NEW LAUNCH OF THE YEAR
BRITISH SOCIETY OF MAGAZINE EDITORS

PULSE PCN
CONNECTING PRIMARY CARE NETWORKS
SPRING 2022

JOINING THE DOTS

PCNs left to figure out the new specifications with a month to go P6

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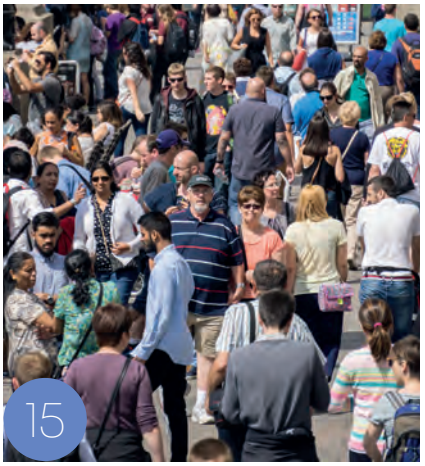

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INCENTIVES TO CLEAR HOSPITAL BACKLOG TO BE CHANNELLED THROUGH £10M IIF FUND

PCNs will be incentivised to support GPs in tackling the NHS hospital backlog through Investment and Impact Fund (IIF) points worth £9.9m.

GPs' role will focus on the use of a dedicated advice and guidance (A&G) service, according to the plan for tackling the elective backlog caused by Covid, published on 8 February.

A&G services involve GPs accessing specialists by telephone or IT platforms, rather than referring patients for a hospital investigation.

The plan said GP access to A&G will be expanded in line with the PCN incentive scheme announced in August.

It warned, though, that the waiting list for elective care is set to continue growing for the next two years.

It said: 'Primary care access to specialist advice and guidance will be expanded through continued engagement and support to PCNs including £10m through the IIF, a scheme focused on supporting PCNs to deliver high-quality care to their populations.'

NHS England said A&G could be used by GPs 'prior to or instead of' making a referral. Also, specialists can 'review the clinical information and provide advice on the most appropriate next steps without the patient having to wait for an appointment' after a GP has made a referral.

The report added: 'This will be further supported by the ongoing development of the NHS e-Referral Service to enable the sharing of images to support clinical teams to undertake more effective triage, while improving patient experience.'

This will include the 'accelerated adoption of teledermatology services to increase access to specialist advice for suspected skin cancers', such as further funding so that GPs can take high-quality photos of suspicious moles and lesions and seek cancer advice. The plan reiterated a goal to deliver about '30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of improved care through system transformation and advice and guidance'.

The recovery plan, which sets out actions over the next three years, also said NHS England will work 'with GPs to avoid a referral if possible'.

However, an accompanying letter added that the impact of the pandemic is 'not limited' to elective care and 'can be seen across mental health, primary and community care'.

'It will be important to give these areas the same focus as elective care, and for the challenges in these areas to be tackled in unison,' it said.

It stressed that the NHS workforce would need to be 'supported' to deliver recovery targets and that tackling the backlog alongside additional demand will be a 'multi-year challenge'. And 'any solutions for tackling the Covid-19 elective backlog cannot rely on making the same staff work ever harder'.

Speaking to our sister publication Pulse, Central North Leeds PCN clinical director Dr Richard Vautrey, assistant secretary of Leeds LMC and former chair of the BMA General Practitioners Committee, said: 'There is a real need for the Government to take the backlog in general practice seriously, as it's having a major impact on access to care for patients and the wellbeing of those working in general practice trying to do their best.'

PCNS TOLD THEY CAN EXTEND SHELF LIFE ON SOME SOON-TO-EXPIRE MODERNA VACCINE BATCHES

PCN vaccination sites can extend the shelf life of some batches of Moderna vaccine, NHS England has advised.

A letter sent to vaccination sites and GP practices said the post-thaw expiry dates for specific vaccine batches can be extended from 30 to 60 days as long as they are unpunctured and undamaged.

The extension, which was agreed by Moderna and the Medicines and Healthcare products Regulatory Agency (MHRA), only applies to vials produced in 20 batches listed in the letter.

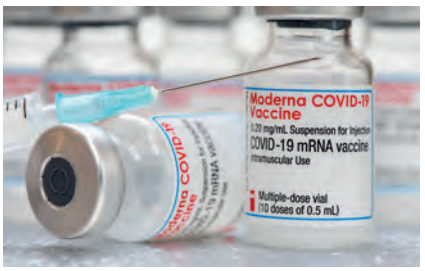
'Moderna has assessed available data and can confirm that stability assessments indicate no impact on product quality through extending the post-thaw expiry period of thawed product from 30 days to 60 days, when stored at 2-8°C, independent of the shelf life printed on the vial,' NHS England said.

The MHRA is reassured there is no detrimental impact on the safety, quality or efficacy of the specified batches of vaccine and has no objection to the proposal of using these stocks beyond their authorised expiry dates, the letter noted.

Clinicians responsible for storage and handling of the vaccines should amend the expiry dates for the batches listed to 'enable more patients to access these critical and life-saving vaccines over the coming days'.

Stocks that are nearing expiry should be prioritised as per normal practice, it added.

This follows advice last month that the shelf life of certain batches of Pfizer vaccine could be extended from 31 to 45 days. At the end of last year, the national protocol for the Pfizer vaccine was updated to extend the frozen vaccine's shelf-life from six to nine months.



PULSE PCN WINS 'BEST NEW LAUNCH' AWARD FOR FILLING 'GENUINE NEED'

Pulse PCN has won the 'Launch of the Year' category at the prestigious British Society of Magazine Editors (BSME) awards, which celebrates 'editorial excellence' among the top consumer, professional and customer magazines and websites.

Pulse editor Jaimie Kaffash and Pulse PCN editor Victoria Vaughan received the award at a ceremony in January.

The judges said: 'The team did not just identify a genuine need in their audience, they also reached out to that audience and got them involved in shaping and providing content from the outset.'

Pulse PCN was launched in print with Pulse's May issue alongside a new section on the website and a weekly newsletter. It aims to foster a community and provide up-to-date news and resources for PCN clinical directors (CDs).

Pulse PCN also hosts a series of roundtables and events for CDs. Details available at pulsepcn-events.co.uk

JOINING THE DOTS

Despite the lack of detail PCNs are figuring out what will be required of them when the specifications are ramped up in April. *Emma Wilkinson* reports

Vague, opaque and unclear are the words PCN clinical directors (CDs) use when looking ahead to the coming phase of PCN work. But that hasn't dampened their enthusiasm for taking this more proactive approach.

April's new specifications of personalised and anticipatory care – tailoring care around patients and keeping patients well for longer – look to be the two areas that will need the most attention. But at present, CDs feel there is not enough detail to be confident about the current work they are doing.

Meanwhile, the architecture of the NHS is shifting around PCNs as CCGs disappear and ICS organisations come to the fore.

The workforce is frazzled after delivering the highest ever number of appointments in 2021 and the accelerated booster campaign. And England LMCs are demanding the BMA does not negotiate any new funding for GPs via the PCN DES as it is a 'failed project' that was mis-sold to general practice'.

It's not surprising that the focus isn't on the coming specifications. There is an element of watching and waiting to see if there are further details from NHS England and NHS Improvement and what integrated care systems (ICSs) will ask of PCNs.

But that's not to say work isn't being done. Link workers and social prescribers are in place. Population health projects are getting off the ground. PCNs are identifying frail patients who would benefit from a more proactive approach. The current challenge lies in identifying the gaps and linking up existing approaches so they are of value, say CDs.

Dr Sarit Ghosh, CD at Enfield Unity PCN says their focus at the moment has to be on recovering services after the pandemic. Demand on practices is through the roof, there are severe workforce shortages, and some aspects of the DES are on the back burner because of the vaccination campaign. Access and long-term conditions are the things weighing on his mind.

'This is why a lot of the Investment and Impact Fund (IIF) indicators were suspended, because of these challenges. If I'm honest, I think we're doing a lot of stuff on personalised care and we're working on anticipatory care through the winter access fund and other areas. Most systems are [looking at this in some form already] because they have to to survive.'

But he says PCNs are probably not doing anything detailed in these two areas yet. 'One reason is because it's so opaque. We're not sure what the requirements are.'

A lot of this work is incredibly transformational, requiring up-front investment, he says. And on top of that everyone is a bit burnt out.

It does seem that the DES specifications are not high on anyone's agenda right now, including health think-tanks such as the Nuffield Trust and Health Foundation, which, when approached for comment, said it had not done work on the anticipatory or personalised care specifications recently.

Sheinaz Stansfield is director of transformation for Birtley, Oxford Terrace PCN in Gateshead, Tyne & Wear. This PCN has been involved in the Year of Care project, which has been instrumental in the development of its personalised care approach.

After identifying a population of frequent fliers - those with multiple long-term conditions who were having 20 appointments a year – the PCN offered longer appointments with a practice nurse. 'We started to do personalised care planning and within six months, patients that used to come in 20 times a year were coming in two times a year,' said Ms Stansfield.

There is a lot of overlap between anticipatory and personalised care and practices are doing a lot of this already, she notes. This is not about starting from scratch but 'joining the dots'. For example, the PCNs have already seen the benefits of having social prescribers and health coaches.

'At the moment the system isn't connected. The anticipatory care guidance gives us that lever to start working with district nurses and with community services on planning and co-ordinating our care. If someone is frail and housebound, why don't we have one care plan? Why don't we have an MDT? Why don't we connect with local authorities and befriending services to help address isolation?'

The focus is on recovering after the enormous demands of the pandemic
Dr Sarit Ghosh

Dr Geetha Chandrasekaran, CD at North Halifax PCN in West Yorkshire, points out that as usual the PCN is working without the detail of the specification – and that this hinders any real planning.

