hospital admission; they should avoid unnecessary attendance from an ambulance, unnecessary lengthy hospital stays and unnecessary falls. The CCG pre-DES judged us on these mutually agreed outcomes, not on whether we have a care plan, or whether we have an MDT meeting every week.

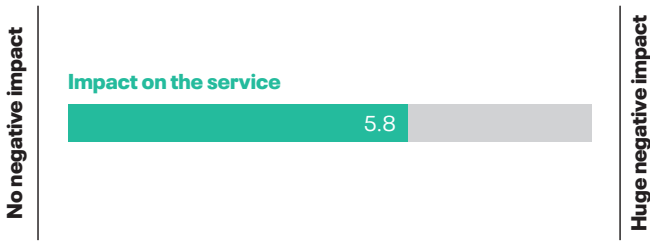
We've found that, because our CCG has been light touch with the DES, possibly because of the pandemic, we have been allowed to focus on the outcomes. We haven't done care plans, we've done care planning – and care planning is a live approach that constantly updates and evolves. You could say the same with medication reviews.

Geetha I found the implementation went worse than expected because of Covid. We had a plan: we'd go in once a week; we'd see the patients; we'd do their SMRs. It didn't go as expected. We've had →

to do a lot of virtual work and we're just starting to pick up again.

Our care co-ordinators do the weekly ward rounds. At Covid times, if there were any outbreaks, the care co-ordinators would do a daily check-in with the care homes that were affected. The clinical pharmacists were in the background in case there were medication queries. The care co-ordinators also have a line to the pharmacist for other times when they have any medication queries.

ON A SCALE OF 1-10, HOW MUCH HAS THE PANDEMIC NEGATIVELY IMPACTED THE SERVICE?



The MDT meets once a month with the GP CD or the clinical lead. Some have nurse practitioner leads as well. We're a little bit light on clinical input from GPs, and we don't know whether we need more, but it seems like it's working.

The point is, if clinically they are safe, and they've done what they need to do, I think practices, because of the workload, should let them get on with it.

Victoria Clearly care homes were devastated by the pandemic and access to patients was limited. Can you discuss how Covid affected your EHCH service plans and delivery?

Paul The care home I work with suffered a significant number of deaths in those first three months. Some we couldn't put down to Covid. Some we could because the testing wasn't available and neither was the PPE. Those first three months, I was so proud of the staff and colleagues – I found it quite difficult to deal with emotionally because I'd built up a relationship.

I've spent the last 10 years in that home knowing a lot of those people. The matron at the home and the nurses and carers are as much of my staff as the practice nurses and my salaried doctors are.

I'm proud that of the people who died, none of them died in hospital. They all died peacefully in the home, even though they were not with their families.

I think that was a sign of accountability and trust and familiarity, [aspects] that this DES has failed to recognise. I'm surprised that doesn't come through in the DES – the strength of continuity, familiarity, the coaching and mentoring of the staff [mean] that you give [them] the ability to trust, that [it] won't go to the CQC just because they didn't call an ambulance last night, that it's excusable for people to have falls and things like that given the situation. I think the Covid situation highlighted that, because we were so dependent on the professionalism of these amazing individuals and Romanian nurses and Bulgarian carers, and people who made a real difference and weren't championed in that first time.

Brigid It goes back to my point about [a situation where a patient like] Dolly is a bit unwell. You trust the assessment that care home staff have made because you know them, and you know that they know that person. They trust you if you say, 'I'm sure this is fine, just put her to bed'. I think when you've built that trusting relationship, it trumps everything. The relational issues don't come across in the DES at all and that's disappointing. I guess you can't bean-count them.

Rajiv In my practice, we have four nursing homes aligned to us, so we have one lead clinician linked to one care home, and roughly 35-40 people in a care home. So they have an established rapport with the staff, the manager and patients. That's probably what helps through the pandemic time. It was so hard to look at the video and identify what was happening with all the PPE that staff were wearing. And the voice coming through [the screen] wasn't very clear. [We had to figure out] what the care home people were saying to us [and then] relate it to what we know about the particular patient and the family demands and dynamics... To be honest, Covid had a big impact, but despite that, I would say it's a positive experience of how we could help.

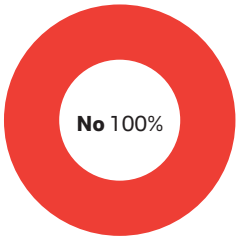
Brigid Our CCG provided some tablets [for remote working], but they were pretty rubbish and we had to use Zoom and that didn't work terribly well. Sometimes we used WhatsApp on the carers' phones. It was difficult not to go into our own care home.

But we could go [virtually] around the lounge, we could have a look at somebody's foot, we could watch somebody walking across the room if there were worries about them. Actually I think it was better than might have been expected.

