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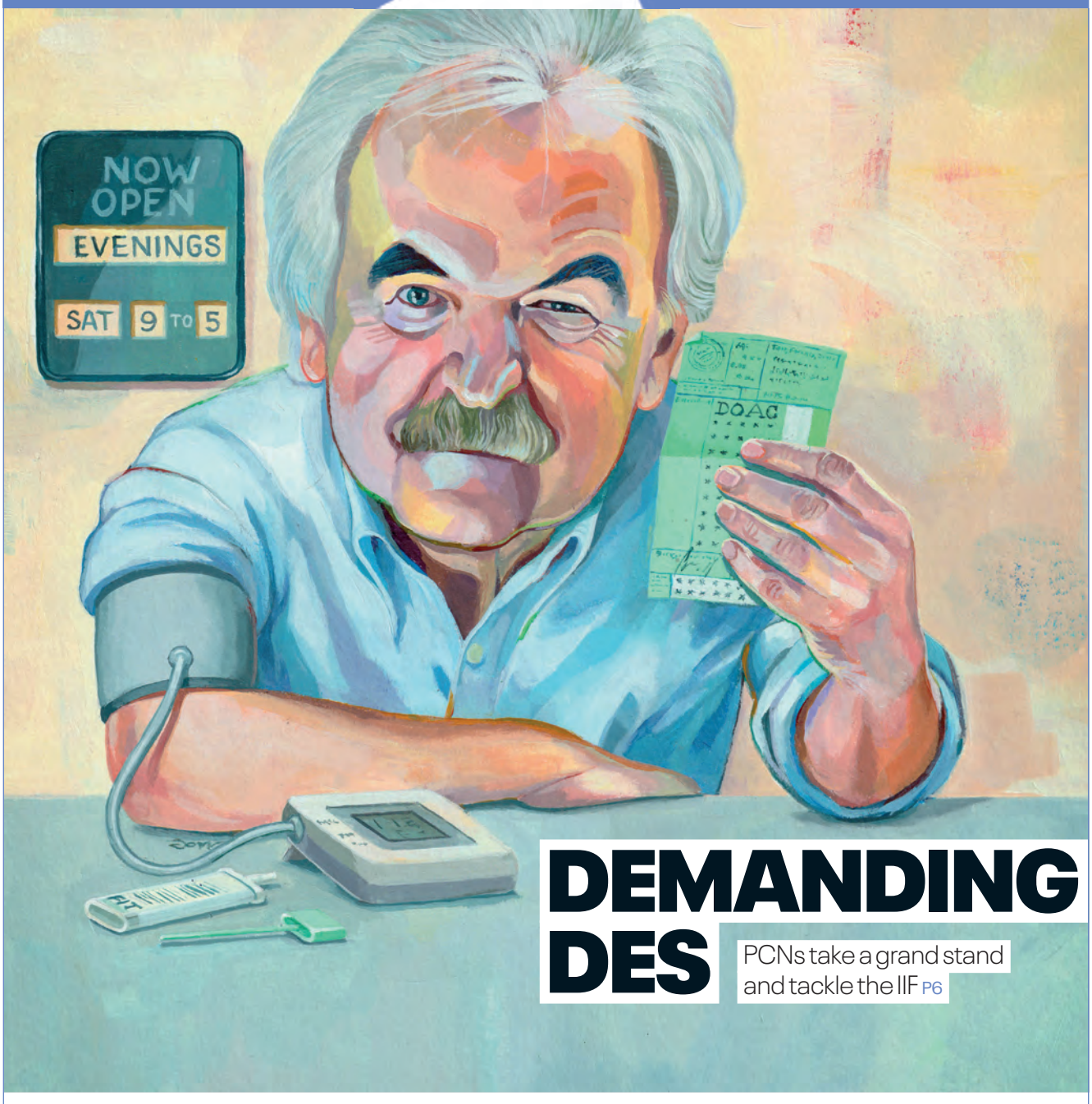
BRITISH SOCIETY OF MAGAZINE EDITORS

PULSE PCN
CONNECTING PRIMARY CARE NETWORKS
SUMMER 2022

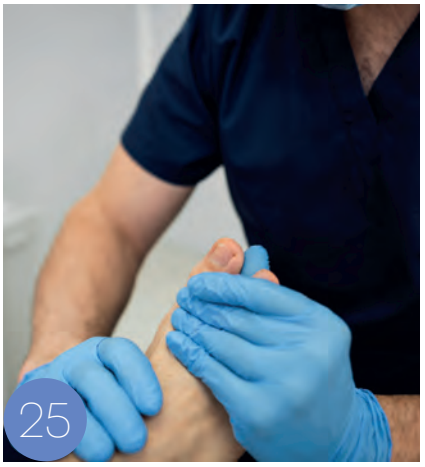


DEMANDING DES

PCNs take a grand stand and tackle the IIF P6

INSIDE

SUMMER 2022



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ICBs TO TAKE OVER FROM CCGs ON 1 JULY

By Jess Hacker

The Health and Social Care Act has received royal assent, meaning CCGs will be replaced by integrated care boards (ICBs) this summer.

