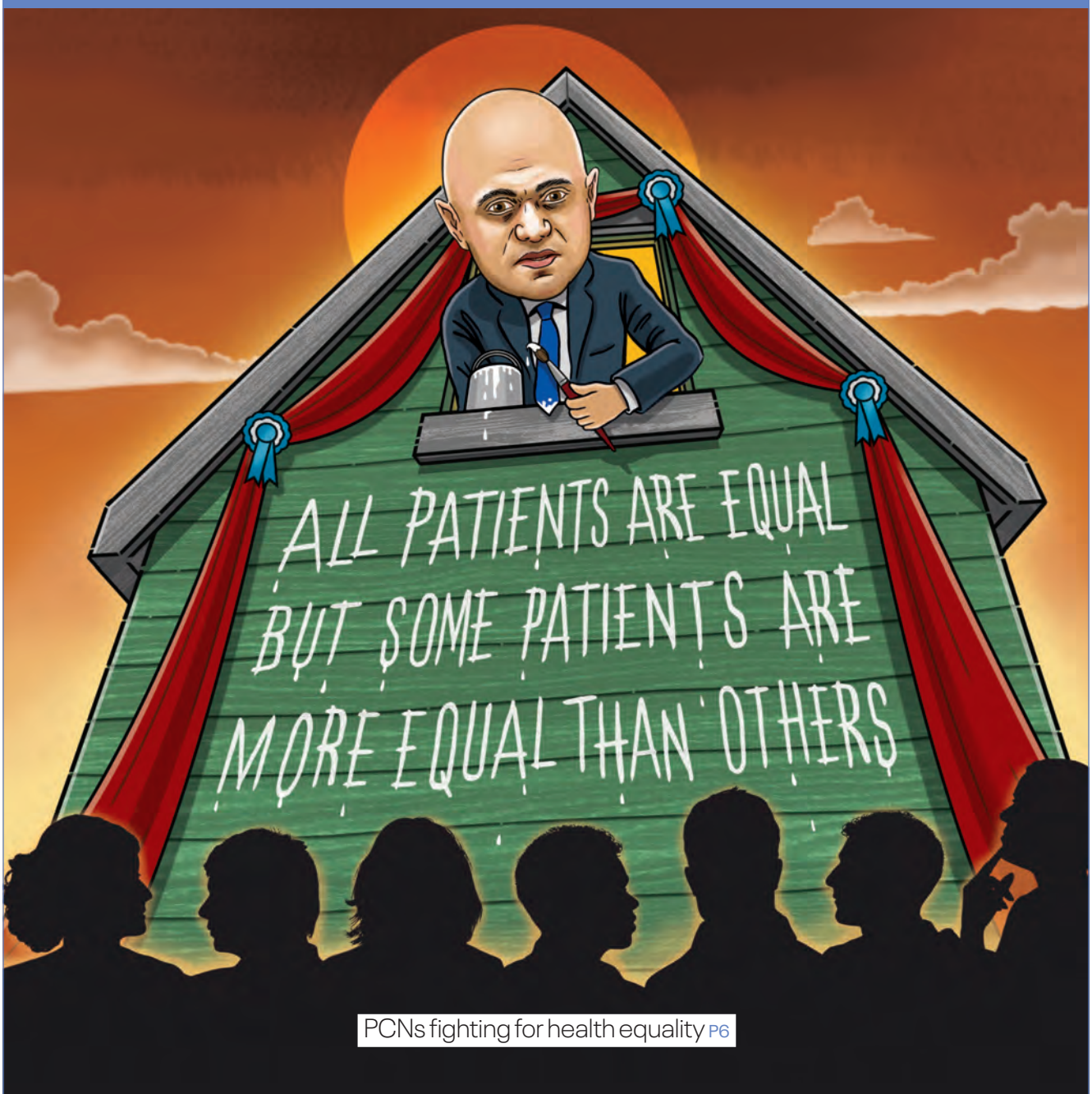
PULSE PCN

CONNECTING PRIMARY CARE NETWORKS
AUTUMN 2021



PCNs fighting for health equality P6

INSIDE

AUTUMN 2021

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ALMOST NINE IN 10 PCN LEADERS WANT 'NO' NEW SERVICE SPECIFICATIONS THIS YEAR

The vast majority of PCN leaders do not want any new network service specifications to be implemented this year, a report has revealed.

A survey of 157 PCN staff, including 88 CDs and 49 PCN managers, by NHS Confederation's PCN Network, found that 87% of PCN leaders said no service specifications should be introduced in 2021/22.

Four extra PCN services are set to be brought in as early as October covering CVD diagnosis and prevention, tackling inequalities and the controversial personalised care and anticipatory care services.

The BMA has already met primary care minister Jo Churchill about the additional workload this will bring for GPs on top of giving flu and Covid jabs and dealing with winter illnesses.

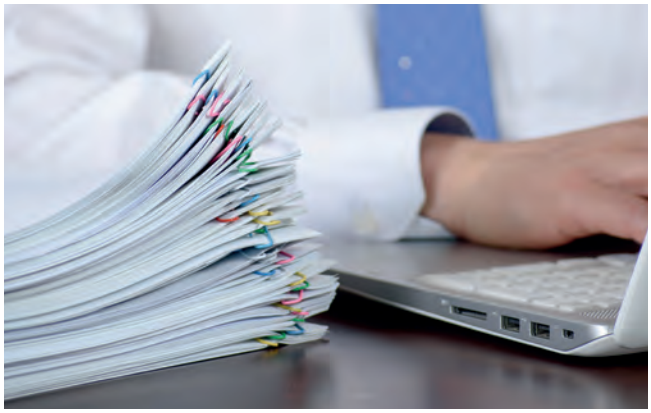
The report by the NHS Confederation, released in August, said networks continue to be afflicted by a host of problems including high workload, development plans disrupted by the pandemic, and a lack of space in practices for newly hired additional roles.

Staff hired through the additional roles reimbursement scheme (ARRS) have also had little effect on GP workload because most patients still need to speak to a GP first.

While PCNs have led to some improvements in general practice, such as stronger relationships with local partners – reported by 66% of respondents – and 'a more appropriate workload for GPs' where staff have been developed, 96% said PCN workload is 'greater than expected'.

The survey uncovered other problems, including:

- Tensions with local partners, with one CD saying the mental health trust 'is solving its CQC issue by trying to give PCNs its waiting list'.
- Problems with some CCGs, vaccination payments not reaching CDs.
- 'High volumes' of unclear communications, with CDs feeling 'much of their role is reacting to prescriptive communications from the centre'.
- 'High and unplanned' clinical workload in general practice alongside the PCN vaccination programme specifications and a 'lack of clarity' about CDs' original purpose.



The report, published two years since the launch of PCNs, said: 'For many CDs this is resulting in fatigue and burnout. [There is] insufficient time for PCN development as they grapple with balancing strategic and operational demands of the PCN alongside their clinical commitments.'

The BMA sent an email to members on 28 June about the meeting with the primary care minister, saying it had raised a range of issues including recruitment to the ARRS, access to the electronic prescribing system, and concerns about the 'overly prescriptive management of general practice' by NHS England.

It added: 'We... pushed for the PCN service specifications planned for October to be delayed until April 2022 at the earliest to reduce additional workload burden for practices during the autumn and winter .'

NHSE TELLS PCNs TO CREATE MORE SPACE IN PRACTICES FOR ARRS STAFF

PCNs will need to free up workspace to 'accommodate' more staff recruited through the additional roles reimbursement scheme (ARRS), NHS England has said.

In a primary care bulletin sent on 29 June, NHS England reiterated that the ARRS initiative provides funding for 26,000 additional staff by 2024 to create 'bespoke multidisciplinary teams', adding that 'PCNs will need to accommodate more people on their estate footprint'.

But GPs have said NHS England's update fails to acknowledge that many practices will need funding to secure larger premises – and questioned the suggestion to make more use of remote working.

NHS England had earlier revealed that PCNs in England have recruited more than 9,000 clinical staff under the ARRS.

The 29 June NHS England bulletin said PCNs should 'reconfigure current estate to reflect patient need', and offered PCNs tools to design patient flow, workforce and workspace to 'assist in reframing the environment'.

It also provided case studies 'demonstrating where PCNs have been rethinking the traditional use of space within and outside' of their networks. One, involving a practice in Portsmouth, said staff members throughout the surgery are now working remotely from home and in the community, adding this has freed space in the practice and 'provided more convenient and flexible appointment options'.

However, Dr Richard van Mellaerts (pictured), PCN clinical director and GP partner in Kingston, Surrey, told PCN's sister magazine Pulse that the primary care estate in England is 'not suitable for 21st century general practice and there's not enough space to incorporate a load of extra ARRS staff'. He said: 'Suggesting that we use other flexible and unconventional workspaces does not address the fundamental problem of insufficient effective estates.'