Victoria Do you think you'll continue to use technology in this way post Covid?

Brigid I don't think the virtual visiting will stay, because assessing mobility and getting the feel for somebody is absolutely better face to face. But I think we're all finding that using Microsoft Teams for the MDT discussions means you're not travelling for half an hour, you can all fit into the same room, and there is an advantage in that. And if you can't all be at the care home on a Thursday every week, maybe you can be once a month, but in between times, you can have half-hour Teams discussions. We've got our virtual clinic with our geriatricians in the city who we can book a virtual appointment with to discuss anybody who's complex. That wouldn't have happened in the old world and it's useful.

IS THE FUNDING SUFFICIENT?



Katharine I think this is the question everybody's grappling with – not just with the DES but with primary care as a whole. How much of this do we hold onto in terms of progress and how much of it do we stop? I think a hybrid will be the way forward, where after discussion we agree on the most appropriate way of consulting. We now have that option. In the pre-Covid world, I don't think any of us would have considered doing a video consultation of an old frail person in a care home, and similarly a care home would never have accepted it. Also, they are doing lots of video calls with relatives, which has also improved their ease and confidence with technology. Certainly for us, with the number of homes we have, we will not be able to deliver the DES as a purely face-to-face model, so we are going to continue some kind of hybrid.

Victoria Is the funding attached to this DES enough?

Katharine Short answer is probably not. Again, I think it comes back to the same thing – is it enough to tick the four main boxes of the DES? To do a care plan, a home round, an MDT and an SMR. Maybe it is for our population of care home residents. But is it enough to deliver high quality, individualised, community-based care, upskill our care home staff, our community teams and our ARRS roles and make this a resilient,

sustainable, impactful DES? No. And is that a wasted opportunity? Absolutely.

Paul I totally agree with Katharine. It's enough money to tick the box, but the boxes are not what is important here. Our CCG pulled the money from the previous scheme and added it to the PCN scheme – I think that is probably enough and we've got the ARRS on top of it. It kind of all worked then, and a lot of it is core [funding] as well. So, I think on its own, it's not going to cover the costs of achieving the outcomes that I suspect they want us to achieve. I wish [there was an emphasis] on the outcomes and less about how to [achieve them].

We should measure the happiness of the care home staff

Dr Brigid Joughin

Brigid We discuss: 'Are the community nursing team paying themselves, or are we?' Should we be paying for them out of our PCN money? In which case, [the DES funding is] absolutely not enough. And even if their services are paid from the community budget, there's not enough. Also, seeing everybody post-discharge and within so many days [is] pretty ridiculous. We found out our specialist nursing team was making sure to see everybody within seven days of discharge and we didn't even know that. Eventually, the GPs were going out and saying the nurse had done a review, but it had to be joined up. I think there's a real issue with people desperately scrabbling around to do things they think they should do without a real overarching plan and vision.

Paul We all know [if we're] looking after people with dementia, it takes at least a couple of weeks for them to settle in, to understand. The idea that you see them within two days... [if you have] a good registered mental health nurse-led nursing home, you don't need to see them in the first two days.

Victoria What would you add to the DES to improve it?

Brigid Happiness of the care home staff. Let's do some assessment of whether they are happy with the situation. Do they feel they are getting a good deal? Give them some boxes to tick.

Katharine Some kind of outcomes approach – but that outcome shouldn't be admission avoidance, bed days saved, calls to 999. It should be dying in the preferred place of care, de-prescribing or medication burden – the wellbeing-focused, positive outcomes that we know make a difference to our patients. That should be the aim – not the boxticking, very fixed, very rigid criteria that have been set out so far.

Paul I'd add satisfaction of the care home manager – that they feel supported, have trust. [I'd add] more qualitative outcomes and more autonomy and fewer tick-boxes. [I'd also add] more autonomy for each PCN; and each practice to model how best it delivers on those outcomes, but with reasonable, good benchmarking and bellwether indicators.

Geetha I'd really like softer, qualitative indicators - indicators that involve the care home staff and relatives, to see if these [changes] have made a difference to families and patients.

ALAMY

STOP. COLLABORATE AND LISTEN.

PCNs must fight to ensure primary care's voice is heard

Covid has shown us the devastating results of not involving primary care in wider decision-making at an early stage. Speaking about the tragedy that befell care homes during the pandemic, Dr Ian Hall, one of the scientists advising the Government, said in the BBC2 documentary *Lockdown 1.0 Following the Science:* 'we didn't know how connected the social care settings were with the community... I'm sure there are lots of academics and policymakers that could have told us, if we'd asked them.' This of course includes GPs, nurses and carers who know how care homes operate and the way agency staff move around. Listening to the people doing the caring is vital.