Following the passing of the bill into law on 28 April, the Department for Health and Social Care (DHSC) and NHS England have agreed for ICBs to formally take commissioning responsibilities from 1 July.

ICBs were initially intended to gain statutory footing from 1 April, but this has been delayed to 'allow sufficient time' for the remaining parliamentary stages of the bill.

Across England, 42 ICBs have been set up already but are still operating as non-statutory bodies.

GP leaders had previously warned that the 'vital expertise' of GPs could be lost with the demise of CCGs. Each of the new boards is required to appoint just one GP.

Under the act, which is intended to boost healthcare integration, budgets for general practice will be pooled with secondary care cash to create single funding pots – and new powers will make it easier to develop joint budgets with public health authorities.

The Government said the act will also:

- Establish the Health Services Safety Investigations Body, an independent public body intended to investigate incidents of patient safety to help improve systems and practices.
- Improve data sharing between health and social care services in a bid to reduce unnecessary delays for patients.

- Reduce bureaucracy, to improve care and free-staff time.
- Address health disparities in oral health and obesity, with greater regulation of advertising for unhealthy foods and drinks.
- Ensure transparency about spending allocated to mental health.

NHS chief executive Amanda Pritchard said: 'As the NHS works flat out to recover services and address the Covid-19 backlogs, these reforms will accelerate the changes set out in the NHS Long-Term Plan that are already giving people greater choice, better support and more joined-up care when they need it.'

ICB chair designate for Nottingham Kathy McLean said: 'By building on lessons from the pandemic we will support our staff to make the impactful changes in the Long-Term Plan. This bill ensures we can rebuild from the pandemic while supporting each other for the public's benefit.'

NHS ENGLAND LOWERS THRESHOLDS FOR DOAC IIF INDICATOR

NHS England has reduced the thresholds for an Investment and Impact Fund (IIF) indicator that incentivises PCN practices to prescribe a specific direct oral anticoagulant (DOAC).

The indicator – initially communicated in a letter sent to practices in March – specifies that GPs should start new patients on edoxaban, and also consider switching patients where clinically appropriate.

Under updates to the 2022/23 network contract issued on 31 March, NHS England reduced the lower and upper thresholds for the CVD-06 indicator to 25% and 35% respectively, from 40% and 60%.

The draft figures had caused concern among some PCN clinical directors (CDs) that the workload would be too great, but the lower thresholds have eased some of the worries.

However, GP finance expert Dr Gavin Jamie estimates the updated indicator will mean the average PCN of 50,000 patients would still need to switch around 180 patients onto edoxaban.

He added that the size of the task, which would yield on average about £69 per patient switched, varied around the country.

Dr Jamie said: 'There are six CCGs that are already over that 35% threshold and should qualify for the full funding without changing prescribing . Two – Norfolk & Waveney CCG, and Bedfordshire, Luton and Milton Keynes CCG – are comfortably over 40%, although there may be some variation at PCN level.'

He added: 'However, we can say that Rotherham CCG in South Yorkshire, at 5%, will have to get about 30% of its patients, giving an effective payment per patient switched of about £50. This is still a significant rise.'

The IIF indicator was announced two months after NHS England entered into a national procurement agreement with several manufacturers – including those of edoxaban – with the aim that savings made would allow more patients to be diagnosed and treated.

Dr Manu Agrawal, CD at Cannock North PCN, said that pursuing the IIF indicator would present GPs with an 'ethical dilemma', wherein clinicians may ask patients to change their medication 'without actually having any clinical evidence'.

He said: 'What PCN CDs and practices are asking for is evidence from NHS England to support informed shared decision-making with patients to switch medications.'

Dr Saul Kaufman, CD for St John's Wood and Maida Vale PCN in north-west London, said: 'Often what is not factored into these financial equations is the time taken talking to patients about the switch. I think basing decisions solely on cost with the input of clinicians isn't a good way to make decisions about healthcare, although I acknowledge that finance is an important consideration for medicines, especially on a national level'.