JULIAN CLAXTON / GETTY

PCNs TO ACCESS REMOTE LOCUM GPs FROM ACROSS UK THROUGH JOINT STAFF BANK

NHS Herefordshire and Worcestershire CCG has commissioned a service for pooling staff that will allow locum GPs – potentially working remotely from across the UK – to provide shifts for GP practices in Worcestershire.

The Worcestershire Clinical Pools Service has been set up as part of NHS England's national programme for creating flexible banks of staff in primary care. The service will give locum GPs access to all of the county's 10 PCNs, which includes 60 GP practices, via an app or website created by technology provider Patchwork Health, which has already worked with Liverpool PCNs during Covid. The service, run by local GP federation SW Healthcare, recruited 15 local locum GPs from its launch on 12 July up to the start of August.

ALL THINGS BEING EQUAL

Tackling health inequalities was always part of the PCN brief, but can they deliver on this huge ask with the extra pressures of the pandemic? *Emma Wilkinson* reports

In his 'Build back fairer' review at the end of 2020, Professor Sir Michael Marmot noted that inequalities in social and economic conditions before the pandemic contributed to the high and unequal death toll from Covid-19. This followed on from his report 10 years before, *Fair Society, Healthy Lives (The Marmot Review)*, which found that health inequalities were widening and life expectancy was stalling. If we do not tackle this now, when will we?

Locally agreed action on tackling health inequalities has been part of PCN priorities since their inception. The service specification for PCNs was supposed to start this year but was delayed by the pandemic and remains under negotiation.

Beccy Baird, senior fellow at The King's Fund think-tank, says in many areas PCNs are already doing work on health inequalities, listing examples from Surrey to Sheffield to South Lancashire. 'I think the potential is really significant and I think PCNs are really well placed to respond to the needs of their communities.

'Bromley by Bow is always talked about as an amazing place in Tower Hamlets where they've really thought and listened to communities, but they've always been a bit of an outlier. Now you see more and more PCNs really starting to think about how they listen to communities, how they understand what the priorities are.'

What is key, she says, is allowing PCNs flexibility. 'It's one of the challenges of how we can balance meeting the needs of communities with what specifications say.'

Yet for all the potential and willingness and innovation she has seen in PCNs, everything could be derailed by issues with contracts and funding.

'The funding formula is pretty rubbish when it comes to deprivation. We can see that through some of the PCN allocations. There are systemic issues in the way the contract works which don't help people in deprived areas,' she says, giving the example of wealthier areas getting extra funding because they've hit all the targets.

One example of this is a warning from the Health Foundation that the additional roles reimbursement scheme (ARRS) could exacerbate health inequalities because recruitment is likely to be skewed to more affluent areas, leaving those that are already under-funded and under-doctored with even less resource. In addition, the Government's 'levelling up' agenda would only work if that included general practice, according to the Health Foundation's report *Levelling up general practice in England: What should the Government prioritise?*.

Dr Hussain Gandhi, clinical director of Nottingham City PCN, knows this all too well. His population is ethnically diverse with high levels of unemployment, homelessness and substance misuse. The PCN most wanted to tackle mental health, which he estimates at 60-70% of GP workload for the three practices in his PCN. But these plans did not fit into the stringent requirements for ARRS roles funding.

'Funding is often very specific and that doesn't lead to a lot of innovation. If I had the ability to do anything I would go out and get six mental health workers – and patients would be far better served by having those roles.'

He adds: 'We wanted a safeguarding coordinator because we nearly have triple or quadruple the number of child protection issues. One of our practices has the same levels of safeguarding as the entire county.

'We have tried to innovate with the resources we have,' he says, but inevitably they are constantly hunting for small pots of money.

'It can only be split so many ways,' he says. 'It has to top up ARRS roles or estate. There just isn't the resource and the stringent requirements of all these pots of money mean you're constantly looking for workarounds.'

He is becoming increasingly disillusioned, he says, noting that the ratios of GPs to patients change from 1,200:1 to 3,000:1 from the leafy areas to the inner-city areas. 'We have less resource, both in terms of finance and workforce, and we're trying to help patients with really complex medical problems but are judged by the same yardstick,' he says. 'We were promised local control but that's not happened at all.'

His PCN's current focus is a project on patient education for those who don't speak English, which he says is where they feel they can have the biggest impact right now.

"Since Grenfell Tower, we've recognised that communities are the answer
Dr Yazmin Razak

Baird says that additional support for PCNs will be vital, not least because the NHS workforce is simply exhausted. 'They're really tired, they're really really overworked. Finding the headspace to do this stuff is really challenging.'

In effect, she says, there has not been the infrastructure to support primary care since primary care trusts were disbanded in 2012. The 'improvement bit of NHS improvement' that exists for trusts does not exist for primary care, she points out.

'There are some practical things that systems can do, like providing good data analytics, helping with supporting volunteer programmes and helping with estate,' she says. She adds that those who have a burning desire to make an impact on improving health inequalities will most likely find a way to get resources and staff.

She also says that the Covid vaccination programme has created many new links between PCNs, community and volunteer organisations and local authorities – and now is the time to capitalise on that.

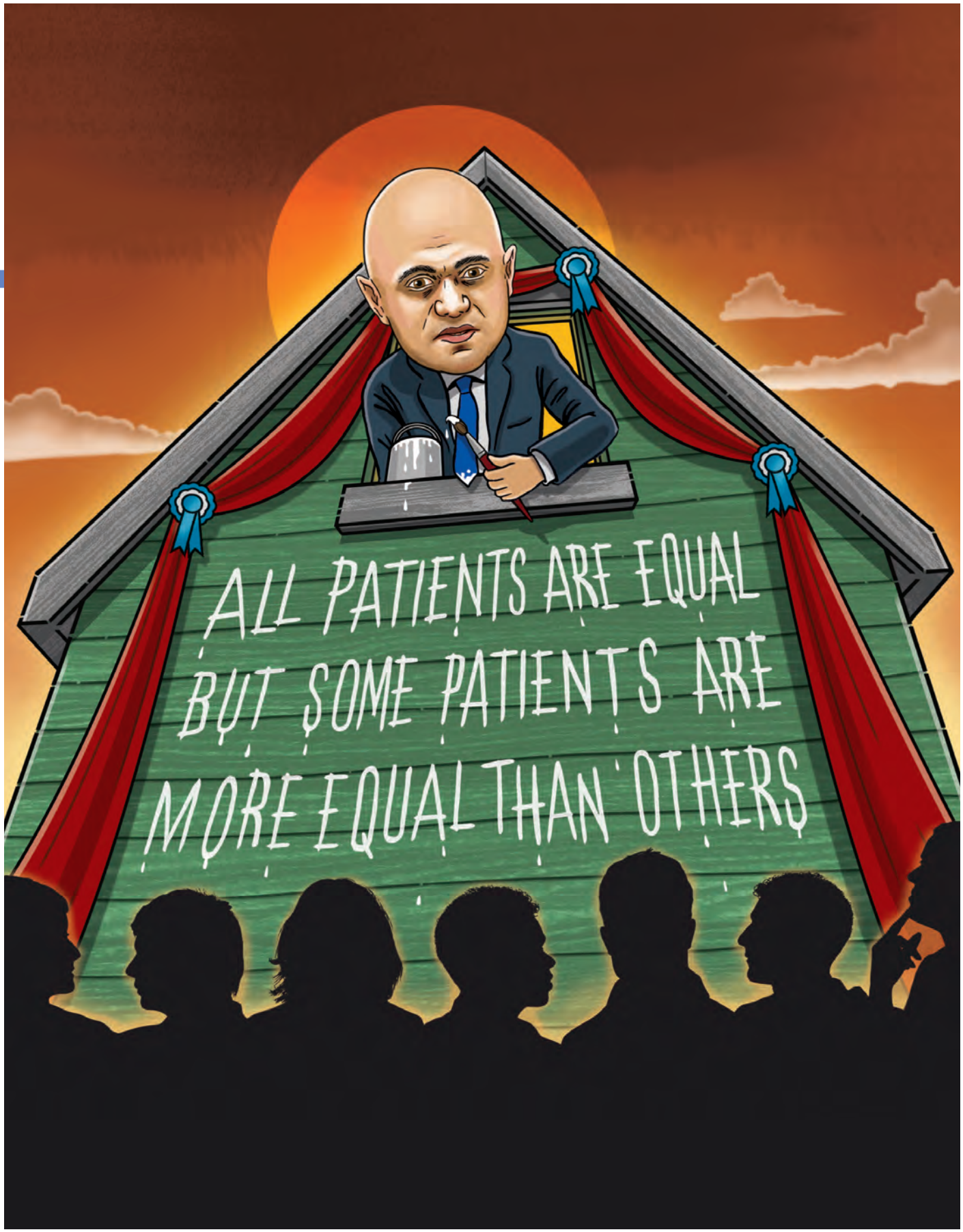
For Dr Yasmin Razak, a GP and associate clinical director at Neohealth PCN in North Kensington, west London, the pandemic was not the reason for forging those community links. Four years ago, the area was hit by the Grenfell Tower disaster. 'We know that communities are the answer,' she says.