In our roundtable (page 10), PCN leaders express dismay that the Enhanced Care in Care Homes service specification misses the importance of the relationship between GPs and care home colleagues. They suggest the DES should include measurements of, for example, the wellbeing of the care home staff and whether people are dying in their preferred place of care. This discussion highlights the disconnect between CDs' experience and the demands from NHS England.

So we can only hope that, with the advent of the new ICSs, PCNs are given the voice they so desperately need. Let's not forget, 'evolution' was supposed to be the buzzword of the 2012 Health and Social Care Act. But many felt the result was actually fragmentation. Now, the new Health and Care Bill is shooting for collaboration. Whether it scores remains to be seen.

However, one thing that is already clear is... lack of clarity. PCN leaders are unsure how they will get a seat at the integrated care system (ICS) table. There is an opportunity, and a willingness, from both sides as demonstrated in our cover feature (page 6). But how that is worked out is at a nascent stage. Many PCNs are still getting organised. And there is the ever-present pandemic.

This should not be solely the responsibility of PCNs but I fear if they do not engage at a system level the opportunity could be lost.

A report by the NHS Confederation, *The Role of Primary Care in Integrated Care Systems*, calls for greater support to allow primary care leaders to engage at this level. It also highlights that half of the 200 primary care leaders involved were unclear about primary care's role at ICS level.

Each PCN has distinct features. Some will have huge care home populations. Others, a large university. How to get representation of those localities and ensure primary care does not get lost needs to be resolved – and fast. Winter pressures and the Delta variant will put more strain on CDs' already limited time. The PCNs that have funded a dedicated manager are the ones making progress. Similarly, it will be those PCNs that dedicate resources to working with their ICS that will ensure true collaboration across the system. You can't have tens of PCN reps at board meetings but you can have a working group that elects representatives. NHS England should provide ring-fenced funding for this if the aims of the Government's white paper, the 'primacy of place' and the PCN project as a whole are to be believed.

Victoria Vaughan is editor of Pulse PCN

JOB PRESCRIPTION

It's time for a proper, businesslike conversation about the funding of CD work

Perhaps it's the change in season, the easing of lockdown or the vaccine programme but I'm starting to feel more positive about the PCN project, albeit with caution.

Since becoming chair of South Staffordshire LMC in April, I've realised just how ill-understood general practice is in the wider system, especially by our colleagues in secondary and community care. There is a real opportunity to fuel recognition that we are not only the best but the cheapest and most efficient part of the NHS.

The proactive systems want to work with us. They want our resources and help to move work into primary care, of course at considerably lower levels of funding than secondary care.

So there have been a few positive moves, but not without caveats.

First, the system has some recognition of the pressures – the DES specifications have been delayed for this year. However, I'm wary of when and how they will be introduced, considering we have a booster Covid vaccine to deliver on top of normal QOF and flu vaccines this year, and we've not even finished the first round of Covid vaccines for our population.

Second, there has been an increase in additional roles reimbursement scheme (ARRS) funding for PCNs. But the CD payments, PCN support payment and network participation payment have seen little or no uplift, which is effectively a pay cut in real terms. Again, this completely ignores the workload the additional funding, recruitment, management and system expectations bring. And no, I'm not talking about the CD uplift purely for vaccination purposes for three months. What about after that?

Although there is some recognition of workload, I still feel we have been sold short as CDs. As a CD, I'm not sure where my role starts and ends – and I'm sure my colleagues feel the same. By taking on the CD role, have GPs opened themselves up to unlimited system meetings and demand?

We need a job description. We need our leaders at the BMA General Practitioners Committee to define what the CD role is – not the broad-brushed notion of 'supporting system development'. And CDs need to start working within their remit, rather than jumping at every opportunity of unfunded work.

We had a great talk the other day from a public health consultant on population health management. We GPs can provide a wealth of knowledge here, but when I asked about resourcing CD and GP time, it seemed like all hell broke loose. Similarly, we were asked to develop a nationally funded scheme by meeting weekly for an hour. On raising the question about time and resourcing, suddenly those meetings were not needed any more.

I feel positive that we can support the system to deliver services, but we need to be more corporate in our approach to resourcing, and this is where we have let ourselves down. Let's have an open conversation about proper resourcing of GP, CD and practice time for non-contractual work. I hope the system can recognise that we are open to adequately resourced work to help the patients and system, and if they appreciate this and agree to work along these principles we can move forward with a spring in our step.