But the PCN has had a personalised care team in place for some time, and is starting by trying to unpick the reasons why referrals slumped during the pandemic. It is also doing a lot of work on inequalities. Dr Chandrasekaran also wants to achieve greater co-ordination of all the different strands.

'The team is growing,' she says. 'We have social prescribers, our care co-ordinators, and we now have a health and wellbeing coach in our PCN. We have put them all together. In Calderdale we have a PCN that's got a frailty nurse and an occupational therapist and that's soon going to be extrapolated across the region because we've identified that it works for people. And we're doing some other work on

anticipatory care.'

While she says it's 'all gone a bit pear shaped' during Covid, 'getting to the proactive' bit has always been at the heart of primary care. Her goal is not just identifying the groups of patients who would benefit, but making all the different pathways robust enough to manage them, whether they need end-of-life care, or help with frailty or other issues, perhaps mental health. The PCN is also working to get the team based in a hub so there can be real connections with colleagues.

All this will, of course, require training of staff, which they are looking at doing at a place level.

'We have to recognise if we do this, we have fewer acute admissions, fewer falls, fewer urgent calls out to practices, and fewer contacts because we're proactive. The downside is it takes time to recruit [these hub roles]. It takes time to train them and we don't have a structure for training,' she adds.

Dr Chandrasekaran's main concern is that the PCN will start doing a piece of work one way, then end up doing it another, just to tick the boxes. 'It is very vague,' she says. 'They've left it very open. I'm wondering whether they will [concentrate on]planning rather than doing this year – that's hopefully where they'll go with it.'

Professor Chris Drinkwater, emeritus professor of primary care development at Northumbria University, has been at the vanguard of work in social prescribing. He is one of the founders of the Ways to Wellness service in Newcastle. He agrees PCNs are in a really difficult position at the moment, and his advice is to look carefully at the groups where you can have the greatest impact.

'It might vary between different areas and different practices,' he says. 'If you've got a largely older population, you might want to look at frail older people and dementia. If you've got a younger population or a BAME population, you might want to look at type two diabetes and obesity.'

And he advises trying to pull together a project on personalisation and anticipatory care 'because there's a danger that you end up with segmentation and lots of little projects [that] become very difficult to manage, and don't necessarily achieve much'.

Through his work he has found the key to effectiveness is building trusted relationships – something that does not necessarily fit into a tick-box exercise and is a long-term proposition.

Look carefully at the groups where you can have the greatest impact

Professor Chris Drinkwater

'The link worker is the intervention rather than the activities because it's about building trusted relationships with often very vulnerable people who, particularly in disadvantaged areas, can be distrustful of authority figures. This is one of reasons why I think PCNs in disadvantaged areas should have a larger number of link workers.'

Signposting to services is not enough, he adds, and the social prescribing role should not become about form filling and data collection. 'You can tell people about services but the more vulnerable they are, the more disadvantage they know, the less likely they are to go along to those services.'

Larwood and Bawtry PCN in Nottinghamshire is hoping to build on a model of anticipatory care it has had in place for some time.

Dr Richard Davey, who recently stepped down as CD, says: 'From our perspective, what good looks like is a diarised meeting that happens regularly with admin support and people buy into it because it works.' This MDT meeting – there is one for palliative care and one for frailty – is attended by the PCN clinical pharmacist, social prescribers, paramedics, care co-ordinators and community teams as well as the GP.

'Hopefully, for us [meeting the DES requirements] should be seamless, but other PCNs that are still relatively immature or [struggling] to recruit into these roles [may have]problems to meet these targets.'

He adds: 'Most individual practices have some form of frailty and palliative care structure but how will that be linked on a PCN footprint? I think that's more challenging for the bigger multi-practice PCNs.'

The focus for practices will largely depend on the agenda set by the ICS, he notes, but there is potentially a lot of scope for reducing inefficiencies in the system. 'I'm hoping there'll be a lot of latitude in how they monitor this and how they sign off for payments so that people engage with it appropriately, because the more rigid and dictatorial it becomes, the less people will engage with it.'

In West Devon the PCN commissioned the first locally enhanced service for population health management in older people last year. Dr David Attwood, a GP and CCG clinical lead for integrated care and older people, says it is based on the premise of segmenting the over-65s, grading them from no frailty to severe frailty and looking at the evidence-based interventions that work in each group. Six out of nine PCNs are now signed up to the fully commissioned service, he says.

For moderate and severe frailty, an MDT of the community services team and a GP do comprehensive geriatric assessments, which includes a medicines review. The service funds the GP time. Dr Attwood says: 'We've also arranged the system so that each PCN has funded time put aside for a GP to be able to work alongside this MDT and each PCN is also funded for a complex care clinic for older people.'

'It seems to be working really well and the feedback I'm getting from people on the ground is that they feel like they're making a difference to patients.'

This approach might not work for everyone, he admits. 'We're in one of the most socially deprived areas of the country and this is the way we've done it, we've built a model around enhanced primary care.' →

Other places might have a central hub area you can refer patients to, he says. 'My key message is for each area to look at its assets and try to find solutions that will work best there – identify the population group, segment that population and look at the evidence-based interventions for each.'

His PCN did have to consider a model that was 'flexible and scalable' because it was not flush with staff. 'We suspect that some practices may struggle with physical bodies to deliver on this. That has been the challenge for the other three networks as they said they really wanted to do it but didn't have the staff. I suspect that is going to be a problem nationally.'

There are things that will need to happen at the ICS level – not least working out how everyone locally can use the same care plans, says Ms Stansfield. 'For anticipatory care to work we need standardised processes that everybody understands and everybody's bought into. Then you need the same training across the board. There are so many variations of what personalised care planning is, so we need to choose which one will work for us and use it across our system. And the ICS really needs to support that; that will be crucial.'

"Check your local assets and find good interventions for your population
Dr David Attwood

Having data on population health is one thing, but the pandemic has added another factor. There are patients who have been shut in their houses throughout, with the isolation, physical and cognitive decline that goes along with that.

'It's a tsunami,' says Ms Stansfield. 'When we open that door, we will be flooded by it. When Covid began we sent out our practice nurses to see housebound patients, and we've found so much unmet need.'

She is planning to start tackling this by building on connections created during the pandemic with local authorities, community teams and the voluntary sector. 'We need to connect, we need to develop relationships, have time to talk to each other. We need to develop trust and collaboration.'

She adds: 'For the past 18 months, CDs have been outward looking on vaccination. Now they have to be inward looking and if they aren't that's a massive risk because PCNs are imploding because practices are imploding and there is no trust. It's essential that they go and talk to the practices and [help them] to understand what this means and how they have to engage.'

PCN DES REQUIREMENTS 2022/23

CARDIOVASCULAR DISEASE PREVENTION

From April 2022 a PCN must

- **Improve the identification of atrial fibrillation through opportunistic pulse checks alongside blood pressure checks**
- **Undertake network development and quality improvement activity to support CVD prevention**
- **Identify patients at high risk of familial hypercholesterolaemia**
- **Offer statin treatment to patients with a QRISK2&3 score ≥ 10%**
- **Support the earlier identification of heart failure**

TACKLING NEIGHBOURHOOD HEALTH INEQUALITIES

By 28 February 2022

- **A PCN must have finalised its plan to tackle the unmet needs of the selected population and must start to deliver from March 2022**

ANTICIPATORY CARE

By 30 September 2022

- **A PCN must agree a plan with its ICS and local partners in line with a forthcoming national model and guidance and should include detail on:**
- **How to identify the population that will most benefit from proactive care, most probably but not exclusively those living with frailty**
- **How to ensure necessary data sharing agreements to provide co-ordinated care**
- **The minimum number to be offered anticipatory care**
- **How assessment of need and care planning will be carried out and co-ordinated**
- **The agreed protocol for engagement of an individual and addition to or removal from the list**
- **How activity, experience and impact will be tracked and quality improved**

This plan must be implemented by 1 October 2022

PERSONALISED CARE

By 30 September 2022

- **A PCN and commissioner to have worked with stakeholders to design, agree and enact a targeted programme of proactive social prescribing in a cohort with unmet needs. This should be provided by 1 October**

By 31 March 2023

- **Review cohort and extend the offer based on population needs and PCN capacity**

By 31 March 2023

- **A PCN must work with other PCNs, their commissioner and local partners, to implement digitally enabled personalised care and support planning for care home residents**

By 30 September 2022

- **A PCN must ensure all clinical staff complete the Personalised Care Institute's 30-minute e-learning refresher training for shared decision-making conversations**

By 31 March 2023

- **A PCN must audit a sample of their patients' experiences of shared decision-making and document improvements made**

GETTY

BACK TO THE FUTURE

We should look ahead and give PCNs the space to innovate for their local populations

Winter draws to a close. Footfall in booster clinics is dwindling. You could be tempted to look back and take stock. But there's the reorganisation of the NHS. The shift in architecture, which sees the end of CCGs and lift-off for integrated care systems (ICSs). Also, PCN specifications ramp up in April to include personalised care and anticipatory care.

As our feature (page 6) outlines, these things may be on the horizon but who has had the chance to look the future? Not PCN clinical directors (CDs); not think-tanks; and judging by my still-pending queries on the next phase of PCN work, not NHS England. But I have the sense that CDs are okay with this. They've become used to hearing things first via Pulse and the national news.

Much of the new work has already begun. The frail and elderly, who will benefit from anticipatory care, have been identified in the care home specification, Covid measures or other PCN work. Population health projects are under way (see our roundtable, page 15). For the personalised care element, social prescribing link workers have been hired through the additional roles reimbursement scheme (ARRS). But this way of providing care tailored to the patient and anticipating their future health concerns requires support.