From the north end of the borough to the south, there is a pre-pandemic life expectancy gap of 18 years. Yet there is 'no extra resource or funding allocated, despite the known deprivation', she says.

'I think we're on the journey with our patients, especially since Grenfell Tower. I think my eyes have been opened; GPs understand the wider social determinants of health. Although we say it's not really in the GP remit, there is an influence that we can have, there is a voice that needs to be heard and a clear need.'

Health inequalities should be the lens through which we look at everything, she says. 'For me, a PCN is about providing good quality primary care and everyone having a basic standard and we're meeting that standard and every surgery in the PCN should get the same outcome. That's the basic requirement. Then we need to work on →

DANIEL MITCHELL



local priorities, whatever they may be, and that's why data must be a driver.

For her PCN, that initially meant diabetes care. 'It's a really good thing for PCNs to home in on a particular area. That doesn't mean they can't switch to a different area. We did diabetes first, then we switched to respiratory health because the data show there are high smoking rates and poor access to spirometry.'

Graphs show these measures have made a difference, she says. 'We can't just look at historic outcomes and say that's how it always is. We've got to gently challenge – and be advocates for our patients.

'We're navigating carefully and being careful not to get too involved in the wrong area. We need to keep our remit quite defined.'

The other part of the equation, she says, is patient advocacy and the involvement of community champions, which was shown to its fullest benefit in the Covid vaccine campaign where community champions worked incredibly hard to boost uptake.

But the funding flows have to be sorted, she adds. 'The truth of the matter is we work until midnight, seven days a week and that's quite a depressing inequality in itself.'

What is missing for Dr Razak is the link between national strategy and PCNs. 'There is not enough support organisationally for PCNs. It becomes a survival of the fittest.'

For Dr Emma Watts, a GP partner at Shere Surgery in Surrey, the lack of flexibility in funding streams means her rural practice covering 45 square miles in a PCN with five other urban practices is overlooked. Extended hours, urgent care, a whole host of services are aimed at urban populations 'and there is no appetite for the PCN to address this'.

Her colleagues are sympathetic and acknowledge the problem, but to develop services that meet the specific needs of their own patients 'seems to go against the PCN model'.

'The rules are that we have to plan for everyone in the PCN. It's too rigid and it increases demands on our practice.'

Clacton-on-Sea in Essex is emblematic of many seaside towns that have seen steep decline over the past few decades. Industries have been lost, leading to unemployment. There are high levels of drug-seeking behaviour and complex mental health challenges as well as obesity and general ill-health.

Dr Tanvir Alam, CD for Clacton PCN, says tackling health inequalities is 'a difficult ask' in one of the most deprived areas of the country. Most recently, they faced an 'astronomical' amount of work to figure out how to manage care homes with their high retiree population, and the work was not reflected by the resource.

'We are trying our best, we are doing population health management to identify vulnerable groups, but that is a huge body of work. NHS England has given us £3,000 for GP manpower time and admin but there are so many areas to focus on and all are equally important.'

The GP profession as a whole is also coping with dwindling numbers of clinical staff, he adds. 'The workload is already high, with increased footfall. We're doing our best to engage with whatever is being asked of us but it is a huge undertaking.'

Use your data, but let your plans be guided by the residents and patients

Dr Mark Spencer

As the Health Foundation warned, the PCN has had trouble recruiting pharmacists for ARRS roles because the funding doesn't match market rates.

'NHS England is being careful. That's fair because it's public money but there is no money to be siphoned at this PCN. It's just one person and an operations manager.' He is particularly disappointed that there are two GPs representing primary care at the ICS but neither is from a deprived area.

At the opposite end of the country in another abandoned seaside town, Dr Mark Spencer believes PCNs need to take a different approach. His patch in Fleetwood, on a peninsula north of Blackpool in Lancashire, was once a thriving fishing town. But now the community has 'lost its sense of purpose'. Now, life expectancy is 10 years below the national average and there are high rates of cancer, heart disease, COPD and mental health problems. All of this is getting worse 'despite very significant investment'.

In 2016, Healthier Fleetwood was set up to give residents back some control. Projects included a singing group, Harmony and Health, and the Men's Shed, which was set up in response to a spate of suicides that shocked the town. What started as a way to improve social connections resulted in a 20% drop in A&E attendances and acute admissions.

Now every decision in the town, including the council regeneration plan, is guided by residents – they set the priorities, most recently about training and digital skills opportunities.

Dr Spencer's advice for PCNs is this: 'Don't be tempted to come up with your own plan. Actively listen to residents. Starting with the data is important but you need to establish relationships with schools, the voluntary sector and housing associations and it takes time. We don't just want to reproduce what has happened in the past 10 years. And the role of the CD is to push back against anyone telling them to get it done in the next six months, whether that's the ICS or NHS England,' he adds.

ALAMY

AN EQUAL SHOT

Primary care at scale can improve patient care if it is properly resourced

Variation in healthcare is not new. The NHS is the world's biggest employer of highly skilled professionals. It is complicated, it is fallible. While there is, and always should be, an aspiration for care to be the same excellent standard across the system, attaining this is another matter. There are under-doctored areas and underserved communities. There are increasing demands, waiting lists and disease burdens. There is not enough funding. There is Covid.

Tackling health inequalities has always been part of the PCN remit. It is one of the service specifications set to come this autumn, although it remains under negotiation. And a report from the NHS Confederation's PCN Network, *Primary care networks two years on*, found that 87% of PCN leaders believe no service specifications should be introduced in 2021/22.

But a delay doesn't mean work will not get under way. PCNs are small and agile enough to know the issues, yet big enough to tackle them. As our cover feature illustrates (page 6), many CDs and GPs are already making a difference, providing services to reduce health inequalities.

But they need support. The problem set out in *The Marmot Review* a decade ago is still there and has been exposed by Covid. Studies carried out in the pandemic found an increase in domestic abuse, a worsening of mental illness, loss of income through self-isolation, an increased burden on mothers and an impact on the mental health of NHS staff. The challenges are now greater.

In a recent US think-tank report *Mirror, Mirror 2021: Reflecting Poorly,* the NHS lost its ranking as the top performing health service, falling to fourth out of 11 affluent countries. In the area of income-related disparities, the NHS also slipped from top spot to fourth. These findings cannot be ignored. The problems health leaders have been highlighting for years are having an impact. This is, of course, all set against the new Health Bill. Primary care at scale can improve patient care if ICSs grant proper resources.

There is also a valid concern that PCNs could exacerbate inequalities as discussed in our roundtable on the additional roles reimbursement scheme (ARRS) (page 17). While the ARRS has improved patient care, particularly in the area of medicine optimisation, it has been less good for communities where recruitment is difficult. Those areas were already underserved. Is the solution for PCNs to help their neighbours to fix this issue – a network of networks as mentioned in the PCN Network report?

Where the workforce is in place there are challenges with space, training and management. The ARRS does not solve the GP shortfall. PCNs need the flexibility to employ who they want as they want, perhaps with part-time or temporary contracts. Larger PCNs, or PCNs in a federation seem to cope better, as outlined in our PCN profile of Tower Hamlets in east London (page 28). But again, inequalities have to be tackled by working closely with communities. The more remote provision gets, the less things will change. PCNs need the flexibility, support and resource to to achieve their potential and make a real impact.

Victoria Vaughan is editor of Pulse PCN

ABOUT TIMING

The new Health Bill will be a big transformation of NHS management – why do it now, in the middle of a pandemic?

I'm sure a lot of my colleagues will have had the chance to read the new Health Bill, absorb the new three-letter acronyms and understand what it means for all of us. I mean, it's not like we've had anything else to occupy our time – apart from delivering 3.5 million more appointments than before the pandemic. Oh, and delivering the biggest vaccination programme ever, and waiting for JCVI guidance just weeks before the booster programme starts. And there are other small matters of picking up secondary care work, handling abuse from patients, coping with staff shortages, Covid self-isolation, and attending countless meetings as PCN CDs.

Yes, I'm sure we've all had time to read and digest the new bill.

And it seems to be the biggest transformation of NHS management since CCGs came into being.