Dr Shahed Ahmad, NHS England's national CD for cardiovascular disease prevention, said: 'Our national plan to accelerate the uptake of DOACs could see over 600,000 more patients receive treatment over the next three years, with the opportunity to prevent tens of thousands of stroke events.

'This activity has been clinically led and in line with NICE guidance, NHS recommendations make clear that it is for the prescribing clinician to determine which DOACs are clinically appropriate for an individual patient.'

NHS England declined to clarify why the thresholds were lowered.

ONLINE

For the full story visit pulsetoday.co.uk/news/pulse-pcn/nhs-england-lowers-thresholds-for-doac-iif-indicator/

NEW RULES ON EDOXABAN

Indicator	Description	Thresholds
CVD-06	**Number of patients who are currently prescribed edoxaban, as a percentage of patients on the QOF atrial fibrillation register and with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a DOAC**	**25% (lower) 35% (upper)**

Source: NHS England

GETTY

DEMANDING DES

PCNs are forced to decide which targets are achievable in the new Network DES. *Emma Wilkinson* reports

The release of the long-awaited new Network DES on 31 March has left many clinical directors (CDs) taking a careful look at what they are able to achieve, bearing in mind the pressures they are under, the work required and the resource provided.

It comes with a potentially significant boost to funding through additional roles reimbursement scheme (ARRS) rises from £12.30 to £16.70 per patient and an increase in mental health roles as well as a dramatic expansion to the investment and impact fund (IIF) from 389 to 1,153 available points at £200 per point achieved.

Yet while the IIF service specifications on cardiovascular disease prevention, care homes, cancer, personalised and anticipatory care are familiar to PCNs, the level of work required to achieve this new tranche of funding is not.

It includes three new indicators, which are being supported by £34.6m of funding focusing on prescribing of oral anticoagulants in atrial fibrillation and faecal immunochemical testing (FIT) as part of urgent referrals for suspected lower gastrointestinal cancer.

As always with PCN funding, the headline figures include a fair amount of caveat. The longed-for flexibility in ARRS roles has not materialised, and much of the core funding, including CD payments, has not moved at all, leaving PCNs to fund cost-of-living increases alone.

The aspect of the DES that caused the biggest stir was the compulsory requirement for PCNs to provide enhanced access between 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays from October.

After repeated calls for clarification, it emerged that PCNs will have to provide appointments through the full period, not just within those hours.

Dr Laura Mount, CD at Central and West Warrington PCN in Cheshire, says she is still digesting what it means for them, especially what is possible with the IIF, and it's taking time to process. 'We're trying our best but it's huge.'

She is concerned about the extra pressure it will put on practices. 'I can't push my practices to breaking point. There is only so much I can ask them to do.'

"I can't push my practices to breaking point; they can only do so much

Dr Laura Mount

Strategic approach

The prevailing view seems to be that the IIF will have to be approached strategically and pragmatically if PCNs are to avoid overstretching themselves for targets they are unlikely to meet.

Overall, the funding does not compare well with the amount of work that will need to be done, says Dr Emma Rowley-Conwy, CD of Streatham PCN in south London.

'We're going to have to evaluate each target and decide if it's achievable for the money. Some of them we will decide not to do. It's overwhelming how many things there are and it will be different from our approach to QOF which was just achieve, achieve, achieve.'

Dr Mount takes a similar view and is going through the indicators one by one: 'I hope we're already good on some of it. Other things we will do if they're really important and will benefit patients because it's the right thing to do. But there are some we know we may not achieve and we will have to resign ourselves to that.'

On cardiovascular disease, many PCNs have already done a lot of work on hypertension, buying additional blood pressure machines. Yet there are serious questions about whether it is appropriate to use the IIF to incentivise a switch of patients to a specific direct oral anticoagulant (DOAC), edoxaban, on cost grounds.

NHS England has now lowered the IIF thresholds from 40% and 60% to 25% and 35% after concerns from CDs that switching patients would be too much work.

Dr Sajid Nazir, CD of Viaduct Care PCN in Huddersfield, West Yorkshire, said GPs are used to CCGs asking them to do medicine switches. 'You see this all the time, but then a year later the original drug comes off patent and is suddenly cheaper and you're asking people to move back.

'I'm not sure why it's been moved into the PCN and it opens the door to other things. It is also a huge amount of work because it's often not one consultation. There is a potentially large impact.'