PCN CDs can see the future for this type of care. They want to prevent children becoming their parents with diabetes, hypertension and cardiovascular disease. But can this new system fund that kind of long-term healthcare? Can those at the ICS reach down and engage with their PCNs? Can they fund a more responsive, locally thought-through kind of care?

Added to these challenges are the findings of the NHS Race and Health Observatory, reported in *The Guardian*, but not yet published at the time of going to press. According to *The Guardian*, the review, led by Manchester university, highlights that woeful collection of ethnicity data has 'negatively impacted' the health of black, Asian and minority ethnic people in England for years. This mirrors the experiences discussed in our roundtable, where one CD says that although data about ethnicity and vulnerability to Covid were good, they weren't available at a practice level and had to be recaptured.

There has long been a problem with the sharing of data in health. As we move to a preventive, responsive health system, data have huge potential to help plan and co-ordinate healthcare. So while the past must be examined, PCNs must look to the future. Now, as ICSs get going, is the time to pull together for the care that will work for your populations. As our columnist Dr Manu Agrawal cautions (page 21) LMCs and PCNs must not be pitched against each other.

So looking ahead ICSs should have a ring-fenced fund to back the preventive work that will minimise costly healthcare in later life. They should also commit to funding PCN-driven work. While there will be easy wins with widespread health issues, local needs may differ around the country and money could be better targeted by PCNs given the space to innovate.

Lastly, work needs to be done on better sharing and collecting of data. Covid has shown that data can be shared. This needs to be looked at again.

Victoria Vaughan is editor of Pulse PCN

SPEAK UP

Primary care has to be listened to – and this review is a chance to be heard

With statutory integrated care boards on the horizon, primary care faces an unrivalled opportunity to harness its local knowledge to deliver better services for patients.

While the pandemic has facilitated greater service collaboration, we all feel the NHS can still be disjointed and siloed in its approach. Now, we have the opportunity to build on the best of system working and to use the expertise of primary care with an independent national review, led by Professor Claire Fuller, who will look at how systems can drive more integrated primary care services at local level.

I work with Professor Fuller in our ICS, and I know she has a genuine drive to empower primary care to do better for our populations, and is committed to a true bottom-up approach.

The review will seek arrangements that are already working well in some areas of the country, and enable them to be developed nationally by developing guidance, infrastructure and removing obstacles.

Examples include South West London Primary Care Provider Alliance, which brought together primary care organisations to share learning, challenges, successes and priorities. That has evolved into a forward-looking partnership that rose to the challenge of winter pressures. It teamed up with out-of-hours urgent care providers to deliver additional capacity in the 111 service and additional practice call-handling linked to directly bookable face-to-face appointments in extended access hubs across south-west London.

In Sheffield, a team of GPs has had training and mentoring from hospital consultants, which enables them to guide primary care colleagues who think a patient needs to be referred to secondary care. Instead of making a referral the GP can be advised on how to treat, or whether to order further tests or supply further information. Sometimes, community-based services may be suggested as an alternative to a hospital outpatient appointment. This arrangement means patients are more likely to get the treatment they need without having to go to hospital, the quality of referrals improves and GPs gain enhanced knowledge.

The review aims to identify these kinds of local excellence, to assess how transferable they are and consider how ICS leaders can make them happen on their own patches. This can open the door to improvements and more collaboration across the whole system, particularly in primary care. The review is about far more than provider trusts talking to other provider trusts.

While there is no simple fix for the myriad of issues facing primary care, this can be a catalyst for improvements, whether that's tackling bureaucracy, providing commissioning powers at place level, or funding better leadership development.

Primary care has to be listened to, and this review – which we are calling the Fuller Stocktake – is a clear opportunity to be heard. So let's speak up.

Contact the NHS Confederations primary care team at PCNnetwork@nhsconfed.org or fullerstocktake.crowdicity.com

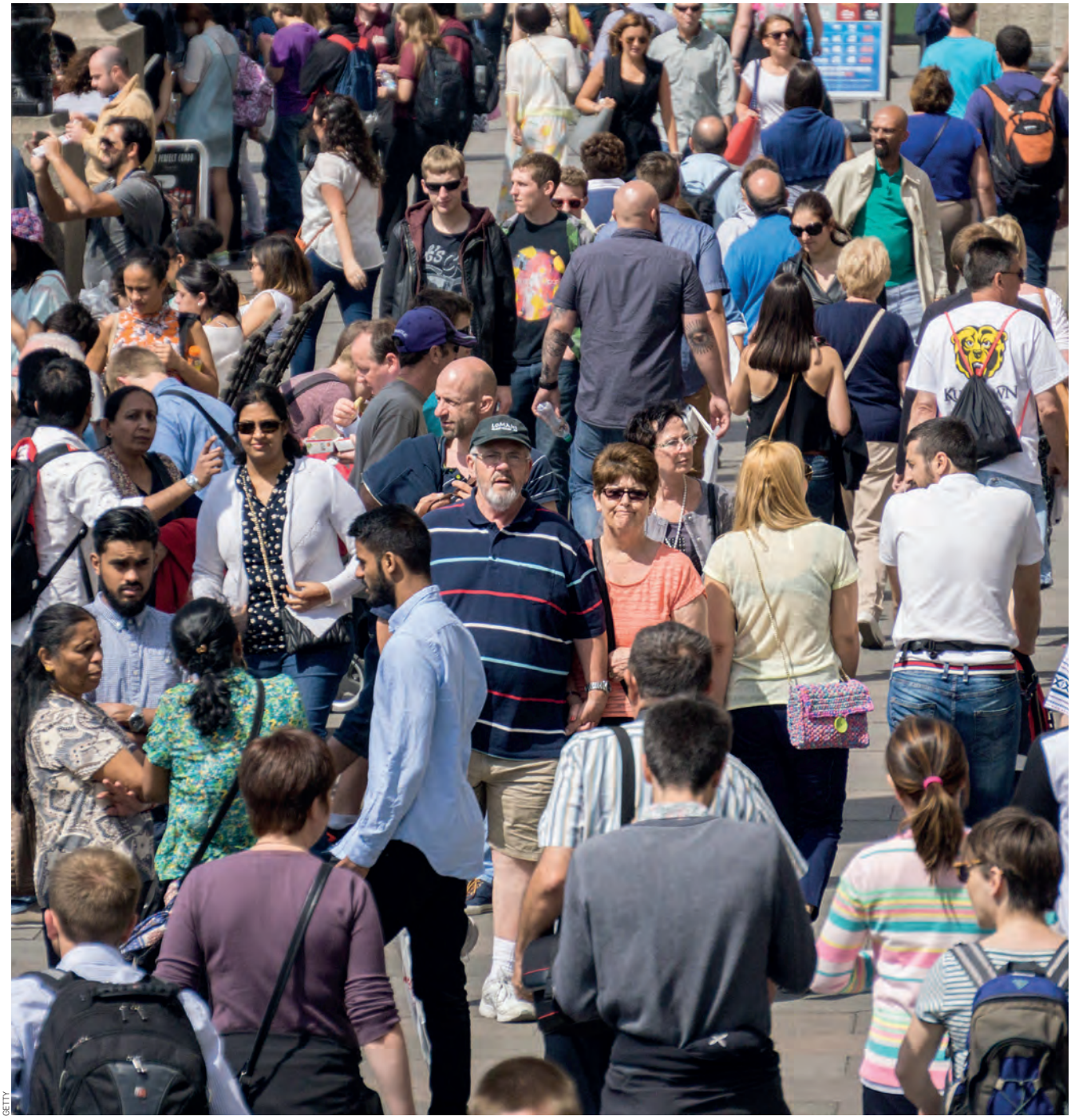
ONLINE
Read more blogs by clinical directors at pulsetoday.co.uk/pcn

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

PCN ROUNDTABLE

POPULATION HEALTH MANAGEMENT

PCN clinical directors and a population health expert joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss how this approach is working in their area



GETTY

DELEGATES

Dr Jeremy Carter
CD at Herne Bay PCN, Kent

Dr Jenny Darkwah
CD at Shoreditch Park and City PCN, north-east London

Andi Orlowski
Director of the Health Economic Unit, Lancashire, and senior adviser to NHS England on population health

Chair Victoria Vaughan
Pulse PCN editor

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

ARE PCNS THE RIGHT ORGANISATION TO DRIVE POPULATION HEALTH MANAGEMENT?

Yes
100%

Victoria Could you start by outlining your current population health projects?

Jeremy We've been doing this in one guise or another for a long time. For many years we've been looking at who we might focus resource on based on prevalence of a disease area, for example using a QOF register. Now, it's got a different name – population health management.

The way I look at it as a CD is this: we've got population health management projects at integrated care partnership (ICP) or integrated care system (ICS) level. Those are things the system is looking at that then get directed down to the PCNs. The example in our area is patients that have diabetes, a diagnosis of depression, live in an area of deprivation and have three other comorbidities. So, we look at a specific cohort of patients that have higher need, identify them and put resources around them.

That dovetails nicely in our PCN because we're working on an integrated care diabetes project for East Kent, so our PCN is piloting that. We have an integrated care diabetes multidisciplinary service with the practice, community and hospital trust diabetes teams all working collaboratively.

As a PCN CD, I'm more interested in how we drive the system. We would like to be doing population health management from PCN level. That's where I think we are on that learning process. Where do you start? Do you identify that from a clinical view in the PCN, do you look at it from a patient perspective, with your patient participation group (PPG), for example? Do you look at it purely from a data point of view? There are obviously all the different data sources we can access from Public Health through to the medical side of things, through IT tools.

So we've looked at that, and we, as a PCN, are going to take a hybrid view with all of that. This is where [our work with] alcohol [misuse] came in. The public health data for our PCN show where we sit as an outlier. But is it something the patients think is important?