Why now? Why test the service further in the middle of the biggest pandemic in a century? Do the powers-that-be think the caring part of the service is separate from the operational part?

I can suggest two reasons.

First, because the pandemic has completely exposed how inadequately the NHS has been resourced and funded for the last decade.

Second, because they realise the system is so busy, that no one has the capacity to challenge this properly so it can be slipped through, especially as the BMA's General Practitioners Committee is not negotiating with NHS England at present.

Perhaps it's both.

Regardless, it is going to happen. So accepting that, my main worry is the lack of adequate GP representation on the new ICS boards. The bill calls for one GP. One GP who would sit on the board, making or influencing decisions on behalf of colleagues across a patch with a population, which in our case would be approximately 1.2 million patients.

No one knows how the information will be cascaded to grassroots. Or does no one think it's important any more? So that one GP will then discuss with CD representatives, who will then discuss with CDs, who will then discuss with practices, and then the feedback will go all the way back up the chain. What could go wrong?

General practice may be seriously neglected in the new system, unless there is proper representation at the ICS board level. And we need to move away from overburdening the already overstretched CDs to take that mantle, unless they are willing, properly supported and resourced.

Prior to the bill, in Staffordshire, we had agreed five places on the ICS NHS board with the system leaders. One from each of the two LMCs, and one from each of the three place-based partnerships CD representatives. I'm hoping by the time this is published, they will honour that under the clause of local flex.

We need a collective voice, a collective representation, a collective body, all singing from the same hymn sheet to make a difference.

There are worrying times ahead, and we need to be at the table, to do things – rather than having them done to us.

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

***Dr Pramit Patel*, the new chair of the NHS Confederation PCN Network and PCN leader at Surrey Heartlands ICS, talks about collaboration**

What motivated you to become a CD and chair of the PCN network?
My passion is to deliver a joined-up service where patients and residents get the best possible care and safest service. I could see from my early years as a hospital doctor how hospitals and GP practices work really hard in their own sectors but there seemed to be a missing link. Patients would often be bounced from sector to sector and I witnessed this, as a medical student, when my mother's subdural haematoma management wasn't closely monitored. From being a fiercely independent and hardworking lady she became unable to work, drive or look after herself. It was a life changing event for the whole family.

With that experience I wanted to make a change for my patients and their loved ones and I could see real value in bringing GP colleagues together to co-design and co-deliver services, which led to the formation of our GP federation. Over the last 18 months, as a founding board member on the NHS Confederation PCN network, I have had the privilege of being part of a talented board. Now, being elected as network chair gives me the opportunity to serve and represent my peers.

What's been the best moment of being a PCN CD?
Seeing practices coming together, breaking down silos and creating a shared purpose and vision. The introduction of additional roles reimbursement colleagues and the way all three practices have supported their development has been wonderful. Seeing the way our newer colleagues have added diversity and flair to practice teams has allowed us to be brave and innovative.

And the worst?
It can be tough to balance being a practising GP and being a leader, finding time to build relationships within practices and partner organisations outside of the PCN. But having the right team supporting me has made it a lot easier.

What has the experience taught you so far?
Don't try to boil the ocean and do everything. Know it is okay to make mistakes as long as we learn. Be resilient and flexible but avoid saying yes to everything. It is okay to say no from time to time.

Where do you turn for support?
I have a coach who helps steer me through tricky moments and would thoroughly recommend this to all my CD colleagues. I had an NHS coach in wave one and now have one through my ICS role. The support coaches can give has been promoted through NHS England webinars and bulletins and there is more information at people.nhs.uk. I also have a supportive ICS primary care team.

Do you have any tips or hacks that help you get through the workload more efficiently?
I am fortunate to have a PCN management team. We also have a proactive federation whereby the management supports me in representing the PCN at boards, co-ordinating meetings and providing project leadership and management. A tip I was given by my coach was that effective teams are made up of leaders and managers and that delegation makes the role achievable.

Do you have a goal or a target in mind for your PCN and the PCN movement as a whole?
I want the PCN to be the multiagency, multidisciplinary delivery unit working with community providers and local government colleagues, developing services to address health and wellbeing inequalities, underpinned by robust population health management linked datasets.

Who or what inspires you?
Being able to improve my patients' journeys but also learning continuously makes me want to push my boundaries. My ICS leader often says 'assume positive intent', believing that a person always meant well and also avoiding conspiracy theories. That helps drive my collaborative approach.

What do you do to relax?
I enjoy road cycling with friends. My nine-year-old son and I also like playing FIFA on the PS4.

Name
Dr Pramit Patel

Practice
Greystone House Surgery, Redhill, Surrey

PCN
Care Collaborative, Redhill, Reigate and Merstham in East Surrey

Number of practices in PCN
3

Number of patients in PCN
48,000

PCN roles hired
4 clinical pharmacists, 4 physician associates, 1 pharmacy technician, 1 care co-ordinator, 1 social prescribing link worker, 2 first contact physiotherapists

PCN roles to fill
1 physician associate, 1 mental health practitioner

Career to date
- 2006 Qualified Bachelor of Medicine, Bachelor of Surgery (MBBS) Guys, Kings & St Thomas', London
- 2006-2008 Foundation Year 1 & 2 Kingston Hospital, London
- 2008-2011 GP vocational training programme, Worthing, West Sussex
- 2011 to present GP partner, Greystone House Surgery
- 2015 to present Founder and chair of the Alliance for Better Care GP Federation, Surrey/Sussex
- 2019 to present Care Collaborative PCN CD
- 2020 to present PCN leader, Surrey Heartlands ICS
- 2021 to present Chair, NHS Confederation PCN network

PCN ROUNDTABLE

ADDITIONAL ROLES REIMBURSEMENT SCHEME

Five PCN CDs joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss how the additional roles reimbursement scheme (ARRS) is working in their areas

GETTY

ADVERTISEMENT FEATURE

Want to get more out of ARRS? Improve your Patient Flow - Here's How

For PCNs, ARRS funding has been a long time coming - but it has also highlighted an absence in effective patient flow management, making it difficult for many GPs to access the funding they need or provide long-term, quality healthcare. Luckily, help is at hand...

The launch of the Additional Roles Reimbursement Scheme has been met with mixed feelings by the PCN community.

Lauded as the fix-all solution to mounting pressure on GPs, ARRS seeks to reduce patient demand by providing practices with additional healthcare specialists, helping them deliver the right care where needed.

But the scheme isn't without its critics, one of the main bugbear being the admin process required to simply apply for it.

Rather than trust the money to GPs so they can independently assign it to the resources they need, practices must apply for ARRS funding with evidence to show the areas they're lacking in.

For some, this seems like an unnecessary hurdle; PCNs are already struggling to find time to meet rising patient demand and deliver quality care.

However, this raises another more pressing issue - that existing patient flow management systems clearly aren't keeping up with the times.

Processing patients and identifying their needs shouldn't be this difficult - and it shouldn't be a barrier to accessing funding that can improve healthcare for all. Patient flow management is important for making the most of ARRS roles. It means that GPs can redirect care to the right resource. Identifying need is crucial to informing the workforce, and online triage can create the data that gives rich insight into need.

'Online triage is providing the evidential data PCNs require to identify staffing needs and apply for ARRS more easily'

To overcome these hurdles (and reap the benefits of ARRS), there's a service PCNs can utilise to their advantage: Klinik.

This online triage platform uses a clinically validated algorithm, using bayesian logic, to assess patients and direct them towards appropriate care. Klinik can set up customisable workflows to integrate ARRS roles. And whether patients contact a practice by phone or online, Klinik allows for both to go through its online triaging solution, supporting efficient decision making if an individual actually needs to see their GP or whether they can be redirected to their local pharmacist or first contact physio instead.

Streamlining patient flow isn't the only perk, though. As Klinik sorts through patients it logs condition types and the care needed on a dashboard in real time, offering key data insights about what specialists are required at a glance. In time, this could provide the basis for an intelligent healthcare network, a vital step for a future NHS that is built on place-based care and population health management.

For Dr Thomas Patel-Campbell of the Haxby Group, this tool has been a game changer, 'Having condition types presented to us like this has allowed us to be more nuanced in our workforce planning,' he says. 'We can now recognise the sorts of workforce we need for each individual population around each of our sites.

'Thanks to Klinik, we can customise and improve the care we're able to deliver.'

In the context of ARRS, this online triage is providing the evidential data PCNs require to not only identify staffing needs, but apply for funding more easily.

But Klinik's technology doesn't just help with ARRS. With Klinik, GPs can identify growing health concerns within a community and better prepare for them, avoiding care issues further down the line.