What often isn't considered is the extra work generated to achieve the indicators, he says.

'The CVD targets are good in terms of picking up more people with hypertension to get them treated appropriately, but if you're suddenly getting hundreds of people diagnosed together and you might not have ARRS staff to do that work it puts more pressure on services,' he says.

There is also little acknowledgment of the work practices are already doing to catch up on chronic disease management and deal with post-pandemic demand, he adds. Their biggest worry is structured medication reviews taking up all of their clinical pharmacists' time.

'When you plot how many we need to do per week to achieve the indicators it's huge and we wouldn't be able to do it even if we employed more staff.'

He adds: 'And what happens to all the rest of the work they have been doing on medicines management and chronic disease management? It's give with one hand and take away with another.'

Some areas have been doing GP FIT testing to accompany cancer referrals for a while, making achievement seem simple on paper. But, says Dr Mount, they must be careful to ensure referrals are not delayed.

'It seems to suggest that the result will have to accompany the referral, so we will need to have conversations locally about what that means. What I don't want is a two-week-wait referral to be rejected or to sit for weeks on end with no one dealing with it.'

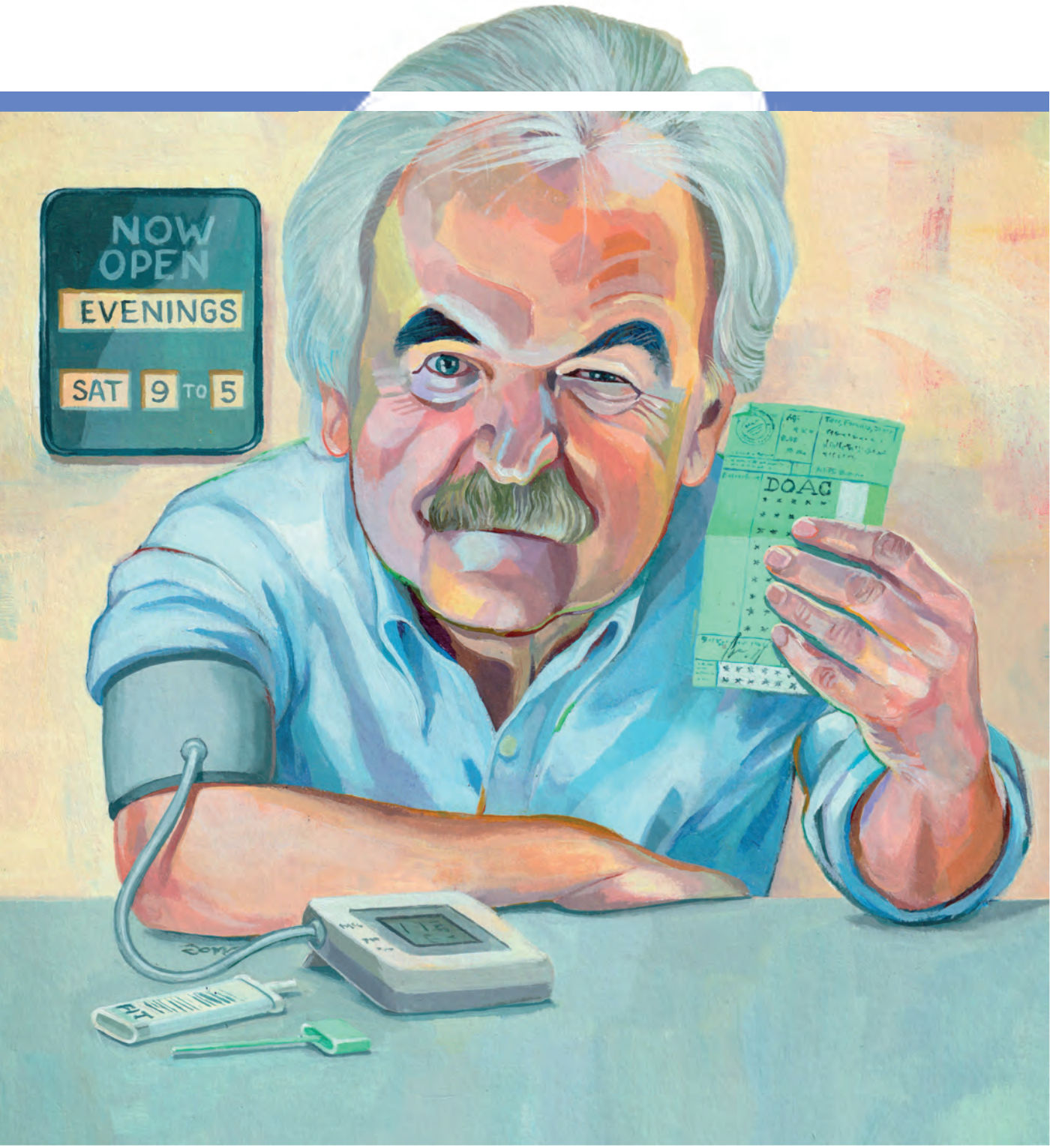
Dr Nazir raises the point that one issue they had locally even before this indicator was introduced was a shortage of FIT testing tubes. 'We're almost rationed already; we can't get hold of them. So there's a danger we're going to start falling behind. I'm worried about this delaying referrals,' he says.