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

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

LEADING QUESTIONS

***Jenny Bostock*, an advanced nurse practitioner and one of 40 nurses running a PCN in England, shares her unique perspective**

What motivated you to become a CD?
As a nurse leader I've been involved in workforce planning and helped raise standards in several practices in East Kent, facilitating an integrated team approach. This, and my experience as nurse representative for the local CCG board, is why I was interested in this role. Collaborative working makes sense. My communication style differs from that of my GP colleagues as my work is generally more about self-help, health promotion, ongoing management and treatment. It's a team effort between me, the GPs and the patient. My ability to engage with all PCN staff from the cleaners to GP partners has played a huge part in bringing all our teams together and I think it is where nurses can really excel as our skill set and experiences are so diverse. Also, I think nurses are seen as more approachable. I am passionate to showcase how effective a nurse leader can be.

What's been the best moment as a PCN CD?
Seeing the practices helping each other and supporting the new roles. They have started sharing good practice and have moved away from silo working. Covid has helped with collaborative working and sharing of staff. New roles such as clinical pharmacists and pharmacy technicians have been a great asset, and have improved patient care and prescribing systems to ensure safe, efficient medication reviews and improved communication with Medicines and Healthcare products Regulatory Agency (MHRA) reporting. Social prescribers have been a source of support for our vulnerable population, preventing numerous GP contacts by offering continuity of care and signposting to alternative appropriate services. Everyone has embraced the changes in the way we work. Being able to innovate and having funding has been amazing.

And the worst?
Trying to balance full-time clinical work with numerous meetings has been a challenge. The additional CD hours have helped, but the sea of emails is relentless. I struggle with the practice's needs and CD role. The evening meetings have also been a negative as work has followed me home. I hope the increase in funding for CD hours will support the workload.

What has the experience taught you so far?
To be resilient, not to stress about things I cannot change and to look at ways of overcoming barriers. To be proactive and to keep pushing boundaries.

Do you have any tips or hacks that help you get through the workload?
Look at meetings and decide if you need to be present. Deputise if possible. Keep on top of emails – allocate time every day. Have regular breaks and try not to email after 10pm or before 8am.

Do you have a goal or a target for your PCN?
To achieve full integration and collaboration between the practices, social care, community services and mental health services, ensuring the PCN addresses health inequalities and raises standards. I would like to see a unified diverse workforce with the funding to provide great services and care, while also valuing the teams that are providing these services. This includes having career pathways similar to secondary care that encourage and secure a future workforce.

Who or what inspires you?
My mother. She taught me to aim high and told me to listen before speaking.

Where do you turn for support?
The WhatsApp groups have been a great source of support. Also, I join the other nurse CDs via the NHS Confederation. The free coaching from NHS England has also been a good resource.

What do you do to relax?
The last year has been a challenge as lockdown has restricted many activities but I have managed to get headspace by walking and baking, perhaps not as often as I would like.

Name
Jenny Bostock

Practice
The Grange, Ramsgate, Kent

Number of practices in PCN
Five

Number of patients in PCN
52,000

PCN roles hired
Four clinical pharmacists, two pharmacy technicians, two social prescribers, two care navigators, one administrator, two trainee nursing associates

PCN roles to fill
Seeking a mental health worker and nursing associates

Career to date
- **1986** Qualified at the Middlesex Hospital London
- **1986-1996** Ward sister in a variety of hospitals and specialties including orthopaedics, general medicine, ophthalmology, ENT, A&E, high dependency units and surgical wards
- **1996** Practice nurse at Northgate Practice and University Medical Centre Canterbury, Kent
- **2000** Qualified as a practice educator, lead nurse in general practice, Christ Church University, Canterbury
- **2004** Qualified as a nurse practitioner, South Bank University, London
- **2006** Lead nurse at Kent University practice and campus walk-in centre
- **2010** Canterbury and Coastal CCG lead of nurse governing body
- **2014** Director of nursing at Invicta Health Community Interest Company
- **2017** Awarded title of Queen's Nurse by the Queen's Nurse Institute (QNI) for improvements in primary care, developing the clinical pharmacist role in reviewing medications and carrying out health checks
- **2018 to present** Advanced nurse practitioner, mentor, clinical supervisor, The Grange practice, Kent
- **2019 to present** CD, Ramsgate PCN

DELIVER THE MEDICATION REVIEW SERVICE

GP partner and PCN co-CD *Dr Rupa Joshi* offers tips on meeting this year's structured medication reviews and medicines optimisation service requirements

The structured medication reviews and medicines optimisation service began last October and continues under the Network Contract DES for 2021/22.[1]

As we increase our focus on implementing the Network DES activities, what can PCNs do to ensure they meet the updated requirements effectively?