The service also allows for headspace to plan for additional roles, and even aids flexible working, creating a centralised, customisable hub that healthcare providers can access wherever, whenever.

Digitising triage with Klinik certainly removes the flaws in ARRS, but it can also pave the way to more efficient healthcare while creating better working environments that are not only more flexible, but better able to respond to ever-changing needs in our communities.

For more information visit **klinikhealthcaresolutions.com**

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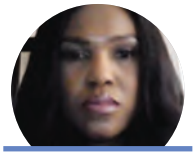
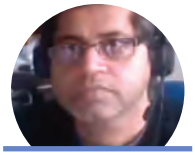


Dr Monica Alabi
CD at Titan PCN, Bedfordshire, from April 2019 to June 2021



Dr Partha Ganguli
CD for South Ribble PCN, Lancashire

Dr Sarit Ghosh
CD for Enfield PCN, north London

Dr Sajid Nazir
CD at Viaduct PCN, Huddersfield, West Yorkshire

Dr Sachin Patel
CD at Harness North PCN, north-west London

Chair Victoria Vaughan
Pulse PCN editor

IS THE ARRS FIT FOR PURPOSE?

Yes	No
40%	60%

Victoria Let's discuss whether the ARRS is fit for purpose.

Sarit Yes it is fit for purpose because from an NHS England perspective, it's to get primary care to employ a range of additional role staff in a funding model that ensures efficacy. So, from the NHS England perspective, it is an effective model. Is it the right model for primary care? I would say no. From a primary care perspective there are lots of complex reasons why it's not the best model.

The NHS England view is: 'We'll give you this funding, you employ these staff, and everything will be hunky-dory.' But actually, there's so much governance involved. Recruitment and retention are a major challenge. When you recruit these staff there's a lot of training and supervision needed to make them effective. That doesn't lead to the outcome that we want – more access for patients, and better quality care. It may do in five to 10 years, with the right support and infrastructure at PCN level, but it's not there yet. At the moment it's not fit for purpose as a programme for primary care, but that doesn't mean that with the right tweaks that it can't be. And I think the new white paper, in terms of the integrated care system (ICS), has mentioned PCNs as key place-based stakeholders so I think there's an opportunity to shape PCNs more to primary care's needs, instead of [using them] just as an employment vehicle [via the ARRS].

Sajid Certainly the idea behind ARRS is good, and there are benefits from some of the staff that are coming through. But in terms of receiving these staff – whether it is training, employment, even space – we are struggling.

We have some providers stepping up to say they can provide these staff, others are employing them directly – and that's even within one town. We have a different level of skill within one town, [and] I'm sure that's replicated nationally. It feels [as if ARRS] was rushed through without much planning. But at the same time we maximised our ARRS last year, and you know, practices saw benefit from that.

It feels as though ARRS was rushed through unplanned
Dr Sajid Nazir

Sachin I agree that if we're looking at a population level across the whole system, and nationally, and we know that we're facing a GP workforce shortage, and we're never going to hit the Jeremy Hunt targets of 5,000 extra GPs, we have to look elsewhere.

And actually ARRS is the right vehicle, but it sometimes feels like a Trojan horse. We're given an opportunity with benefits and funding, but beneath that lies all the challenges of bringing a whole new workforce into general practice, which is ultimately what it is. There are massive benefits from having additional roles, but there are significant challenges. I think as CDs our task is to go with enthusiasm and encourage our colleagues that there will be future benefit from the additional roles, but also acknowledge it is a journey, and a clinical pharmacist or a pharmacy technician won't come in knowing how to be completely functional within primary care, because it's a new field for them.

Partha No [the ARRS is not fit for purpose]. I feel that GPs have been adaptive from the first time QOF came in, and all the changes that happened in primary care. We GPs have adapted to that very well. And when this opportunity came for getting some workforce, we all adapted and used it to our benefit. I would say [the ARRS] was [done] in a hurry to just put some money to general practice.

Monica The management hasn't been thought through. We recruited a PCN manager as soon as I took on the [CD] role. We couldn't afford a full-time manager because [there isn't enough funding allocated for management costs]. We are now recruiting a business apprentice as well to support her [as it's a big task for which there isn't enough resource]. The challenge for the ARRS is having enough management time to support the other people, to co-ordinate the roles, making sure the staff sharing agreements are in place, [and] the contracts, making sure that we can listen to their complaints. [Additional roles are]a whole industry, not something you can just throw into primary care and expect to be done, and expect the CD who's resourced for one day a week to manage and understand it all.

Victoria You've all mentioned the challenges of space, recruitment and training. Have any of you have found a way to tackle those in your PCNs?

Partha Yes, Covid has changed our way of working. We used remote consultations more. Our ARRS pharmacist is working part time from home, and part time from surgery premises. We are doing the musical chairs with our rooms better – but still we are struggling with estates at the moment.

Sarit Yes, the estate problem is interesting. As one of the largest PCNs in the country, and in London, we perhaps find it even more challenging. There are two factors with space – one, there isn't enough, and two, it's not in the right place. The challenge is, how do we provide an equitable service on a weighted list size basis for each of our practices? If practice one has no rooms, how do we give its patients access to an ARRS service?

That hasn't been an easy conversation, but our strategy is to self-fund remote consultation suites. The plan is to have a big room full of lots of ARRS staff with GP supervision, providing a service to each of our practices on a weighted list size basis, because that's the only way we can have a fair and equitable service with enough supervision to make it work.

That's a while away because we will have to build, and to get that through NHS England governance took about a year, even though we're funding it ourselves. We have to jump through lots of hoops to just get that model approved.

But I think that will set up other PCNs for similar things once we've done this. That's the only solution we could find. →

I'm not saying it's the right solution [for everyone], but it's the most effective one for us.

Sajid Covid possibly helped with the influx of staff because people were working remotely but now we're finding they've not really integrated with the teams. The staff don't know them very well. One example is the social prescriber who has been working remotely, but some practices are not referring [to her] because they don't really know her. That's an issue to consider with remote working.

Sarit Yes, people still have to go into practices to do face-to-face work, so it's a blended model, you're absolutely right.

And the other feedback we've had – and we've had relatively decent retention – is that people like working in teams. So, even though they're working remotely, if they're sitting next to some of their peers , that team building has a value as well.

Victoria What about the training? How are you managing training ARRS recruits?

Sachin Training overall needs a substantial amount of planning to ensure there are suitable GP supervisors.

Our journey with additional roles started before the PCN came in because we were part of the NHS England pilot for clinical pharmacists to come into general practice. Our aim in our two PCNs was to build an academy that trained itself. I think that was probably the best thing we've been able to achieve.

Sarit We appointed two GP training leads, who take an overarching view of training and provide online training that they develop on a weekly or biweekly basis.

From a generic perspective, the bigger challenge is how to provide effective supervision on a regular basis, because that's time consuming. There's a physician associate (PA) preceptorship programme, which specifies how you deliver that. And again, that's resource intensive but it comes with funding, so it is beneficial for people to use for PAs who are quite early in their careers and don't have much clinical experience.

DID YOU USE YOUR ARRS BUDGET LAST YEAR?

Yes	No
20%	80%

Victoria PCNs varied in whether they managed to spend the ARRS budget. If you didn't spend all your budget, can you elaborate on why?

Partha First of all, the challenge was time, waiting for the [details and the CCG criteria]. Then once we started the recruitment process, we didn't get much response. We are up north and recruitment is difficult. We got one pharmacist and then the pharmacist moved out of the post, so we had a problem with retention. We looked for PAs and couldn't get any of them into our network.

We struggled to attract appropriate candidates. Some were quite good but their banding was not [compatible with the requirements], and we would have had to put in extra money if we had to retain them and that was another issue.

ALAMY

There wasn't enough support from our CCG because we said that whatever money was left over, we could use it in a slightly flexible way. And NHS England said: 'You can't do this. You can't do that.' We couldn't get short-term pharmacy technicians or pharmacists because it had to be a long-term contract, the CCG said. We wanted to use [these staff] for our vaccine work but we couldn't employ short-term with the extra funding we had. These were the problems we faced.

Victoria If you did spend all your budget, how was that possible?

Sajid We were lucky in that, the year before, the very first year, we recruited a pharmacist. Most of our recruitment was not done by advertising, it was done by word of mouth. We had one pharmacist and then two and they enjoyed working with our practice as we gave them a good induction. We didn't really need to advertise, so we currently have 10 pharmacists and one pharmacy technician.

[We focused heavily] on clinical pharmacists, although they're doing different things. Some have little experience in general practice but we were able to use [our experienced pharmacists] to train them without disrupting service too much.

The other two staff we recruited are a social prescriber [and a first-contact physiotherapist. The social prescriber was] recruited [and employed] through our local authority. Our first-contact physiotherapist was employed through the local hospital trust, so we haven't needed to advertise jobs yet.