Inequalities

While CDs are keen to tackle neighbourhood health inequalities there are concerns about whether the demands of the DES will get the desired results.

Dr Mount says that if the Government is 'really serious' about →

JON BERKELEY


NOW
OPEN
EVENINGS
SAT 9 TO 5
DOAC

SUMMARY OF INDICATORS: DOMAIN ONE

Domain	Area	Indicators
Prevention and tackling health inequalities	Vaccination and immunisation	VI-01: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
		VI-02: Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
		VI-03: Percentage of patients aged two or three years on 31 August 2022 who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
	Tackling health inequalities	HI-01: Percentage of patients on the QOF learning disability register aged 14 or over, who received an annual learning disability health check and have a completed health action plan
		HI-02: Percentage of registered patients with a recording of ethnicity on their GP record
	CVD prevention	CVD-01: Percentage of patients aged 18 or over with an elevated blood pressure reading (≥140/90mmHg) and not on the QOF hypertension register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension
		CVD-02: Percentage of registered patients on the QOF hypertension register
		CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20%, who are currently treated with statins
		CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia
		CVD-05: Percentage of patients on the QOF atrial fibrillation register and with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a vitamin K antagonist
		CVD-06: Number of patients that are currently prescribed edoxaban, as a percentage of patients on the QOF atrial fibrillation register with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a DOAC

ONLINE For the full IIF information visit
england.nhs.uk/wp-content/uploads/2022/03/B1357-investment-and-impact-fund-2022-23-updated-guidance-march-2022.pdf

improving inequalities it 'would look at where they really are, and fund work in areas of inequality'.

'But instead they want you to look within your PCN. We enjoy doing this work. We have set up a service for housebound patients and do proactive care and we do a lot of hypertension and atrial fibrillation outreach work. We did lots of Covid outreach, and that's enjoyable, but it's inconsistent because each PCN is doing something very different and maybe there needs to be more sharing of learning.

'We never know what to pick across the many things you could do. The health inequalities dashboard is often out of date, and we don't have data analysts,' she adds.

Dr Nazir says, 'With health inequalities, on the surface, [for example] with the flu [IIF indicator] for adults we it do anyway and we learnt a lot from Covid vaccinations about recall and getting through to people so that's not a massive concern. But flu vaccines for two to three-year-old children is something we have struggled with as a PCN - it's been very hard to reach out.

'The concern with this, along with some other indicators, like A&E attendance, is that you are exacerbating health inequalities despite doing tonnes more work. Patients don't turn up or they keep going to A&E despite your efforts.

'I'm not sure if the IIF is best for that sort of target because it doesn't really address those issues or give solutions. More needs to be invested in education,' he adds.

We might be exacerbating health inequalities despite doing more work
Dr Sajid Nazir

Workforce

Dr Partha Ganguli, CD of South Ribble PCN in Lancashire, believes workforce problems are a serious impediment to achieving IIF points. The increase in the ARRS is not necessarily for the types of staff they need, including nurses, and a significant chunk of funding in their area has not been taken up anyway.

'If there was an opportunity to divert that money for general practice needs that would be the best option. There are lots of limitations including availability of workforce and flexibility,' he says.

They too are concerned that their clinical pharmacists – who were employed to increase capacity – will be tied up trying to achieve targets.

'We're missing the fundamental point that they are there to improve access to care,' he adds.

In Streatham, any increase in ARRS funding has already been swallowed by London weighting, explains Dr Rowley-Conwy. They have already avoided hiring mental health practitioners because they know it would be impossible to get staff.