1 Be creative with workforce funding

Most PCNs now have pharmacists on their teams, with the help of Additional Roles Reimbursement Scheme (ARRS) funding. A senior clinical pharmacist or clinical pharmacist with the support of a suitably trained pharmacy technician can deliver the structured medication review (SMR) requirements. However, remember that any prescribing clinician can complete SMRs, with oversight from a senior pharmacist if needed. Note also there is a new banding 8a option for clinical pharmacists in this year's ARRS.[2]

2 Consider employing an extra pharmacist

Clinical pharmacists and pharmacy technicians are already working extremely hard delivering the daily demands of general practice. PCNs may benefit from employing an additional pharmacist to ensure they can deliver the service, as well as meet the increasing demands in primary care. This may be particularly beneficial for PCNs with, for example, a large number of care-home residents or elderly complex patients.

3 Use both proactive and reactive ways to identify patients

Patients who must be prioritised for SMRs are those:

- In care homes.
- On 10 or more medications; on medicines commonly associated with medication errors; with severe frailty and isolated or housebound, or with recent hospital admissions or falls; and using one or more of opioids, gabapentinoids, benzodiazepines and z-drugs.

Patients may be identified proactively by simple searches for numbers of medications, via the GP IT system, or by the use of tools such as PINCER, the electronic frailty index and the Integrated Populations Analytic tool.[3-5]

Make sure you can also include patients reactively, based on clinical need, for example via MDT meetings or PCN team referrals, or following abnormal biochemistry or rationalisation in end-of-life care.

4 Set realistic SMR targets

The number of SMRs offered depends on your capacity to deliver. Collaboration between CCGs and PCNs to set an achievable target is essential. Each SMR should take between 20-45 minutes, depending on complexity. We consulted our CCG medicines management lead, who recommended we aim to complete one or two SMRs per session initially, giving time to embed the process, with capacity to be reviewed in April 2022.

5 Offer a tailored approach

Patients on long-term opioids and gabapentinoids can be difficult to engage. They are often concerned their medications will be stopped or reduced. This is where your wider workforce can be crucial to delivering an effective review. We have found using a personalised approach, via a group consultation, beneficial. Psychological approaches such as coaching techniques and teaching the biopsychosocial model can help, and be delivered by social prescribing link workers and health and wellbeing coaches. There are also useful reading resources, and if appropriate patients can be referred to discuss psychological causes with their GP or mental health practitioners or pain psychologists.[6]

6 Make use of local and national frameworks

It will really help reduce your PCN workload if you can align activities with local and national quality incentives. In my region we have CCG initiatives to identify high-risk patients for medicines optimisation and new medicines reviews. The NHS Long Term Plan also sets out aims for medicines optimisation, while the national antimicrobial action plan and Stopping over-medication of people with a learning disability, autism or both (STOMP) initiatives also overlap.[7-9] It is important to share lessons learned here among PCNs, CCGs and integrated care systems (ICSs).

7 Forge bonds with community pharmacy

Your community pharmacy colleagues can offer vital support here, in particular with the new medicines reviews. We already have a PCN lead community pharmacist who works with community pharmacy colleagues and can identify patients who may benefit from this service, which supports patients with adherence to newly prescribed medications such as for asthma, COPD, type 2 diabetes and hypertension, and newly prescribed anticoagulants.

ONLINE
References online at pulsetoday.co.uk/pcn

Dr Rupa Joshi is a GP partner in West Berkshire, co-clinical director of Wokingham North PCN and NHS Confederation PCN board member

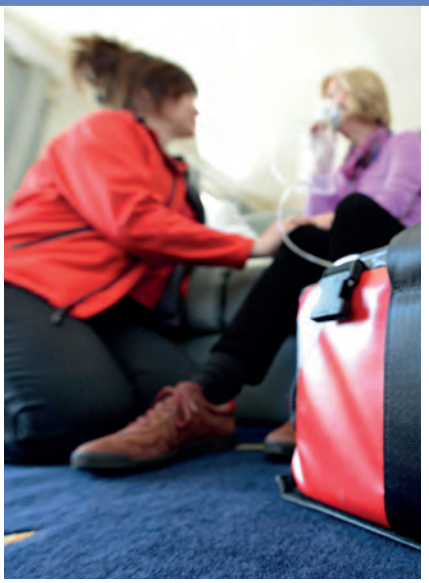
WORK WITH A PARAMEDIC

GP partner and PCN co-lead *Dr David Coleman* outlines what paramedics can bring to general practice and how to decide if the role would suit your network

A paramedic can be a highly valuable addition to the primary care team. Paramedics can now train as independent prescribers, and with our ambulance services under immense pressure there are likely to be many paramedics considering a career change.

Under the Additional Roles Reimbursement Scheme (ARRS), PCNs are now guaranteed 100% reimbursement for the costs of employing a paramedic including a salary at Band 7 – or at Band 8A for an advanced practitioner – on the NHS Agenda for Change pay scales.[1]

Here are tips based on my experience of employing a paramedic, on how the role can support general practice and what to consider before hiring.