Monica We also spent all [our ARRS budget, except in] the first year because we didn't have time. We got our pharmacist in the first year, 2019, and our social prescribers very early, so we had a little bit of an underspend and that wasn't given back to us, which was annoying, so we made sure that the second year we used all our money.

We are recruiting based on what we want as a PCN, so we're very social prescriber heavy. There's a lot of restriction on how you employ. We are very lucky, we've never struggled for staff. I put [the job ad] on my LinkedIn feed, on Twitter, everywhere. We've never had any problems recruiting. But there is a ceiling. We have to pay above and beyond for some of our staff, because we want to recruit the best, we don't want to get people who we'll have to be hand-holding. So that's one of the challenges, this cap, and not going high enough for the best roles, and then not having enough in the pot to make up the gap.

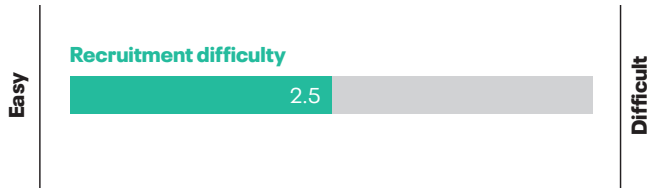
Sarit London weighting only came into play recently, so [before that] we couldn't compete with [posts in] inner London that were often offering more wages but we used all our funding.

We changed our strategy a bit. We're pretty big. We've got 20 pharmacists, 10 PAs and a number of other staff, but we realised we couldn't compete salary-wise, so we decided to give a better package, offering training. In the pharmacy team we have three or four senior clinical pharmacists who provide peer support and structure and that's quite attractive for pharmacists. For PAs, we're developing relationships with universities, so they attend for education when they're trainees and when they qualify. That introduces them to primary care, so there are lots of strategies [apart from] salary that make you more attractive as an organisation.

Does ARRS improve care? It certainly improves access

Dr Sarit Ghosh

ON A SCALE OF ONE TO FIVE, HOW DIFFICULT HAS RECRUITMENT BEEN IN YOUR AREA?



DO YOU THINK THE ARRS WILL IMPROVE CARE FOR PATIENTS?

Victoria Do you think the ARRS will improve care?

Sarit Does ARRS improve care? It improves, potentially, access, which, in itself, will improve care. If a patient gets seen by an ARRS staff member, that could free up time for the GP to do some other work. But as we've said, these are very new members of staff, it will take time for them to develop to be effective as clinicians.

The pharmacists have improved care because previously GPs used to squeeze in audits and medication reviews and the effect was variable. With pharmacists, these are much more structured, so they look after high-risk medications and things like that a lot better. So I think that has improved.

Sajid Freeing up time for GPs to focus on specific stuff may improve care but it's too early to measure the outcomes of some of the new roles.

Victoria Will the ARRS reduce health inequalities?

Monica Yes, I think it will improve health inequalities. Maybe I'm saying that because we've been involved in the population [health] programme, which has worked well for us, particularly with our social prescribers. And taking the population health approach, I have seen the possibilities with the ARRS staff and being able to use them for patients who really need support.

Sarit The inequalities element is very complex. The ARRS in itself won't, because I don't think [additional roles are] really the solution. →

WILL THE ARRS REDUCE HEALTH INEQUALITIES?

Yes

100%

[The solution is] much more layered. [ARRS] frees up time for us to focus on other things, but inequalities are about an opportunity engagement and many other things, so we need further discussion.

Sajid [I have a] slight concern that, if not all PCNs are recruiting, this [could] exacerbate health inequalities. Nicer places might recruit more staff and you may [find] people not wanting work in inner-city, deprived areas. Some parts of the ARRS have helped address health inequalities.

We have been doing local projects targeting various things such as diabetes where there have been various levels of quality. Some of our ARRS staff pharmacists are doing that work. Clearly, they will help but it's quite complex.

Partha I believe in primary care that every little helps. If we are getting [people] working in our team, whether they are pharmacists, paramedics or PAs, this will free up time and improve access for patients. [That] reduces the inequality.

We are doing a population health management project at the moment where we are looking at a group of patients who have not been able to use the digital modes – those who are mildly to moderately frail, according to the Rockwood scoring. That has [brought us] resources that are available from the council to improve [their access to digital tools], and our social prescriber has played a pivotal role. This shows how we can eliminate an inequality.

If we can gear projects, [we can] use ARRS in the right way to address [inequalities].

Victoria What would you like to see in the ARRS, to make it better?

Sarit I'd like to see more investment in infrastructure. And not just ARRS, this is for PCNs as a whole.

We need to invest as a system in management time, leadership time and clinical leadership time. All of that is really important as we're going to be one of the building blocks of the integrated care partnership (ICP) and system.

Look at the vaccination programme. We achieved what many would say were miracles in getting so many people vaccinated, 75 million people vaccinated.

We can do a lot more but we need the tools to do it. With the ARRS we need a bit more flexibility, a bit more pragmatism, about how [it is] used.

I understand why NHS England has decided that if PCNs want to recruit paramedics and they are band 6 with no primary care experience, like the vast majority, they would have to train up to band 7 [via a mandatory rotational scheme with the local ambulance service] to attract the ARRS funding. But rotational schemes can be very difficult to co-ordinate, making those staff less attractive to recruit without a better support infrastructure. I can understand that the system doesn't want a huge exodus of paramedics from ambulance services but a more pragmatic approach seems sensible.

We need a bit more voice at the higher levels, in terms of ICSs, which is happening but it's taking a lot of work. For me, it means a lot of meetings and a lot of raising the profile of primary care to get heard at the big tables with the acute trusts. That's going to be a challenge moving forward, for PCNs as a whole.

Sachin I'd like to see more flexibility on on the stipulated requirements on contracts for ARRS staff and the use of funds for training and supervision.

Sajid It would be good to have a greater level of independence at local levels. A lot of the rules are nationally guided but we could have local solutions. People have mentioned difficulties in recruiting certain staff and CCGs are very reluctant to go against national guidance. [It would be good to have] flexibility with recruitment roles, and funding if you needed more in a certain area, even outside London. Also, the PCN is given £1.50 core funding per registered patient to help with the support

ALAMY

and running of the PCN but it's not enough if you look after 20 staff. You need human resources, you need management, you need someone to look at a rota. That's not really been thought about. I'm sure everyone's doing more than the allocated time. We need more support. Once CCGs are disbanded, perhaps some of that [resource] can come into PCNs and we can use it.

Partha We need to realise that in the change scenario, when CCGs are being dismantled, there will be lots of extra responsibility coming to PCNs. Proper infrastructure and accountability are important and if, in five years' time, when we are looking at using so many staff, [and] under one roof, [with] all the HR and everything else going around, there is a lot of management cost that is not taken into account.

The [PCN allocation] of £1.50 per registered patient is not going to change with time as the patient numbers are not going to increase that much. I think we are looking at more staff, to be managed in the same amount of management and CD time, which [will] not [be] possible. We are looking at lots of goodwill and lots of input, which are unpaid and might not happen.

That might be one of the pitfalls, so I think we need to put more resources there and be flexible. We need to innovate and use the recruitment funding to maximise our potential for benefit according to the local need.

PCNs must generate income as the NHS can't fund everything

Dr Monica Alabi

Monica True innovation is what we need. We have to allow PCNs to be entrepreneurial and to be able to generate income.

We understand that the NHS cannot fund everything [on] our wish list. For instance, if we wanted to provide services in our area that are paid for, such as an allergy service (as we have the expertise). Innovation has not been as encouraged in my area as I would like it to be.

Generating income will be very important as we go forward, otherwise we will implode.

We need an estate strategy. I'm employing people over and over and over again and I'm making them work flexibly from home. We're hot-desking. [We need funded] management time, like everybody said. [We need to] really encourage innovation and not stifle it. [We need] headspace to be truly part of the ICS partnership board and I worry that primary care will just be a tick-box in the ICS partnership minutes rather than genuinely involved.

EMPLOY A PHARMACY TECHNICIAN

GP partner and PCN leader *Dr Helen Maxwell-Jones* and team explain the benefits and practicalities of employing a pharmacy technician in general practice

The role of the pharmacy technician (PT) is complex and diverse.

A PT working in general practice will assist with strategic and operational planning of medicines and chronic disease management services, and support pharmaceutical care of patients by working with the pharmacy team to deal with medication issues, such as identifying discrepancies in medication histories and ensuring drug monitoring is actively managed. They contribute to processes that help to maximise benefit and minimise risk to patients from their medicines, and ensure the smooth transition between primary and secondary care.