Some of the difficulty PCNs might have in achieving targets is if they are already doing well in an area, for instance, access. They will struggle to show an improvement. 'And it's not because they're doing badly,' she adds. 'It's just badly worded.'

Dr Mount notes that getting ARRS roles in place, with training and supervision, has absorbed a huge amount of their core funding. 'We have had to set up a quality committee to monitor the care they're providing, patient experience and outcomes. We are like mini-CCGs.' But CCGs had teams of people and experience in things like data analysis. 'Everything seems to be falling to us.'

Dr Nazir says there's been 'no acknowledgment' that there is a lot of catch-up work to do. 'We should have had a year to reset,' he says, adding that staff resilience and morale needs to be considered.

'I'm glad we recruited our PCN manager a few months ago because it is a full-time job to keep on top of all this,' says Dr Nazir. 'I'm not sure how PCNs are doing this if they don't have dedicated staff.'

This event is intended for healthcare professionals only.

NUTRICIA ACADEMY
Feed your mind

08.45	**REGISTRATION AND REFRESHMENTS**
09.30	**Welcome from Nutricia** **Victoria Blewett,** Medical Affairs Director, Nutricia
09.40	**Chairperson Opening** **Dr Anne Holdoway, BSc DHealth RD FBDA,** Consultant Dietitian, Fellow of the British Dietetic Association, Education Officer, British Association for Parenteral and Enteral Nutrition
09.50	**Breaking Down Peptide-Based Feeds: Who, Why, and When to use?** **Mary Phillips,** Senior Specialist Dietitian, Royal Surrey County Hospital
10.30	**TEA & COFFEE BREAK**
11.00	**Showcasing the Extended Roles of Dietitians:** **Dysphagia Practitioner** **Laura Clarke,** Clinical Dietetic Team Lead and Dysphagia Practitioner, Doncaster Care Group **Supplementary Prescriber** **Alison Culkin,** Lead Intestinal Failure and Rehabilitation Dietitian, St Mark's Hospital, London **Extended Role in Enteral Feeding, including the placement of feeding tubes** **Clare Lewis,** Advanced Dietetic Practitioner, Salisbury NHS Foundation Trust
12.00	**The 3P's of Cancer Prehabilitation... Prepare, Prepare, Prepare** **Mhairi Donald,** Consultant Dietitian Oncology, Sussex Cancer Centre
12.40	**LUNCH BREAK**
13.40	**Chairperson Address**
13.50	**The Emerging Role of a PCN Dietitian** **Kayennat Toofany,** Primary Care Network Dietitian, Dudley Integrated Healthcare NHS Trust
14.30	**Protein Quality as well as Quantity and their interactions with exercise** **Professor Phillip J Atherton Ph.D, AFHEA,** Chair of Clinical, Metabolic & Molecular Physiology, The University of Nottingham
15.10	**TEA & COFFEE BREAK**
15.40	**Driving Sustainability in Tube Feeding - A Best Practice Example** **Odette Dicke,** Advanced Dietitian Paediatrics, University Hospitals Sussex NHS Foundation Trust
16.20	**Final Questions & Close** **Dr Anne Holdoway**

ALL ABOARD

CDs are motivated and want to help patients, but the dictatorial tone of the DES makes it hard to keep practices on board

The Health and Care Act 2022 has set the wheels in motion for the Integrated Care System (ICS) to let go of the brakes and charge ahead to improve care for the populations in their patch in an integrated way. And as the integrated care boards (ICBs), the drivers of this giant system, begin to accelerate, the pressure is building lower down the chain for PCNs.

In the engine room, PCNs are grappling with the demands of the DES (see our cover story , page 6). When deciding what to go for out of the 1,153 points available in the Impact and Investment Fund (IIF), the prevailing view is that clinical directors (CDs) will choose indicators with the most gain for patients and practices and the least pain for their worn-out, pandemic-fatigued staff.

Similarly, the enhanced access ask in the DES has got CDs in a spin (see our roundtable, page 15). Our sister magazine Pulse sought clarification from NHS England and was told that 'yes' the contract does mean that a GP must be present during the network standard hours of 6.30pm to 8pm Monday to Friday and 9am to 5pm on Saturday. The BMA said that was not the case because of the ambiguity of the contract.

The jury is still out on whether this means a face-to-face presence, or on call, or via remote consultation. It is also unclear at the time of going to press whether there would be a breach of contract if PCNs make sensible decisions based on the needs of their population and perhaps don't include face-to-face GP time throughout the enhanced access hours.