And, really importantly, [there is the] question of funding as you want it to be achievable and deliverable. You could look at integrating with community support, with alcohol support services, with the police, with A&E services, third sector support. There are lots of things you could do, but where's the funding?

The answer is 'you've got ARRS roles', and that's true but they are already doing things. If we are going to start doing more work, how do we square that circle? That's where we are.

Jenny I'm approaching this from three angles. In my CCG role we have been doing this for a long time. When we started looking at sickle cell anaemia as a population who had severe illnesses, we set up a board with consultants, A&E staff, patients and voluntary workers, to identify the needs for that population. Over the last few years we've been able to get GPs involved in the care of these patients, because quite often they had gone into hospital for their care. We've set up pathways so that GPs are able to share in the care of some of these patients. I think that's worked quite well for a set population.

In my CD role, we sat together as a network and looked at what we felt as GPs was needed. Some issues came up – the isolated male was one of them, a hidden population that doesn't come into the statistics. We set up a way of reaching those men who never present. They could be sitting at home with their diabetes or their hypertension. We've used our social prescriber to set up an isolated male group – a drop in service where they can have a chat about male issues. What we're hoping to do, in the network, is link that to our health inequalities lead.

We then decided to seek a patient's perspective on what we actually needed and what the patients wanted from us. So we enlisted Health Watch and set up a survey of about 1,500 patients. From that, we have set up focus groups. We still discuss the document that came out of the Health Watch survey and are using it to inform what we do next.

One innovation that came out of the survey was a smear clinic for women who were working. We have a young population who are working in the city and quite often couldn't get to the practice. We've used nurses to set up extended access smear clinics for the network.

The other thing that has come out of the survey is the issue of childhood obesity and a drop in take-up of childhood immunisations.

HOW ADVANCED ARE POPULATION HEALTH PROJECTS IN YOUR AREA?

Non existent
0

Well under way
2

Under way
1

Advanced
0

That's also been formed from public health data and we've got a population health hub that looks at the data across the city and Hackney. We're in discussions with child and adolescent mental health services (CAMHS), voluntary sectors and schools, to work out together how we tackle childhood obesity. We recognise tackling it should come from the top, with things like adverts. But maybe we can also set up small groups where we teach healthy eating, healthy cooking and get families eating together.

The other thing that helped in bringing services together was looking

at our homeless population. When we had the recent displacement of refugees they were brought into a couple of the hotels in my network, so we worked with the councils, MPs, mental health services, language translation services, and it brought everybody together, just having those meetings, to ensure that these people were able to access services in a way that they would understand. Those are some of the projects that we've been looking at at a network level.

Also there were bigger projects on long-term conditions that came down from integrated care boards (ICBs). I think those are things we have been doing for a long time in general practice. They are more established; it's a way of making sure we are working in a way that is beneficial for patients.

"We could integrate with police, A&E services, third sector support

Dr Jeremy Carter

Victoria That's a great overview of how it is working in Herne Bay and Hackney. Andi, can you discuss what the thinking is at NHS England level and at the analytics level?

Andi I think Jeremy and Jenny were downplaying how advanced they are with health management. Working with the patients, the pragmatic approach to finding what counts in their population and then coming up with the alcohol programme [for example], is exactly one of the actions we would expect to see. No one understands the populations better.

Of course making sure the funding is there for bigger and wider projects [is a key issue].

Jenny [gives a] wonderful example of what we talk about with pop health analytics – the people who are well today who may be sick tomorrow, the populations that are missing from the data, these 45-year-old men who haven't seen their GP for 20 years because they think 'I'll get over it, I'll be fine'. It's a sophisticated type of analysis, this whole-population approach, understanding those 'well' people today. They may not be well.

So [we ask] 'can we have a catch-up,' and we find [a patient] is double their previous weight, is drinking too much and smoking. We [had them down] as fine because of the last interaction [with them].

Working together is the real challenge for PCNs. How do they integrate? Population health management only really works if we deal with wider determinants, great big things, but act [on them] locally. Having PCNs that are already linked to the local authority, as well as the ICS, [gives us] this system view.

We might concentrate on the same five things that come from joint strategic needs assessments. They all tend to be the same things in different orders. So it will be obesity, COPD, cardiovascular disease, depression and anxiety and one other health issue depending on your area.

That system level is pushed down to say 'Where is the greater variation on your patch and what would your population best respond to?' How do those populations [in deprived areas] access the care? How do you change big things like education, green spaces, pollution, jobs, those kind of things that are beyond our PCN's direct remit, but are →

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WHAT CLINICAL AREAS ARE YOU LOOKING AT IN TERMS OF POPULATION HEALTH MANAGEMENT?

- **Comorbid diabetes patients**
- **Alcohol-related harm**
- **Childhood immunisations in low-uptake areas**
- **Housebound patients in areas with health inequalities**
- **The homeless population**
- **The vulnerably housed**
- **Recently arrived refugees**

intimately involved with. One other thing that's super-exciting is the fact that Jeremy and Jenny are doing all of the population health analytics themselves. There's clearly a lot of capability already in PCNs. How can we fund them, or resource that better for them to do the work?

Victoria What kind of data are you able to provide to PCNs or is it up to them to work it out for themselves?

Andi NHS England has a number of tools available through the National Commissioning Data Repository, and there are wonderful tools like Fingertips and others. But, of course [because of information governance rules] we don't have access to that granular primary care data which is absolute gold dust compared with [data from] the secondary user services, acute hospital data.

Now we are trying to talk about whole populations, we need to have even more than primary care and secondary care [data], we need local authority data.

For instance, who is on the assisted bin register? If they need help getting their bin to the kerb, they may be isolated because they are too frail to get to it [themselves] and don't have a friend to [help].

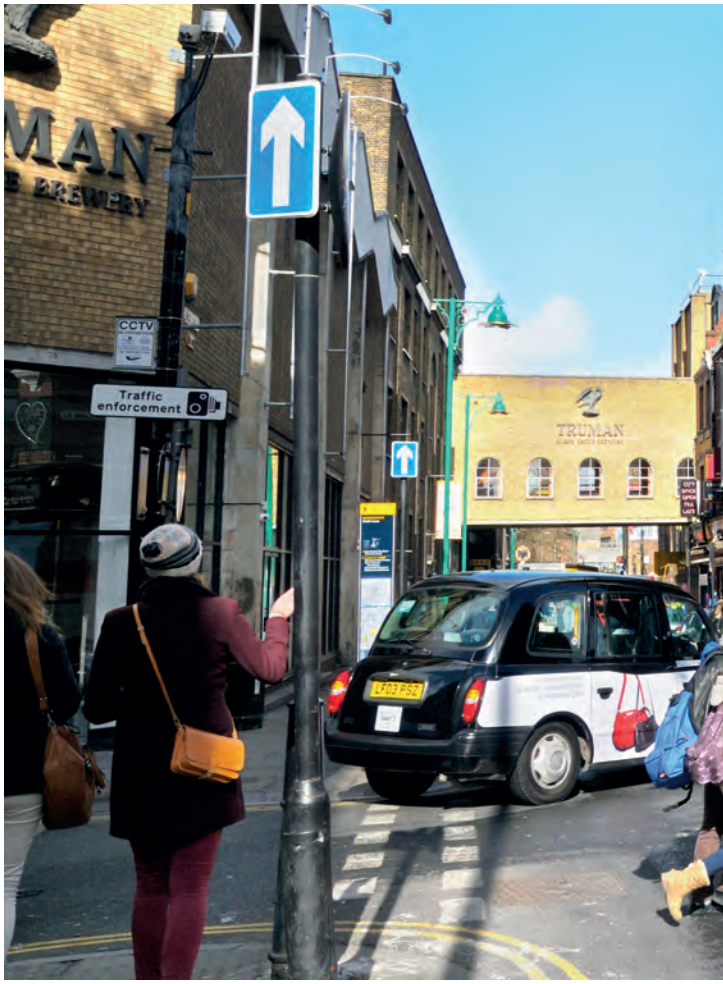
There's loads of additional data available, [but] systems, even the ICS, doesn't have access to [it]. What [we can get] is the tools, or additional analytical resource.

But it's also difficult for PCNs to link their data to all these additional data sets [and] become more powerful. So what NHS England has provided, and can provide, is analytical approaches and tools but without the data we are still relying on people doing their own work. It's wonderful to see that work is being done.

Victoria And is there a data protection problem that means you can't support PCNs further?

Andi Yes, we could do the information governance (IG), but I guess this would take a long time as individual patients would want to be informed and give informed consent. We remember what happened with care. data. Covid has shown we are able to share data when needed, and in an appropriate way that's legal and above board. But we've got to have the same sense of urgency to do it and with population health management, is there the same kind of drive?