More specifically, the PT can:

- Undertake some medication reviews (guided by standard operating procedures).
- Transcribe medications from discharge summaries and clinic letters.
- Answer drug-based queries from patients and health professionals.
- Undertake shared care drug monitoring, for example for DMARDs, NOACs, and high-risk medications such as amiodarone.

The role of the PT can also be expanded with supervision and protocols to include chronic disease management, immunisations and phlebotomy.

The main difference between a PT and a pharmacist is that a PT cannot become an independent prescriber and therefore cannot conduct structured medication reviews (SMRs). However, in our PCN we haven't found this to be limiting as PTs can perform simple medication reviews and support with SMRs.

GETTY

What qualifications, experience and personal skills does a PT need?

The role requires a pleasant manner and an ability to work across different teams. A PT must therefore must be adaptable.

They will need qualifications such as the City and Guilds Level 3 NVQ diplomas in pharmacy services skills and pharmaceutical science. We have also found it advantageous for the PT to have a good knowledge of secondary care medicine, especially from working on wards, and experience of handling discharge summaries.

A ward-based medication management technician with ample face-to-face patient experience is the closest secondary care role to that of the PT in primary care. They are experienced in transcribing discharge summaries and clinic letters, and have detailed knowledge of the shared care pathways, so they are used to dealing with such drugs and can navigate the hospital systems.

The job is a patient-facing role. PTs are vital in improving patient compliance, so good consulting skills are essential. And as primary care is constantly evolving, a PT needs to be adaptable and forward thinking.

Salaries

Practices should expect to pay a PT at Agenda for Change band 6-7 in line with their experience and responsibilities.

Currently, practices can choose to recruit a PT themselves or access one through the PCN DES additional roles reimbursement scheme (ARRS).

As with most ARRS roles, the maximum reimbursement rarely covers salary plus associated employment costs. Adequately experienced PTs will usually be recruited from ward-based medicines management roles or CCG medicines optimisation teams and this raises recruitment issues with the move to hire staff in general practice roles at scale. The pool for recruitment is therefore limited and starting salaries are likely to be at the higher end of band 6 for retention purposes.

Benefits

PTs carry out medication reviews, and their expertise in specific drugs also improves patient safety. They also help with monitoring and compliance issues, as well as overuse or over-demand for medications, and give another layer of risk assessment and response.

Therefore PTs can significantly reduce day-to-day workload for GPs.

PTs can also increase practice income by improving QOF compliance and flu vaccination uptake.

Challenges

Dedicated GP time will be required to develop protocols and processes for the PT to work within. The PT will also require some ongoing GP supervision. Overall, as with any new role, the time invested tends to correlate with the benefits seen.

Summary

- A PT can do much of the work a clinical pharmacist would do, except prescribe.
- You will need to factor in training and supervision.
- The PT can free up GP time and help improve QOF and other enhanced service performance.

Dr Helen Maxwell-Jones is a GP at Henmore Health – The Surgery in Derbyshire and CD for the Henmore Group, **Sarra Hardy** is clinical PT at The Surgery, **Samantha Fitchett** is operations manager at The Surgery and **Danny Smart** is CEO of the Henmore Group.

MEET YOUR IT NEEDS

PCN clinical director and primary care IT specialist *Dr Neil Paul* offers tips on developing an IT strategy for your network

As primary care contracts and targets are increasingly directed through PCNs, it makes sense for your network to have an overall IT strategy.

IT is critical to everything we do – for the planning, delivering, monitoring and evaluation of care as well as for claiming income. In addition, it seems likely that PCNs will be given notional budgets for IT and an approved framework and software, so it is important for PCNs to be ahead of the game and know what IT solutions they want.

Here are my tips for developing a strategy to identify and deliver the best IT solutions for your PCN.

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Take stock of your hardware

First, ask yourself:

- What hardware do you have?
- How old is it and what specification?
- When is it due for replacement?
- Do you have significant variation in the standard of hardware in teams?

You may find there is a need to level up practices' hardware, which means starting conversations with your members about helping the worst off.

Explore telecoms options

If, like us, your infrastructure is provided by the local commissioning support unit (CSU) you will benefit from professionalism and resources, but this also restricts choice and can disable large numbers of practices if a system fails.

Where possible you may want to look at alternative suppliers, such as X-on, to give you more choice of services and flexibility – for example, additional support during extended hours.

Align software where possible

It is important to review your clinical system software too. Are you all on the same systems and if not, why not? A historical legacy or attachment to a particular vendor is understandable, but there can be advantages to moving to one supplier.

Doing this at PCN level can support collaboration while still giving practices some control. It also makes sense for practices to use the same add-ons, such as dictation software.

For example, most practices in our GP federation, which covers three PCNs, now use Lexacom's digital dictation transcription software – this gave a discount, enabled staff to use a familiar system across different practices and made training and support easier.

Share your IT skills

Look at your people and do a stock-take of skills. Each practice will usually have one or two staff members with efficient approaches to automating appointments, searches or protocols.

For example, one of our pharmacists created an EMIS protocol to automate generation of controlled drug prescriptions for palliative care patients, which other practices across the PCN have found invaluable. Consider organising practice visits or exchanges to share processes like these.

Centralise processes

Look at harmonising processes for administrative work such as coding of incoming letters and summarising notes. Having consistent coding across a PCN will help quality of care and make population health management analysis more reliable. Other processes such as information governance, document shredding and IT training could also be standardised.

Make use of business intelligence tools

There are a number of business intelligence tools that practices can use to analyse partners' activity and quality of care, such as Apollo or Graphnet Health for patient data and the pharmaceutical focused tools AnalyseRx and Eclipse.

Draw up a data sharing agreement

A robust data-sharing agreement will save a lot of time. Know what your members are comfortable sharing at a practice, PCN and wider level and write that up. Then you don't need to create lots of paperwork each time you test a new piece of software or do a cross-practice search or audit.

Hire dedicated IT support

Hiring an IT trainer for the PCN can be a cost-effective way to level up skills and knowledge across practices. My PCN did this for three months and it really improved IT knowledge among the reception and administrative staff as well as clinicians, in particular where employees had missed original training on software, or did not know about new functionality. The IT role could also include reviewing each practice's IT disaster recovery plans to create one central plan and share resources.

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

Dr Neil Paul is a GP partner in Cheshire and CD of Sandbach, Middlewich, Alsager, Scholar Green and Haslington (SMASH) PCN

TOWER OF STRENGTH

Tower Hamlets in east London is a leading light in primary care innovation. *Tracy Cannell* and *Chris Banks*, joint chief executives for the Tower Hamlets GP Care Group federation, explain how PCNs are working in the borough

Tower Hamlets has several challenges – some of them like other cities, some of them unique. We have a high population density with 325,000 people living in less than eight square miles, and the youngest average age in the country.

Our community is ethnically diverse with 32% white British and 32% Bangladeshi, with a 20% churn of residents. We have a lower healthy life expectancy at birth, which for men is 60.5 years, and unusually even lower for women at 57.6 years. These figures are well below the average for London (80.9 years) and England (79.8 years). There are high levels of child poverty, child obesity, severe mental health problems, homelessness and early deaths due to cancer, heart, circulatory and respiratory disease. We also have high levels of pollution and, recently, comparatively lower levels of Covid vaccination uptake.

These challenges led Tower Hamlets to innovate in care provision. More than 10 years ago we established eight networks, which set us up well for the introduction of PCNs. In 2015 the Tower Hamlets GP Care Group federation was set up with nothing but our ambition to grow a strong integrated primary care-led system to improve care and outcomes for a very deprived community.

The GP Care Group is owned by all the practices on a not-for-profit basis. We have grown from four staff and a turnover of £242,000 to more than 600 staff and a turnover of £34m. We are one of the largest community focussed primary care federations in England, and we work closely with the local council and other partners in the NHS and voluntary sector.

Every service we took over had been failing. Now they are high performing, they produce better outcomes, improved patient and staff satisfaction, and fantastic value for money.

Unfortunately there is no mention of federations and working at scale in national policy plans. Our federation has delivered major benefits including online access to all of our practices and face-to-face care 24/7. We offer one of England's best performing 0–19-year-old services. We have set up social prescribing, acute phlebotomy and a virtual Covid ward caring for 260 patients at a time. The federation has also reduced urgent care costs by more than £1m, reduced estate and IT costs by 55% and reduced pre-Covid staff sickness from 10% to less than 3%.

Primary care still struggles to be heard as loudly as large trusts in many local systems. Having a GP federation of all PCNs and practices has helped us achieve this. It also lets us deliver at scale on behalf of all PCNs where appropriate, reducing duplication and achieving more, faster because of the focussed and experienced management support that is not available at a PCN level.