PCN CDs at our roundtable were largely positive about the move, believing it to be good for working patients, a chance to catch up on various health checks and potentially an opportunity for team development on quieter Saturdays. But in other areas the idea of asking staff to take on more is a non-starter. What is striking, although not surprising, is the variation in PCNs and their resilience to cope with the new demands of the DES. For some, enhanced access nearly broke up the network and it was only eleventh-hour reassurances that the federation would take on the work that kept the network on track.

And part of this negativity is the fact that this Network DES feels imposed. It doesn't feel like a collaboration. It feels like coercion – and that has put some CDs in an uncomfortable position. CDs are the doers, they are motivated and want to increase the wellbeing and lives of their patients, but the more dictatorial the tone from NHS England the less chance there is of keeping practices on board. Also, CDs feel that the negativity from the BMA about the DES and the focus on opting out is not representative of them or helpful.

To combat this discord and capitalise on this moment where ICBs are about to take charge, PCNs could get together to form general practice leadership groups (see our online column by Ben Gowland) on the same footprint as the ICBs. These groups are already forming in some areas as there is no point expecting the ICB to come to PCNs. A leadership group would provide a strong primary care voice, use primary care leaders' strategic voice – perhaps even that of CCG chairs – and rise above the negativity, turn conflict to collaboration and endeavour to get everyone on board before the train leaves the station.

Victoria Vaughan is editor of PCN

SEASONS OF CHANGE

As we start our fourth year as networks, I feel there is much to be hopeful about

Spring is a season of change, where we see the shoots and buds of what will be the flowers and fruits of summer and autumn. Similarly the NHS, this April, saw the start of the PCN contract and next month will see the formal start of integrated care boards (ICBs), subject to Parliament. Change and new beginnings can be seen as a challenge as well as an opportunity.

So, what does the future hold for PCNs and at-scale primary care collaboration? How do we build on the foundation our networks have laid in their first three years, while being realistic about what is achievable? How do we continue to inspire and support colleagues to flourish and innovate, and not be overwhelmed by the day job with its rising demand and complexity?

There is no quick answer. Being honest with ourselves and colleagues about the challenges is important. Using the collective talents in our networks will be critical for future success. However, as we start our fourth year as networks, I feel there is much to be hopeful about: working with neighbouring practices and local community care teams, sharing best practice, bottom-up innovation, new roles and additional investment in networks.

Although there is a wide spectrum of challenges with the 2022/23 PCN contract, there are many elements to support the long-term sustainability of primary care, while helping our patients and communities. For instance, this year's £280m uplift in additional roles investment, with the hope we see 21,000 full-time equivalent (FTE) additional roles in PCNs by March 2023. Nowhere else in the NHS will we see workforce numbers rise in such a short time, with the aim of creating a wider MDT approach to primary care.

Sadly, this will not be a quick fix to primary care workforce issues as colleagues from the additional roles reimbursement scheme (ARRS) require support and supervision – for many this is their first role in primary care. But if we hold our nerve and embed these roles they should bring a new way of working in the longer term.

The ongoing investment in primary care clinical and non-clinical leadership in networks is key to future success, to ensure primary care at scale has a strong voice in developing places and systems as the health and care landscape shifts. Whether supporting care-home residents through the enhanced care in care homes specification or addressing PCN health inequalities, the at-scale collaborative approach brings economies of scale that will be good for the populations we serve, and should reduce demand.

Will this fix all of today's problems? No, but it does give a solid foundation for the future.

This isn't something our networks can do alone. We need to ensure they are supported nationally, and at a system and place level, now and in the future. We await the Fuller Stocktake to see what system-level support will look like.

We need to make sure our networks and primary care provider collaboratives develop a strong collective voice. Primary care's voice at a system level remains critical for the success of any integrated care system (ICS) because if primary care fails, the NHS fails. We must remain open to the wealth of opportunities that PCNs offer us and our patients and to developing solutions together.