Jeremy Covid is a really good example. [It was one] condition, [and] as



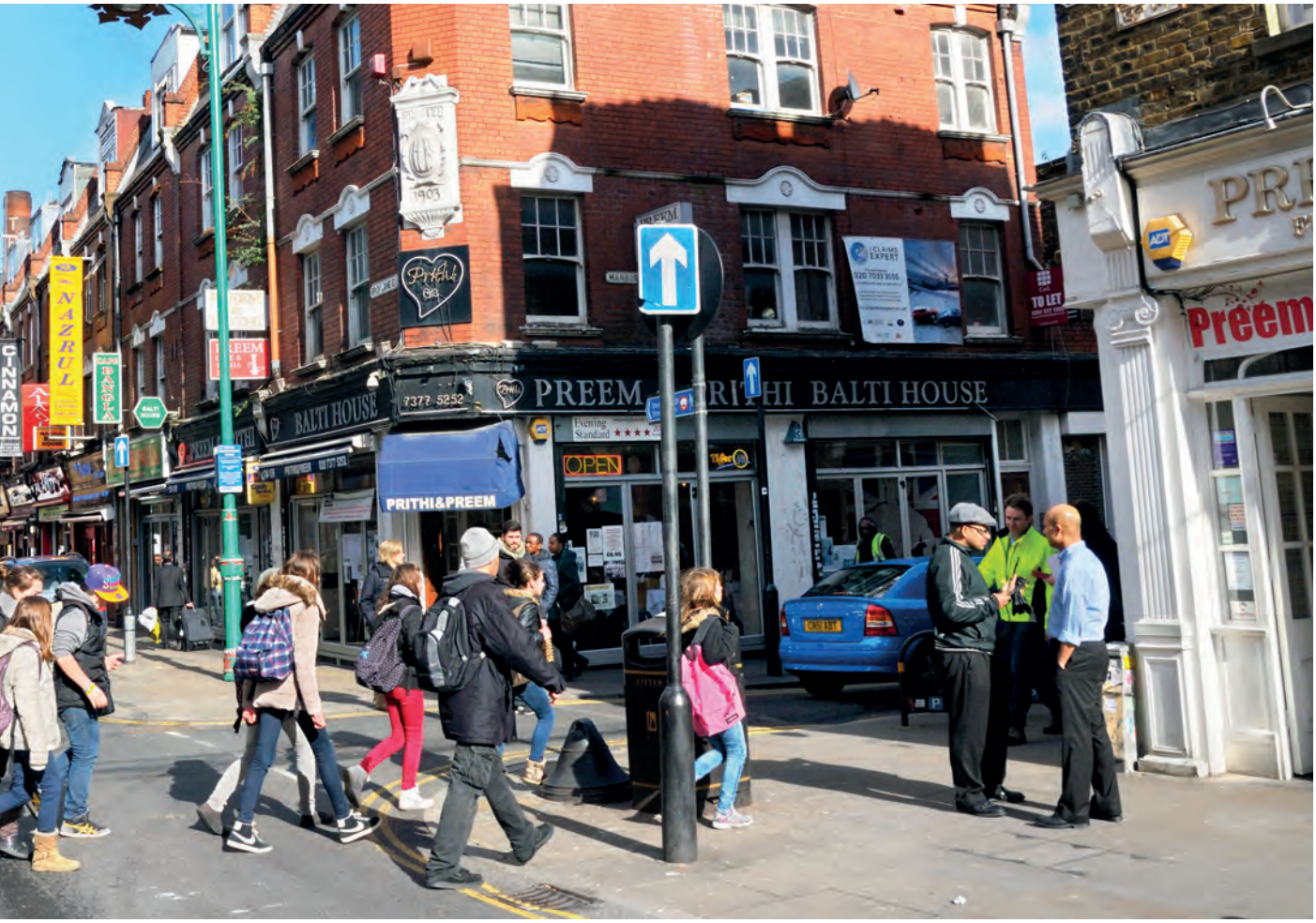
we developed, [we saw] that certain factors put [a patient] more at risk. And we were then tasked with, essentially, focusing our resources on that population. That's population health management. The problem is, some of those metrics hadn't been captured on our system.

Ethnicity is a great example where there was really good data, broken down into specific sub-sets about who might be more vulnerable. We capture that on the census every decade, but we don't have it at practice level, so we have to then recapture it. The other metric was deprivation. Andi, you mentioned the bin collection, and that's interesting. I've never

IS THERE ENOUGH FUNDING FOR POPULATION HEALTH MANAGEMENT AT A PCN LEVEL?

heard of that, but it's broadly available – but on ward level.

We in our PCN have 42,000 patients that span the whole spectrum of demography in social privilege. But in the deprived ward, not everyone has the same need. So, during Covid I asked 'How do we break this down to postcode level, road level, list level?' To me, that's the bit of the jigsaw, as a PCN CD, that's missing. We can only do what we can do with the data available to us. We focused our work more on the clinical.



ALAMY

However, there is a PCN next to us that has, I think, three universities. Its population is completely different. It would make no sense for the system to say everyone needs to focus on diabetics with comorbidities. [That PCN has] 20,000 students and issues with mental health while we've got issues with genitourinary medicine and so on. That's where the PCN needs the data, and the more granular detail we can get [the better], about things that go beyond the classic general practice data of condition, prevalence and prescribing. Things like deprivation – that's the sort of data you could cross-reference to target limited resources to better effect, which is ultimately what this is about.

PCNs need access to much more detailed data

Andi Orlowski

Jenny I was really excited to work with PCNs. Because it meant I was looking at a smaller population of people. I think there's a big disconnect between what my local population needed and what I was being asked to do as a GP. Being able to ask 'What do my patients want? What do I need?' was completely different from what we are asked to do on a wider scale.

When I sit on the ICB board it feels removed. [It's good to be] able to work out what our populations need and feed that back up.

I think that there's a link that needs to be made. We need to say: 'Even though the other networks might not need this, my network needs it. Could you fund that?'

At the moment that's not how it works. At the moment [we're given] a bit of money and told 'Do a project you want to do and if it affects the whole patch that funding gets taken up and it comes down from higher up'. But actually I don't think that's how it should be. Because Hackney [has] different populations.

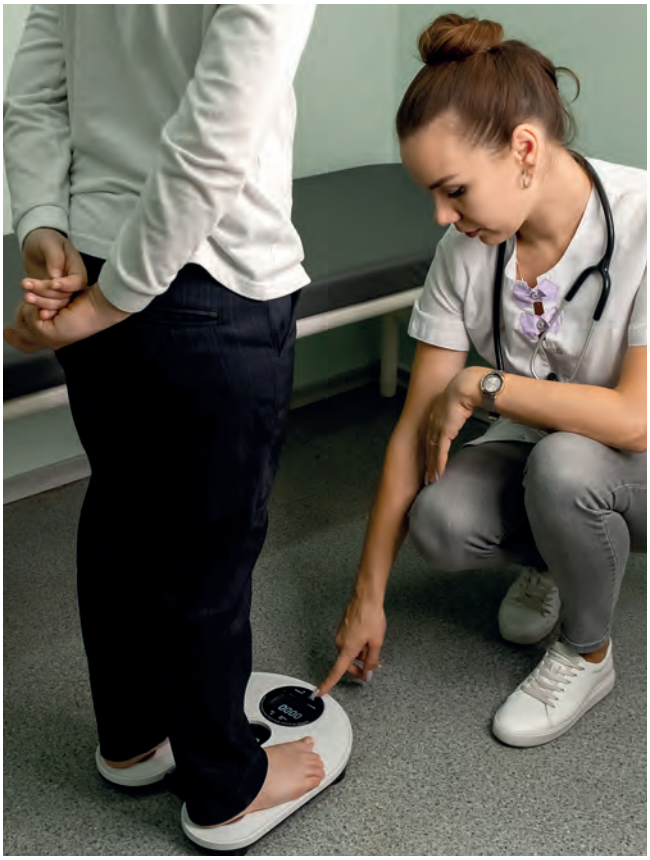
Because we're quite ethnically diverse in City and Hackney, we record things like ethnicity. What we didn't record was the wider determinants. So, I wouldn't know if [a patient] lived in a council place or whether there were 10 people living in the same household. Those are the [data] we don't have access to. If we did, I think we'd have a more enriched data set for our PCNs which hopefully we'd be able to feed up to ICBs.

Victoria Where can they get that from, Andi?

Andi Tower Hamlets has an amazing integrated data set but it's for about 250,000 people. This work was funded and some of [epidemiology Professor Sir Michael] Marmot's team sat with them [helping with that work] over a few years. I think the problem we have is that there are pockets where there's integrated data for the purposes of planning and population health management rather than just direct care. [We need to make] sure PCNs get access to this for their needs, the same way that they can [interrogate] Read codes or SNOMED to, say, find all the people between 30 and 45 who have had certain conditions, who are on certain drugs with certain risks and findings.

Those case-finding tools could be even better if, as you say, we could provide Acorn and Mosaic [demographic data tools]. So, you could take a street, and know what the average house price is and how people live to get an index of multiple deprivation because we know [the] crime [figures]. Could we give that street-by-street [data] for everyone? Because it's available. We use that nationally. How can we go down to lower super output area, LSOA, rather than ward, to give a better view?

The huge challenge here is integrating data for the right reasons. IG has been inconsistently played across the country because different →



populations feel very differently about sharing data. Also, sometimes we haven't been good at communicating that in the past. But once those data flow and people better understand the wider determinants, think how quickly it would progress.

We've also got problems with long-term outcomes, of course. The other thing I take away from the work that Jeremy and Jenny are doing is that we can very quickly see the results. From working with alcohol problems, from screening. And when we start to address obesity at schools, we're hoping to stop diabetes in 50-year-olds. But who is going to give you a 40-year wait time and keep paying for it because it's the right thing to do? And to be fair, I think the system level is prepared for that. But we can see that there's a desire to get it done [more quickly].

Victoria If you could get the funding, if you could have the correct data flows, what is the potential benefit for population health management in a PCN?

Jenny If we could have no barriers to what we were doing, I think patients would get the services they needed and wanted and ultimately, this is what this is all about.

You know, it's not about making a system so we can say we've done it. We want to know: what do patients need from us? Quite often we think we know what patients want and we create that system for them, but actually, they might not want that.

So, if there was no barrier to funding and there was no barrier to IG and it made sense because the outcomes for those patients would be good, I think [population health management] could be fantastic.

For preventive medicine, which is something that we've not been brilliant at, this could be the absolute way forward. When I think of my example of childhood obesity, yes, I'm looking forward. I'm looking forward to make sure these children don't grow up to be their parents who are on my list for diabetes, hypertension, heart attacks and strokes. So that's what I'm doing and that's how I see it being beneficial for PCNs to do that work at local levels so that patients are getting what they need.