This was never more evident than during the height of the pandemic. Before the end of March 2020, we:

- Set up a Covid lead group involving PCNs and the LMC.
- Agreed a plan for primary care.
- Set up a 24/7 integrated primary care service providing face-to-face support and home visiting to all our practices, keeping services going when they were closed because of staff isolation or illness.
- Established a central virtual ward with home monitoring, taking referrals from practices and hospitals.
- Set up a local test and trace service very rapidly in partnership with the local public health team from the borough of Tower Hamlets with a multi-lingual staff team.

Chief executives
Tracy Cannell and Chris Banks

Federation
Tower Hamlets GP Care Group

PCNs
Tower Hamlets 7 PCNs – The One network, East End Health network, Tower network. Bow Health network, Mile End East and Bromley by Bow Health network (MEEBBB), Poplar and Limehouse Health network, Healthy Island Partnership

Number of practices in TH's 7 PCNs
35

Number of registered patients in TH's 7 PCNs
325,000

PCN hires
20 clinical pharmacists, 10 social prescribers, 8 first contact physiotherapists, 7 care co-ordinators, 2 health and wellbeing coaches, 3 occupational therapists. Not all at FTE

Recruiting
Still looking for 7 clinical pharmacists, 3 social prescribers, 4 care co-ordinators, 2 first-contact physiotherapists, 1 health and wellbeing coach, 1 physician associate, 3 mental health practitioners, 1 nurse associate, 3 trainee nurse associates, 1 dietitian and 1 pharmacy technician

Introduction of PCNs

Since the Network DES was introduced in 2019, our networks have all become PCNs. The transition was straightforward. However, there was some unravelling of plans for co-ordinated borough-based work because the focus of government policy is on individual PCN development, rather than collaboration at a borough level. For example the extended access hubs have been provided at a borough level, which all registered patients in the borough can access. With the move of funding from CCGs to PCNs there is a risk that PCNs will not continue to collaborate in this way, as some are planning different arrangements, which may reduce patient choice.

Because the networks (now PCNs), were already well established the focus has been on establishing the roles of the CDs and how to use additional roles reimbursement scheme (ARRS) monies. The PCNs all appointed CDs, many of whom were already leading the networks. However, the CDs have limited time and limited direct management support. We meet regularly with the CDs as a group and employ the management that supports them.

Initially, lack of recognition of additional pay costs in London, limited access to NHS pensions and the pandemic all hampered PCN development plans. We have supported PCNs to recruit additional roles including pharmacists, physiotherapists and occupational therapists. We have requested more flexibility for extended roles, and as we are an NHS employer we can offer staff good support so recruitment has not been difficult.

The introduction of PCNs has provided more funded time for clinicians to develop networks. This has led to local innovations, for example long-

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term condition (LTC) management with multidisciplinary teams (MDTs) at a network level.

It has also meant we can take a tiered approach to supporting practices, for example, with Covid vaccination. All the practices in Tower Hamlets signed up to a borough-wide arrangement led by the federation with borough-wide clinics and a booking helpline, a central roving team to support 68 care settings and pop-up venues. The majority of housebound patients were vaccinated by practices with support from the roving team. Practices have also held vaccination clinics to increase uptake. This has meant that practices have been able to largely continue focussing on their mainstream priorities.

Over the last five years, a key lesson we've learned is to evaluate options for service development and delivery to scale cost effectively. Our population doesn't like to travel, so we provide care as close as possible to them and work with the PCNs to evaluate the most cost-effective approach.

Having a well-established federation with mature partnerships means issues can be resolved very quickly. Recently, this included borough-based Covid home monitoring, 24/7 primary care and a vaccine helpline. We also work closely with the borough council which invests an enormous amount of time at senior level to improve the health and wellbeing of residents. The culture of primary care in Tower Hamlets is one of collaboration.

Future hopes

We want to increase our borough-based digital offering. Over the last few years we have developed and implemented online consultation across all practices. We have both web-based forms and video consultation, as well as two-way text messaging – and this really helped maintain care during the pandemic. We implemented centralised online registration and are now exploring how we can provide a portal at scale to help individual practices meet needs on a 24/7 basis.

We intend to fully implement personalised care planning for both adults and children with patient-held care plans. This will reduce the fragmentation of care and will help patients to lead their own care. We already have a team of social prescribers linked to each network.

We are actively helping to reduce poverty of children and older residents. For example, we have a project that covers two of our networks helping families to access benefits.

We also campaign to reduce pollution and be an environmentally conscious primary care service. We have declared a climate emergency as a board and are taking active steps to reduce our carbon footprint. This includes adopting re-useable masks in the pandemic.

Covid and recovery from Covid are a key focus, and this includes supporting primary care staff. Early in the pandemic we set up a third-party counselling and support service for PCN and practice staff, which has been well received. Uptake has been high, so we are continuing the service. Staff empowerment is key to success. Throughout Covid we held webinars for primary care staff to identify and explore issues, develop solutions and shape plans and we continue to do this.

Collaboration, dedication, professionalism, support and respect are the key ingredients of the primary care system in Tower Hamlets. Our focus is on making residents' lives better and we feel very privileged to be part of it.

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

AIMING TO BUILD ON REALITY

Hello primary care support fans! It's Penny here again.

Now that the Government has published the bill that will give formal powers to the Sackwell & Binthorpe ICS (and the country's 41 other ICSs), I thought this would be a good time to explain what transformative changes you're likely to see going forward as we aim to move towards the future.

Competition time

First, some really exciting news. We're running a competition to choose a new name and logo for the ICS. What better way to celebrate our focus on meaningful partnership and collaboration than to make the naming of the ICS our first act of co-production?

Your process for coming up with a name is completely up to you, but the following mandatory guidance may help. The winners will be chosen by the Identity Task and Finish Group of the Values and Signage Subcommittee. Please note that practices are expected to remain open for the duration of any in-hours workshop sessions. Details of out-of-hours workshop funding arrangements and discretionary payments for Patient Branding Champions can be found on the ICS website.

1 Work in one or more teams, preferably involving all practice team members and other stakeholders, as appropriate. Consider inviting a patient or someone with lived experience of names and naming to participate. Listen to all ideas, particularly those from people with hard-to-hear voices. Try to include as many of these ideas as possible in your final 'name'.

2 What message is your name trying to convey? It should ideally be aligned with or related to the ICS's vision. You can access a copy of our vision and mission statement from the contracting section of the ICS website – you can find it under rent reimbursements in the premises sub-menu. A downloadable Our Vision poster for display in waiting rooms is available in Word and PDF formats.

3 Your name should and preferably must include one or more of the following words: 'delivering', 'together', 'better', 'healthier', 'care', 'partnership', 'alliance', 'your', 'our', 'all', 'community', 'working', 'integrated' and 'forever'.

4 Your logo design should ideally reflect your choice of name and should express the ICS's core values in a visual format. These are inclusion, compassion, diversity, ambition, collaboration, integration, scale and financial balance.

5 You are strongly encouraged to use the following symbols in a fresh and original way to convey the aims and values of the ICS: circles, interlocking rings or hands, colourful representations of people (preferably in a circular and/or interlocking arrangement), one or more pieces of a jigsaw puzzle, rainbows.

Your ICS questions answered

Lots of you have asked what the new legislation will mean in practice. Here we address some of your questions.

What are the main changes we are likely to see?

Ever since we formed the STP, the forerunner of the shadow ICS, we have been aiming to build on meaningful collaboration and partnership working at a local level. By putting the ICS on a statutory footing, the forthcoming legislation makes, or aims to make, that aim a reality.

What does good look like?

Of course, success depends entirely on culture and relationships. What culture looks like and how we start an honest conversation to take relationships to the next level are the next challenges we face as a system. We shall publish a relationship maturity matrix so that ICS partners can self-assess their partnership readiness and identify the relationship domains where they still have work to do.

How will governance work?

The reforms brought in by the 2012 act were sometimes criticised as complicated. Thankfully, the new act promises to streamline everything, making it much easier to understand. The integrated care board (ICB) will be the main decision-making body working with the integrated care partnership (ICP) at local authority (LA) or place level, where it will collaborate with the health and wellbeing board (HWB) to ensure that the relevant ICB and ICP strategies, and the joint strategic needs assessment (JSNA) under the auspices of the HWB, are fully aligned. The ICB will be involved in ICP strategy and the HWB will need to be consulted on the ICB strategy. The JSNA, refreshed every three years, should inform the five-year, annually refreshed plans that ICBs are expected to produce, as well as the place-based plans of the ICPs. One or more of these plans should ideally clarify remaining details such as who is responsible for what, how much time will be left for commissioning services, how decisions will be taken, and who, if anyone, is 'in charge'.

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