ALAMY

Think beyond acute presentations

Paramedics can primarily offer support with assessing patients with acute symptoms, but they can develop wider clinical expertise and also become involved in audit, education and even management.

The ability to assess and manage emergencies makes paramedics ideally suited to undertaking home visits in the community. Their experience and communication skills also mean they can handle challenging discussions about future wishes, including attitudes towards resuscitation and end-of-life care. With experience and the support of a multidisciplinary team (MDT), paramedics can contribute to anticipatory care, care home ward rounds and even learning disability care as part of a small team of clinicians.

Indeed, the requirements of the ARRS stipulate that as well as managing acute presentations, a PCN paramedic must work as part of its MDT, support delivery of anticipatory care plans and lead certain community services.[1]

Decide on your PCN's priorities

Think about how a paramedic will fit into the wider MDT. For example, if you base the role in a small number of practices with a particular need, such as a high visiting caseload, consider how the role will be shared out equally.

The ARRS allows for a rotational system with the local ambulance trust, and PCNs should co-operate with the trust to ensure a sustainable workforce. Direct employment by the PCN would be preferable in my view, to allow the role and relationships with the MDT and wider ARRS team to develop. However, the support of an ambulance service, for supervision and host employment, may be an attractive option for some PCNs.

Consider the benefits to your wider team

A paramedic can bring a unique perspective to practice clinical meetings and significant event analysis, particularly if the case has an acute care aspect.

A paramedic may also be a qualified CPR instructor. The role can provide a welcome degree of flexibility as well – for example, where GPs are struggling to manage the volume of home visits, paramedics can pick up the slack.

Make it a long-term investment

Most practices could benefit from an experienced paramedic. The key is having the capacity to provide the right level of supervision, particularly in the first 12 months. Build in time for regular progress review meetings in the first six months and make sure the paramedic can attend appropriate GP registrar tutorials and clinical meetings.

If you recruit a non-prescribing paramedic, you will need a system for prescription management. An on-call doctor – allowing a paramedic to discuss a case and obtain the script – prevents delays in prescribing.

Factor in equipment and space

You may need to provide additional resources for the role, including equipment and a room. We provide our paramedic with a doctor's bag of basic kit, but she drives her own vehicle and has car insurance that covers business use. We also have plenty of room space, but this is something more spatially constrained practices or PCNs should bear in mind.

Keep patients informed

Patients are generally very happy to see a paramedic, particularly if they have an acute problem. The key is transparency. We make it clear over the phone that they will be seeing an experienced paramedic practitioner.

As with any new additional enhanced skills role, explain to patients the rationale for employing a paramedic. A video in the waiting room, an article in the practice newsletter or a presentation to the patient participation group are all good ways of doing this. You might even consider referring to staff as, for example, the 'GP doctor', 'GP nurse' and 'GP paramedic', with all primary care clinical staff wearing scrubs.[2] We haven't gone as far as that, but it is one approach to consider.

Dr David Coleman is a GP partner and PCN co-clinical director in South Yorkshire

ONLINE
For more articles on staffing, visit pulse-intelligence.co.uk

References

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KERNOW HOW

While Cornwall will be this summer's domestic holiday destination of choice, *Dr Dale Staff* and *Dr Mike Waldron* tell us how their PCN is planning care for locals in all seasons

Bosvena Three Harbours PCN covers a varied geography and patient demographic, which includes a large portion of remote Bodmin moor, some central Cornwall urban areas such as Bodmin Town that have high deprivation, and the popular coastal harbour town of Fowey. The new PCN footprint crossed some historical boundaries, which made the initial set-up challenging.

The PCN is made up of two clinical neighbourhoods which were in different CCG locality groupings. The Three Harbours group moved from the Mid Cornwall CCG locality to North and East to accommodate this. The community healthcare teams and social care were aligned around the old boundaries, so this change has affected more than just the practices. We have begun aligning the community teams such as district nursing, but there is still a long way to go with other services.

The two Bodmin practices were already working together under the name of 'Bosvena', as were the practices in Fowey, Lostwithiel and Middleway as 'Three Harbours'. Each group considered applying to be individual PCNs but they were too small. So an application was submitted for one PCN, in which we planned to maintain two clinical neighbourhoods. Dr Dale Staff (Bosvena) and Dr Michael Waldron (Three Harbours) run the PCN as joint CDs with two strategic managers. As time has gone on, these boundaries have blurred.

Once we decided on our make-up, agreeing and signing the PCN agreement was straightforward. But how to organise the management of the PCN was a dilemma. We considered a standalone strategic manager, but decided we didn't want to see the PCN as a bolt-on to GMS, we would integrate it fully with our practices. So we freed up time from the management team and expanded the management structure as a whole. By appointing two existing practice managers – Michelle Pratley and Amanda Bone – to work part time as PCN strategic managers, we were able to recruit a PCN IT and business intelligence officer.