"If we had no barriers, patients could get services they need

Dr Jenny Darkwah

Jeremy For me it's about targeting resources and saying we have resource available. To be fair, if you look, in the last years, more has been put into that resource. Then [we need to] use accurate information, [or] as accurate we can to target that resource to give the best benefit to the health of the local population. [This should], in turn, depending on the timeline, give a net benefit back to the health economy but it might be over long periods of time.

As part of our diabetes plan, we're looking at education in schools, but that's playing the long game, the 40, 50-year game. And health economy cycles don't operate like that. It's all well and good theoretically saying we're going to improve health and there will be net gains everywhere. Another point is this: if we're targeting unmet need, that doesn't mean the existing need disappears. [Instead], we might actually create more work. We might save things long term because if we've got a lot of unmet need that probably comes out in the system as late diagnoses and expensive episodes of care later on. We might be able to prevent that but there's a potential problem that in the end we might create more work by finding that unmet need while trying to meet the existing need.

Andi Without PCNs, without people doing it this way, we're lost. This idea of tailoring care to better meet the needs of our population, there is no other operational unit in the NHS that better understands the population than primary care and, therefore, PCNs. This is key. Absolutely, systems may have budgets and understand the big approach of where the variation lies. Jenny and Jeremy have both said how they've involved patients in this. To really have the impact that population health management has, it has to be driven by PCNs. The big problem is how they integrate in a much larger system, because we don't have boards and project managers and all the infrastructure that an ICB will have. So, how do they keep in touch with all of these parts of the system? It would be a full-time job for CDs to speak to the local authority, public health environment, justice, Department for Work and Pensions, let alone the other clinical parts. So how do we create infrastructures that allow PCNs to have that influence, to be able to say: 'This is what we want. This is how we want it.'

POPULATION HEALTH MANAGEMENT IS A KEY APPROACH IN REDUCING THE BURDEN ON THE NHS

Yes	No
2	1

We talked about the data and the problems that come with it. Data is biased anyway and Jenny's alluded to this. White, middle-class people are very well represented in the data because we have the time and the ability to be able to go to our doctor, our GP. If I'm sick, the NHS doesn't mind me taking the morning off to see my GP. But my parents? My mum was a cleaner, if she didn't turn up to work, she didn't get paid and then we wouldn't be able to pay the bills. So, she went on, with diseases and illnesses and, most probably, died 20 years before her time.

Data is biased but the people that understand that are the PCNs, the GPs who work in those communities and serve those communities.

You can't just have PCNs delivering. They have to be involved in the infrastructure, how it's pulled together. No one likes being told what to do. They like to work together in partnership. [They must be enabled] to do that, to do the analysis, to have access to the data and the resources. None of this is easy. There are loads of papers to say integration doesn't happen overnight, especially when there have been combative relationships in the past, between commissioning and providing and other units. It's a real challenge, but they're the people to do it, the PCNs.

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ICEBERG AHEAD

The titanic task of the NHS reorganisation is full steam ahead. The formation of ICSs is gathering momentum. The outgoing CCGs have been focusing on what the structures will look like. CCG chairs have suddenly decided to portray themselves as true representatives of general practice as they get involved with creating the new structures. All very understandable, and everyone is looking for a role in the new system.

What remains unclear is the role of PCNs or, indeed, LMCs.

I and my colleagues have being fighting during the last few months for the grassroots GP voice to not be ignored. We are looking at continuing the membership engagement that was set up for CCGs to ensure we have a voice.

Where do PCNs sit in all this? The system wants PCN CDs to represent general practice at place level and every other possible level under the sun, but predominantly place. We've been advised that is where the decisions will be made, with other partners. In truth, we've had place for the past year and nothing tangible has come out of it, so I do not have high hopes about this.

The bigger concern I have is how as a CD I am suddenly making decisions on behalf of sovereign independent practices, which can affect their livelihoods.

The system just wants to talk about PCNs, yet England's LMCs conference mandated the BMA's General Practitioners Committee (GPC) to get rid of PCNs, or tone them down massively. This seems to have been ignored in this round of contract negotiations, though I hope I'm wrong.

But let me seek a positive spin. At place, we have discussed how to do things differently - create pathways together and provide more services in the community, not by general practice, but by PCNs. This can be done if there is a political will to do it properly, without vested interest and by protecting core GMS contracts and the independent contractor model, otherwise the engagement will be very shortlived.

Then there are system leaders, some from a general practice background, who do not want the LMC voice and involvement. This is because the LMCs have an agenda - protecting GMS. Supporting the PCNs comes after that.

The problem now is that a certain section of PCN CDs are conflicted or are trying to not engage with the LMC. This is dangerous. It will prevent us having a strong voice and undermine general practice. Call me cynical, but this divide-and-conquer atmosphere is something we should be wary of.

We need to get shipshape. We need PCN CDs and LMCs to work together to protect the independent contractor model, using PCNs for facilitating changes that capitalise on the strengths of practices, rather than undermining them, otherwise there will be no practices to provide the care. When the next wave of reorganisation hits in five years' time we want to ensure general practice is ready to weather it.

The system wants to work with us, let's work with it, but together.

General practice is on a collision course with an iceberg. Our conversations do not harbour an element of surprise. Rather, there is an inevitability: 'Captain - we know there is an iceberg, how quickly can we go into it?'

Can work together and miss the iceberg?

We must protect core GMS contracts and the independent contractor model, or the engagement will be shortlived

ONLINE
Read more 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 Caroline Taylor*, GP, chair of the National Association of Primary Care (NAPC), vice clinical chair for Calderdale CCG in West Yorkshire and clinical lead for mental health and children, shares her insights**

In the regions where the NAPC's primary care home (PCH) model was working, PCNs have had a flying start. How do you feel about PCHs evolving into PCNs?
The PCH model was launched by NAPC in 2015 as an innovative approach to strengthening and redesigning primary care. The idea was for health professionals to collaborate with a range of organisations – including the voluntary sector, councils, police, acute and mental health trusts and housing bodies – to focus on population health needs and bring care closer to people's homes.

When PCNs were introduced in 2019, the intention was to incorporate the PCH philosophy. But, in reality, the DES provided financial incentives for GPs to work with other practices but not the wider network. So, while PCHs may have had a flying start in terms of forming relationships in their neighbourhoods, the DES pulled them back because the need to tick so many boxes narrowed their outlook, and incentives to continue with the broader agenda were lacking.

In my PCH we have kept a PCH and a PCN running in parallel because while the GPs were focused on the DES, other providers wanted to do the broader work. Other places have found their own solutions. In some – mostly the original PCHs – the GPs have kept the broader work going, but others have been inhibited and some have given up.

What is the current status of the PCH? Will NAPC continue it?
PCH still exists as a vision of working together at a broad community level to support patients. But the former PCHs are now called PCNs, even when they have a broader membership. The flame of PCH burns now at place level and we support places as well as PCNs to bring together providers to serve communities.

What support do you offer PCNs?
Our support is tailored to the individual needs of a PCN at whatever stage they are. We take our lead from what they want to focus on, for example population health improvement, but we will also bring in other factors such as premises, additional roles, staff wellbeing and the workforce in the neighbourhood. We have programmes to help PCNs bring health and care together, to develop their leadership and to harness digital tools that increase efficiency for staff and encourage patient self-management. We know outcome measures are critical, so we help anyone we work with to measure the effectiveness of their initiatives so that the work can continue after we leave.

Do you think PCNs and the requirements made of them still chime with the original PCH vision?
Yes and no. Yes, practices are encouraged to work together, but the collaboration is stuck at practice level. The broader vision of health and care working together in their neighbourhoods is stifled. The PCN DES is a tick-box contract that narrows primary care rather than broadening it and doesn't allow people to do genuinely innovative work for patients and communities.

Are you advising NHS England and NHS Improvement on the Network DES?
We engage with them on the wider agenda of primary care rather than the specifics of the DES, which we don't get involved with. We brief them on our different work programmes so they know what we are doing, and we hope to influence their direction, but we don't officially advise them.

The vaccination programme would never have been so successful without PCNs
Dr Caroline Taylor

Do you think PCNs will exist beyond the DES?
It depends how the integrated care systems (ICSs) develop, how GPs and other providers of primary care work with ICSs and how successful PCNs are in working at place level. Where a strong PCH vision is embedded, and people have seen the benefits of working collaboratively, that entity is likely to continue even when there is no DES to incentivise it. But there is great variation between PCNs, and if the DES and its financial incentive goes some people will retreat into their silos.

Do you believe PCNs destabilised general practice?
In some places PCNs have helped bring practices together in a way that has been supportive. The Covid vaccination programme, for example, would never have been so successful without PCNs.

But in other places they have destabilised things by forcing people to work together when they don't want to. The system is also potentially divisive because if one practice takes on work another practice doesn't want or doesn't think is needed, that practice loses resource, becomes less viable and less able to help its population.

If you are being asked to take on more work and don't have the headspace you need to be convinced why it is worthwhile. That's where we come in, helping people to understand that collaboration helps patients and boosts staff retention by bringing the joy back into working.

What can primary care do to ensure it's heard at a system level and not overshadowed by secondary care?
NHS England and NHS Improvement need to make sure the ICS is not focused on secondary care. If all the sectors respect and understand each other and are focused on population health management, that will shine a spotlight on primary care. If we descend to a level of them versus us, that is unhelpful, particularly to patients. The PCH approach, which we model, is about working collectively, with mutual respect, keeping the patient at the centre, gathering evidence of the benefits of that way of working and, crucially, demonstrating the return on investment.

HOW TO GET THE MOST FROM FIRST-CONTACT PHYSIOTHERAPISTS

GP *Dr Maggie Walker* and physiotherapist *Jehan Yehia* describe their local model for employing first-contact physios and how they ensure the role has maximum impact in primary care

When the additional roles reimbursement scheme (ARRS) funding came into play in 2020, all five PCNs in Kingston upon Thames, south-west London, were keen to have physiotherapists to help with musculoskeletal conditions, reduce community referrals and improve patient outcomes. Locally, there were long waiting lists for outpatient physiotherapy and it was hoped that this service would help patients receive more timely care.

Since it's estimated that musculoskeletal conditions make up 30% of GP appointments, one of the main aims was to ease pressure by allocating appointments for patients with musculoskeletal conditions to first-contact physiotherapists (FCPs).

What did the hiring process look like and what were the key requirements of the role?

Our model was based on the PCNs recruiting the FCP roles, with support from Kingston Training Hub (KTH), which is funded by Health Education England (HEE). Each PCN has one full-time equivalent FCP working at band 7 to 8a on the Agenda for Change scale. Each FCP offers services for between three and six GP practices.

In our experience, one FCP working in two to three sites is manageable, but anything more becomes challenging, because of differences in how each practice works and lines of communication.

As set out by the Network Contract DES, PCNs employing an FCP under the ARRS must ensure they have these qualifications:

- An undergraduate degree in physiotherapy.
- A master's level qualification or the equivalent specialist knowledge, skills and experience.
- Level 7 capability in musculoskeletal areas of practice or equivalent (such as advanced assessment diagnosis and treatment).
- Ability to operate at an advanced level of practice.
- Registration with the Health and Care Professional Council.

KTH created a governance FCP lead role to help GPs with the logistics of employing FCPs. Our FCPs are working as part of a GP practice and have an allocated GP supervisor and mentor as well as an FCP supervisor, so work-based assessment and supervision responsibilities are shared. The GP mentor oversees non-musculoskeletal and primary care development, ensuring the FCP post develops as an integrated primary care role, not as a musculoskeletal practitioner located in a practice but working separately.

For GPs, major challenges are finding the time for supervision and understanding the scope of the role. However, these are both vital. Time invested in supervising an FCP is rewarded by improvements in patient safety and outcomes, and also in the retention of practitioners as they are supported in achieving advanced practitioner status. In addition, improved understanding of FCPs leads to integrated working.

What is the FCPs working week?

Each of our PCNs has an average population of 41,800. An FCP provides the equivalent of 10 hours for every 6,000 patients. The FCPs have 80% of their time allocated to clinical work and 20% to non-clinical work, and complete a 2.5-hour CPD session every month. FCPs have a mix of face-to-face appointments and telephone follow-ups. Appointment times are usually 20 to 30 minutes.

FCPs can take on any patient presenting with a musculoskeletal condition, without the need for a GP referral. They can diagnose, screen, identify red flags and also refer any non-musculoskeletal issues to the GP. When FCPs have provided evidence for competency, they can order imaging, blood tests, refer to orthopaedics, rheumatology and neurosurgery. They can also upskill, completing a non-medical prescribing module. In addition, FCPs can help with long-term conditions such as osteoporosis screening and management. Most of our FCPs have undertaken health coaching to help with management of long-term conditions and obesity, and to support the management of frail patients.

What support does the role require?

It is important to have a named GP supervisor for debriefing sessions soon after the FCP starts in their role. You will get more out of the FCP role if it is integrated into the wider team with a full induction, especially for FCPs who haven't worked in primary care before. The Chartered Society of Physiotherapy provides a checklist for FCP staff inductions.

How have FCPs helped practices so far?

Data from a 2019 audit of 40 patients at one practice, Canbury Medical Centre in Kingston upon Thames, Surrey, showed that the FCP service potentially saved 270 face-to-face consultations with a GP.

Outcomes over a three-month period were:

- 82% of the patients were seen once and did not present again for the same problem.
- 15% were referred to a musculoskeletal service.
- 12% were referred to the GP for other management.
- 12% were referred to a community physiotherapist.
- 16% were given an onward referral.
- 41% received social prescribing.

Dr Maggie Walker is a GP and clinical director at Churchill Canbury Orchard Berrylands PCN in Kingston upon Thames, Surrey.
Jehan Yehia is a musculoskeletal physiotherapist, FCP lead and governance lead in Kingston upon Thames, south-west London, and FCP at Canbury Medical Centre in Kingston upon Thames, Surrey

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DEVELOP YOUR PCN LEADERSHIP SKILLS

Stepping up to be a GP leader is no easy task. How can you hone your leadership abilities in a way that won't cost you a lot of time and money? GP and clinical leader *Dr Rupa Joshi* shares her advice

PCN clinical directors (CDs) have had a steep learning curve – and for many GPs it has been their first time in a leadership role. GP CDs are also often overwhelmed with supervision responsibilities, and finances have increased in complexity too. So developing leadership skills is vital. The good news is that leadership development doesn't have to involve expensive programmes and courses. Here's how to make it a continuous process and part of your routine working life.

1 Understand what good leadership looks like

Our emerging clinical leaders are using their GP skills to listen to concerns, be democratic, develop trust and negotiate. Many are taking time to build relationships, adopt and spread best practice, network, and improve care. A leader ensures that individuals and teams feel appreciated, understand their team's values, motives and behaviours, and aligns priorities to these. Leadership is increasingly about using soft skills, such as good communication, listening to concerns and recognising the efforts of everyone.

2 Appreciate that leadership is a continuous learning process

Learn from every project and meeting. Reflect on 'what went well'. Question what could be 'even better if'. Focus on building trust.

I use a 'Before Action Review' (BAR) template to prepare for important meetings. A BAR is a way of assessing the knowledge and experience that exists before embarking on a new activity. It can help identify potential challenges and risks by drawing on lessons learned from past experiences. A BAR could include the following questions:

- What are we setting out to achieve?
- What can be learned from similar situations from elsewhere?
- What will help deliver success?
- What are the actions we need to take to prevent problems?

After a meeting, talk to your team and evaluate using the model, 'what went well, even better if.' I also like to set monthly goals and priorities and review these, checking whether the goals were achieved and what can be learned from trying to meet them.

3 Develop soft skills

Listen with fascination, don't interrupt. Reflect, use appreciative enquiry, be curious, ask questions, learn from expertise, use your GP skills. You will learn something from every conversation or meeting if you listen, instead of just talking.

4 Perfect the art of running effective meetings

Always put your vision and goals at the forefront of any meeting. Ensure you have a good chair acting as facilitator, that there's an opportunity for everyone to be heard and a clear decision-making process. Also ensure good clear notes are taken and documented. Don't put more than eight items on the agenda. Practise storytelling to get your point of view across. Use a 'hook' and stick to three to five main points. You will need to repeat messages, as people are very busy.

5 Read up on leadership

I recommend *The Leadership Hike – Shaping Primary Care Together* by Amar Rughani and Joanna Bircher, *Compassionate Leadership* by Michael West, *The Seven Habits Of Highly Effective People* by Stephen R Covey; *How Women Rise: Break the 12 Habits Holding You Back from Your Next Raise, Promotion Or Job* by Sally Helgesen and Marshall Goldsmith; and *The Five Dysfunctions of a Team* by Patrick Lencioni.

Also, take a look at Brené Brown's blogs and the TED talks by Simon Sinek, author of *Start With Why*. The NHS Confederation's website also has useful material on leadership, as well as details about networks.

GETTY

6 Find a mentor

A mentor is an experienced and trusted adviser. Ask if you can do some shadowing, use them for peer support and for talking through difficult conversations to help you gain new perspectives. Experienced managers can also provide excellent insight. You can find a mentor and more information about mentoring at the Faculty of Medical Leadership and Management.

7 Use coaching

This is goal-based support for your own personal development. Coaching helps individuals find the answers to their own questions and unlock their potential. Coaches can be found through the local NHS leadership academies or the NHS Looking After You Too programme.

8 Take on new challenges

Every challenge is an opportunity to grow as a leader. Ask for guidance from your support network. Learn from social media, adopt and share learning – not just what went well, but what didn't go well, exploring why and what you might do differently next time.

Dr Rupa Joshi is a GP and joint clinical director at Wokingham North PCN in Berkshire as well as a qualified coach. She is also primary care improvement clinical adviser for the Time for Care programme, a QI facilitator for the Phoenix GP mid-career retention programme and she sits on the PCN network board at the NHS Confederation

MOTIVATIONAL BOOSTER

Running the Covid vaccine and booster programme became a transforming mission for Central Middlesbrough PCN, which adapted swiftly to the demands – especially, working with the community to ensure hard-to-reach patients were not missed

Clinical director
Dr Vaishali Nanda

Practice
The Discovery Practice

PCN
Central Middlesbrough

Location
Middlesbrough, North Yorkshire

Number of practices in PCN
7

Number of patients in PCN
50,000

PCN hires (ARRS employed)
2.5 care co-ordinators
4 social prescribers
2 pharmacists
1 pharmacy tech
2.5 physiotherapists
1 mental health practitioner

Recruiting (ARRS roles still to fill)
Pharmacist
Physician associate
Paramedic

The challenges faced in the pandemic by our PCN are not unique. We had to evolve fast to deliver the vaccination programme alongside our general practice duties. I believe the trust we've built up in these times is essential to the way we work.

Covid vaccine programme

The vaccine programme became my personal ikigai – a Japanese word for purpose, motivation, reason for living. Many of us lost loved ones and colleagues to Covid and the vaccination programme gave us a positive way to fight back. I felt that all the years of my leadership journey were coming to fruition with this vaccination programme.