We also had to align our IT as the practices were on different clinical systems, so the Three Harbours practices migrated from Microtest to EMIS – which was much appreciated by the Bosvena team.

Despite the challenges of the footprint, being a PCN has benefits in terms of additional funding and the additional roles reimbursement scheme (ARRS) roles. We have hired 12 new full-time-equivalent members of staff. We now have a team of three pharmacists and two pharmacy technicians meeting the requirements for structured medications reviews and also supporting care homes, managing medicines safety, handling prescribing incentives, medicines reconciliation and community pharmacy integration work. This has had a significant impact on workload and also quality improvement.

Being able to employ new roles at a scale where they make real impact is great. We already had a pharmacist and paramedics in some practices. With expansion comes a more consistent service level.

PCN power

Also, as a larger organisation, we have felt able to take part in larger health improvement projects. We are one of five PCNs in Cornwall working with the Complete Care Communities Health Inequalities national team to tackle health inequalities in our learning disability population using a community integration approach. We are also one of three PCNs using population health management with the help of Optum, a private healthcare company.

With our neighbouring PCN in North Cornwall, we set up a Covid vaccination service using our community hospital site – this involved two PCNs and 10 practices, including two that were not in a PCN.

The less tangible benefits have been felt from working more closely with neighbouring practices and supporting each other through the pandemic. We had regular video catch-ups for the practice management teams and established a PCN strategic managers group. This continues to meet weekly. We also have shared support for the interpretation and implementation of procedures and guidance, sourcing PPE, triage models and IT.

This supporting culture goes further than our own PCN. Before Covid, the Cornish CDs were already meeting on a monthly basis to share PCN development ideas and tackle wider issues of concern to PCNs. With the crisis, this group met remotely twice a week in the early days, forging strong bonds and laying the groundwork for what is now an effective and cohesive group. This, plus links with others such as the LMC, has helped the rest of the system in Cornwall hear the voice of primary care as we are able to speak with a united voice as we understand each other's challenges and views.

Estates challenge

Currently, space is our biggest challenge. The practices are woefully undersized. There are plans for building projects but in the meantime we have had to fund leases on private office space to accommodate the extra staff and the new space is already full. We think the network DES should better reflect the increased number of staff employed.

Supervision and development of new roles is another challenge. Though the ARRS roles have been a welcome development, we have needed to identify a way to free up GP time to train new recruits. We currently fund a session a month for a GP for each of the ARRS roles we employ through the PCN development fund.

IT is another challenge. Our clinical systems have not developed with the pace of change in practices. Some of our ARRS team operate across the PCN, such as our three pharmacists, two pharmacy technicians and the two paramedics performing home visits for the Bosvena practices. The workarounds for shared record access are clunky and are inhibiting further integration. A similar but more marked problem exists with our efforts to integrate with our community services. A shared clinical record would be a strong driver of change.

We are also currently debating the pros and cons of incorporating.

Thoughts on the future

We have tried to view the PCN contract under three broad themes. First, to support existing GMS, to shore up an increasing fragile general practice. Second, to deliver enhanced care to patients through the national PCN service specifications. Finally, to operate at scale to tackle locally determined issues, for example, to redesign diabetes care or tackle health inequalities for our learning disability patients.

A limitation is the restricted nature of the roles and the lack of funding for management. If PCNs are to achieve greater service redesign, they will need management and project support, but this is not currently funded. We have employed a data and IT support role, but

CDs
Dr Dale Staff and Dr Mike Waldron

Location
North /mid Cornwall

Practices
Carnewater Practice, Bodmin and Fowey River Practice

PCN
Three Harbours and Bosvena Health

Number of practices in PCN
Five

Number of patients in PCN
43,500

PCN hires (ARRS employed)
Three clinical pharmacists, two pharmacy technicians, four first contact physiotherapists (through community provider shared model), one physician associate, two paramedics, one health and wellbeing coach, two care co-ordinators and two social prescribers. (Not all staff are full time.)
Recruiting: Still looking for a paramedic, a mental health practitioner and a first contact physiotherapist.

Dr Dale Staff with PCN strategic managers Michelle Pratley (left) and Amanda Bone (right)

EMILY WHITFIELD WICKS

additional project management support will be essential for sustained development.

For the coming year we will be focusing on delivering the health inequalities and population management projects. We will need to embed our latest recruits, two clinical care co-ordinators, who will work with our two care-home nurse leads and the wider primary and community team involved with the care of the frail elderly. This will be key for delivering the new PCN service specifications that are due later this year and improving integration with our community teams. Embedding the other ARRS roles already employed is an ongoing task.

Our clinical projects include integration with secondary care, working with our community teams to reduce duplication in home visiting and progressing our work with care homes beyond the service specification.

There has been a lot to learn during these first years. Our main thoughts are: that practices are far more alike than the few differences we are prone to focus on; it takes time, lots of time, to embed changes; and while it's been a positive to have these new roles, introducing them in rapid succession is hard. But with support and collaboration between practices in the PCN and in the wider network of PCNs, primary care can be a strong force for positive change for patients.

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

CLARIFYING THE FACE-TO-FACE ADVICE

Hello everyone!
Hello again from Penny and the Primary Care Support Team at Sackwell & Binthorpe ICS. Once again, it's time to reach out to PCNs with our latest newsletter. This issue is packed with even more news, practical tips and helpful information, including the results of our latest poll, further details of our forthcoming collaboration tool, and news of an exciting new scheme from NHS England, which is expected to transform the lunch experience for PCNs and their populations.

SOP: how we're supporting you
We've had a lot of messages following our letter about the new Standard Operating Procedure, which some of you seem to have misunderstood.

When we appeared to say in our previous letter that we want you to stop all face-to-face appointments with immediate effect, what we meant was that it's vital that patients who want a face-to-face appointment should be able to demand one immediately.

We're grateful to the *Mail on Sunday* and Matt Hancock's office for pointing out that this could have been made clearer, and we hope our latest letter removes any remaining doubt.

I want to reassure you that all of us in the commissioning strategy and primary care support directorate really sympathise with the strain primary care has been under. Not only do we regularly acknowledge your hard work, commitment and sacrifice in our newsletters, we are also taking more practical steps than ever to help. These include:

1 Our popular webinar series Easy Steps to Resilience – completing all 17 modules qualifies participants for a Compassionate Coping Certificate and a #StayStrong lapel depicting smiley faces in a range of ethnicities. We've even made the course available at evenings and weekends, to make it easier for you to develop coping strategies outside work hours. Well done to practice manager Sandra Stokes for being the first person to complete the course. (I'm sure you'll all join me in wishing Sandra a speedy recovery after her recent breakdown.)

2 Our bite-size Lighten the Load guides have also gone down well – hundreds of pages of tips on how to 'work smarter', culminating in a compulsory 10-page 'fun quiz' to help you put your new learning into practice. The results of the questionnaire will also help me and my team to come up with great new support materials, courses, guides and surveys to help you reduce workload still further.

3 New 'Be Grateful' posters and leaflets for reception areas explain how the new SOP works and remind patients to do their bit to reduce overcrowding and maintain social distancing. We're also refreshing our handy guide to conflict resolution for reception teams, which has been rebranded as the Constructive Conversations toolkit.

Poll news
Thank you to everyone who took the trouble to respond to our poll asking what you think of the newsletter. An overwhelming 22% of you thought it was 'quite useful' or 'fairly useful'. We were delighted to receive so many suggestions about how to improve it. One came from Ravi, a GP and CD from the north-west, who said the 'unsubscribe' function is broken. Don't worry, Ravi, NHS Digital is on the case!

The Matrix
Last time we promised you more information about our Collaborating to Prepare to Collaborate programme. My team is working to develop a self-assessment tool to test your collaborability. The Collaboration Matrix identifies the Domains of Collaboration that PCN leaders are expected to work towards, the performance assessment methodology, and the sanctions for non-compliance. We can't wait to share it with you.

Alternative rolls
Further details are emerging of the new ARSS initiative. Not to be confused with the Additional Roles Reimbursement Scheme for onboarding PCN staff, the Alternative Rolls and Sandwiches Scheme links part of every PCN's income to its ability to provide a diverse and healthy range of rolls, sandwiches and wraps for staff. NHS England is also looking at extending the scheme to patients awaiting face-to-face appointments.

Final details of the new DES are still being ironed out, but there have been a number of important breakthroughs in discussions between NHS England and the BMA, including clarity about the contractual levers to ensure adequate provision of vegan and gluten free alternatives.

A major sticking point over the name 'club sandwich', which had been criticised as insufficiently inclusive, has been resolved. From now on this will be known as the 'network sandwich'. The BMA continues to argue that the current scheme is too prescriptive. In an open letter to primary care medical director Dr Nikki Kanani, the BMA wrote: 'We shouldn't be telling practices what fillings to have. This should be a matter for local determination.' Nikki has made it clear that while she supports the idea of some freedoms for PCNs to design sandwiches around the needs of local populations, 'we can't have a situation of uncontrolled spread'.

Next time
In the next issue we'll publish an explainer about the Sackwell & Binthorpe ICS and more exciting news about what's in store for your PCN.

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