We started the service in January 2021. We chose a small practice with a list of 2,000 patients to be the designated vaccination hub – it has a large parking area and its sister practice was able to absorb the patient footfall. We set up temporary cabins at the front and back of the building to create a one-way system, check-in and observation area.

We consulted with patients and commissioners and nominated a receptionist to field queries. Our patients were very understanding.

Setting up the vaccination hub also gave us experience in working with the local authority and businesses. We had to ensure adequate street lighting, road gritting, police and street warden patrols. This was a real taste of working beyond the realms of general practice.

There was also the work of setting up for vaccination. We assembled a team of 30-40 vaccinators who would rotate through the hub. Our pharmacists and pharmacy technician, recruited through the additional roles reimbursement scheme (ARRS), were also trained by the clinical lead at the PCN to become vaccinators.

We also became a vaccination training hub for the local fire services, who then worked in mass vaccination centres and other PCNs.

We linked with local sixth form schools and our site became a hub for work experience. These young adults will be our future workforce and we feel proud that we have played a role in shaping their life experiences.

We also recruited around 30 volunteers who have continued to support us through the programme. While this created additional work with a contract, a lead practice and an induction, they formed an integral part of our team and felt aligned to our PCN.

After the first round of first doses we created 'Covid vaccine warrior' badges and certificates for all our staff and volunteers.

As the vaccination programme progressed, we released the hub site for some days of the week for normal running of the host practice.

Get boosted

When the announcement was made on 12 December to accelerate the booster programme, we were not surprised. However, we were fatigued by the increased general practice workload alongside the work of delivering vaccination clinics. And we were finding it was tough to keep up with the ever-changing guidelines on testing, isolating and PPE.

Two practices in our PCN opted out of the booster programme because of workforce issues, but the remaining practices absorbed the work.

By this time our ARRS appointments were well established. Our physiotherapist and mental health practitioner were able to support in direct patient care. Our pharmacist and technician managed the vaccination hub and also helped vaccinate. The care co-ordinators multitasked between admin roles at the vaccination site, marshalling, booking patients and also supporting housebound and care home vaccinations.

We've been working on shifting sands with Covid for the past year. At first, when we met with NHS England and the CCG, it seemed it might be necessary to cancel holiday leave in practices, but we managed to find a solution that improved capacity for vaccination and did not affect the much awaited Christmas and New Year break. We got authorisation from the CCG to open a practice for extra hours from 6pm to 9pm and opened extra clinics for the first week of January for those who preferred not to be vaccinated in the holidays.

We'd already been quite agile and set up more than 25 pop-up vaccination clinics for hard-to-reach areas.

Our first pop-up vaccination site was at a mosque and was sparked by vaccine hesitancy in the local BAME group. With support from local religious leaders and other community leaders, we vaccinated 185 people with their first dose in May 2021. This attracted a lot of media attention and was recognised in November with a local award. We won for the public health teams' Covid champions – a mixture of lay and council workers who help with community outreach by myth-busting and distributing leaflets.

There are significant areas of deprivation in our community. Car ownership is low, which makes it hard for some people to get to vaccination sites. We took vaccines to charity shops in these areas and were encouraged by the uptake.

Walking through the mall, I noticed many shop units were empty, so we worked with the council who talked to landlords about using them for pop-up clinics. We have now done two pop-up clinics in the heart of the centre and have another planned for the Valentine's Day weekend.

Dr Vaishali Nanda (in scrubs) and volunteers at the Mobile Educational Learning Improving Simulation Safety Activities (MELISSA) bus Covid vaccination pop-up clinic in Middlesbrough, North Yorkshire.

Our next project is vaccinating the homeless, working with charities and public health.

We hope that the relationships we have built during the vaccination programme will go further. For example, in the BAME community we have poor uptake of cervical smears and learning disability health checks. We also suspect that people in this community do not readily seek help for family members who are developing dementia. They see it as part of ageing and become carers without seeking advice and support. We are doing research to assess whether this is just our perception or if it is a reality and if so we'll seek a way to support the carers and the patients.

We have appointed a multilingual care co-ordinator who understands the culture. I feel this will help us develop better connections with the community.

As a PCN we have delivered approximately 45,000 vaccines, including first, second and booster. We delivered at a scale that was unprecedented and was certainly needed.

We now need to look at the sustainability of the vaccine programme. The vaccination site needs to return to full-time general practice duties so patient care is not affected.

I think it would be a shame to lose all the work we've done by only having mass vaccination sites. These do not work for everyone – for those without a car, the vulnerable, the elderly, those in care homes.

There should continue to be a range of options and the vaccine should also be brought into practices and administered like the flu jab.

And there is, of course, the other PCN work we want to focus on.

Beyond Covid

People in the North East don't get the benefits they are entitled to so we are working with a benefits adviser to address this as poverty leads to poor health. Working with our neighbouring PCN and local authority, we are setting up a project to put a benefits adviser in our practices on a few days a week.

We also now have much better links with public health at the council so we are hoping to build on that by working jointly to address health inequalities as part of the DES for the PCN. We have a joint working group with two other PCNs in our area and the local authority, and have identified our key priorities. With an overarching theme of addressing poverty, we will be looking to address mental health and alcohol-related problems.

> **We hope that the relationships we built in the Covid vaccination programme will go further**
> Dr Vaishali Nanda

We have challenges with estates, which are woefully inadequate to take on the additional roles. I don't feel new staff are well suited to remote working. Unless premises are created where PCN staff can work together, the sense of belonging will be missing.

We struggle to secure the resources to handhold, to welcome and integrate these new members. While the reimbursement of the salary takes away the financial strain, it does not always cover the finances involved in recruiting, managing and the usual HR processes.

We have employed a PCN manager but there is no extra funding directed to the PCN to support this financially. Lack of adequate administration support will burden practice managers and this needs to be addressed.

We also want to focus on leadership development to establish a model of distributed leadership.

The vaccine programme has really shown how important the PCN structure is and how vital it is that we work beyond our practices – so we hope to build on that to tackle the other health issues in primary care in our area.

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

CLARIFYING THE FACE-TO-FACE ADVICE

Hi primary care front-line colleagues! It's Penny here again, the friendly face of the Primary Care Support and Strategic Integration Unit (PCSSIU).

In this edition of the bulletin, I thought it would be good to share some of the many questions you send us. Do keep them coming.

I'm constantly asked what we're doing in the primary care support unit to prevent GPs from leaving the profession. It's a great question. Here are just a few of the initiatives we have in place.

The PCSSIU offers a range of support for GPs and practice staff suffering from stress and burnout through our accredited partners. These include wellbeing and resilience sessions and a range of 'quick guides' containing tips and strategies for managing your time, being a more effective leader, and coping cheerfully with relentless pressure.

We work with national and professional bodies on strategies to encourage new entrants to the profession and to persuade recently retired GPs to come out of retirement. We frequently hear how you value the support and advice of older GPs who can share the benefit of their experience and tell you 'What it was like in my day' and 'Why you shouldn't do it that way'.

PCNs have made a huge difference to GP workloads already and that can only improve as Covid pressures begin to ease. Anecdotal evidence suggests that a single practice pharmacist or paramedic can do the work of three GPs at a fraction of the cost.

Our social media and poster campaigns also play a significant part in maintaining morale and boosting job satisfaction. We have had excellent feedback on our recent campaigns, including What Else Would You Do? and What's So Great About Canada and New Zealand Anyway?

Finally, we know from our surveys that you really appreciate being kept up to date through regular communications by email and in newsletters like this. When we asked recently, 'Would you like to continue to receive this bulletin or would you prefer to risk contract sanctions and lost income by missing an important item of information?' 97% of you chose to opt in. The figures speak for themselves.

Returning to 'business as usual'

Several of you have asked 'Do we need to return to routine general practice or can we just rely on volunteers to keep the money rolling in from Covid vaccinations?'

We have an official answer to that question from the national primary care team at NHS England. You should by now have received a letter from Nikki Kanani and Ed Waller, but just in case PCSE has mislaid your contact details, I've summarised the main points below.

- Thank you for all you've done, etc. It has been noted.
- Uptake of Covid vaccines is falling, so it's time to return to 'business as usual'.
- You must see patients face to face when it's clinically appropriate. You are usually best placed to make that decision, but the BMA, the RCGP, NHS England and your local CCG/ICS will sometimes be best placed to decide what a best-placed decision looks like.
- National communications campaigns will direct patients who didn't come forward during Covid to seek an immediate appointment with their GP if they're worried about anything they've just read about in a national communications campaign.
- You will be expected to manage symptomatic Covid patients in the community. Note that this is now part of routine care, not additional work.
- Uptake of vaccines is falling, so it's up to you to redouble your efforts to get them to vulnerable groups including care home staff and others who don't yet know that they want them or actively don't want them.
- We value your professional judgment, so we will continue to provide guidance on how to set your clinical priorities.
- Thanks again. Do take care, etc.

Training matters. Period

I've had a query from a GP specialising in menstrual disorders who wants to whether she needs to complete mandatory training before running a virtual menopause clinic.

The answer, of course, is yes. End-of-life care, fire safety, blood transfusion, sepsis and anti-radicalisation training are as relevant online as they are face to face.

What if a patient were to report a large blood spillage? How many hypoclorite tablets would you advise them to dissolve in a litre of water – one, 10, 50? Fumbling for an answer would seriously undermine your professional credibility.

What would you do if a patient had to tackle a chip-pan fire during one of your sessions? Could you tell them which type of extinguisher to use? Would you want disfiguring burns or secondary infection on your conscience?

And, if the worst were to happen, would you want to be the one to explain to their next of kin that despite 10 years of medical training, you weren't adequately prepared to deal with the situation?

Training is training, and it's mandatory for a reason.

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

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