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

ENHANCED ACCESS

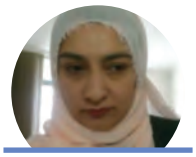
PCN clinical directors joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss the arrangements for enhanced access

GETTY

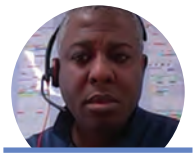
DELEGATES

Dr Emma Chapman
Clinical director (CD) at North Dartmoor PCN, Mid Devon

Dr Bal Duper
CD at Oldham East PCN, outer Manchester



Dr Farzana Hussain
GP in Newham, former CD at Newham Central 1 PCN, East London

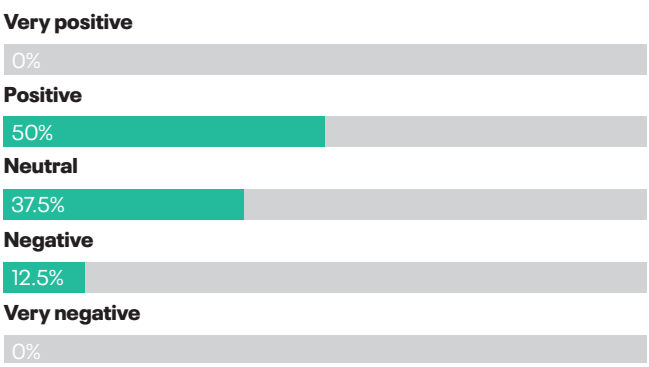


Dr Seun Akande
CD at West of Waverly PCN, Surrey

Dr Shanika Sharma
CD at Barking and Dagenham PCN

Dr Roy Boodhun
CD at Ivel Valley South, Central Bedford

HOW DO YOU FEEL ABOUT EXTENDED ACCESS?



Victoria How has your PCN responded to the enhanced access requirement in the new Network DES?

Sarit The key [thing to remember] is that we're all starting from a slightly different baseline. We've had extended access services for a while in our borough, we've got the infrastructure, it won't be a big ask to deliver it. We're relatively positive about it, it's just going to be a continuation of business as usual. We'll still probably be offering services beyond the 9am to 5pm stipulated in the DES with locally commissioned incentives. From my perspective in London it's not going to be a terrible departure from what we're doing now. But I fully understand that there are places around the country where it may be much more challenging to deliver without the existing infrastructure.

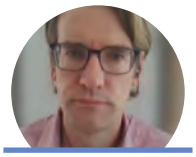
Geetha We're in a slightly similar or even better position than that, because our extended access now is delivered by the federation. But luckily, the staff who run it are mainly based in our PCN. So, like Sarit, we don't see it as a big burden. We've been asking to deliver it as a PCN and to come out of the federation model from the CCG for quite a few months now. So we think it will be better for the patients. There is always the balance of how you do the day job and do this; that's always going to be one of the considerations.

Emma We're a very small semi-rural PCN. We've only got 25,000 patients – a larger practice and four smaller practices. We're already providing this as part of the DES anyway. And it's giving us more flexibility to use other healthcare professionals so it doesn't have to be so GP heavy. [That] will be easier, and might be more beneficial to the patients. I guess I've not properly looked into the finer details about how much flexibility we're going to have. Can we do more group work and things like that? I think there's potential here, and I think some of my colleagues felt it was a burden, but when you go to the wider group, we've got quite good cover from the healthcare assistants and the nurses. We've got a lot of clinical pharmacists happy to do some later hours. And some of the

Dr Sajid Nazir
CD at Viaduct Care Network, Stockport

Dr Sarit Ghosh
CD at Enfield Unity PCN, north London

Dr Geetha Chandrasekaran
CD at North Halifax PCN, West Yorkshire



Dr Robin Harlow
CD at Gosport Central PCN, Hampshire

Chair Victoria Vaughan
Pulse PCN editor

JULIAN CLAXTON

GPs prefer doing really early mornings rather than evenings or weekends. I'm glad to see we don't have to do Sundays, because actually patients don't want to have input on a Sunday, I think they like a day off for normal life. [As for] the Saturday, if we have to cover 9am to 5pm, that could be a challenge, because most people would rather work for just the morning. But even on a small scale like ours, I think we can meet the hours because we've got flexibility with the workforce.

Shanika I'm in a similar situation to Sarit in terms of London and having extended access and GP hubs mobilised for eight years now, and providing services. It becomes challenging in areas that don't have established federations, or the working relationships between federations and PCNs.

The other thing is the maturity and structure of different PCNs. If you've got a smaller PCN with a few practices, it's easier to design and deliver something. But some PCNs have more than 10 practices, which can be challenging. There are enablers that need to be looked into, such as estates, workforce and interoperability, which again, some PCNs are really struggling with. Having said that, overall I'm quite positive about it. We had an evening meeting at the end of April with our practices about the correspondence from the LMCs and BMA General Practitioners Committee (GPC) [which said] practices can opt out of the enhanced access and the PCN DES. As with everything, some PCNs are feeling positive about it, but some are worried because key enablers are not in place for them.

In a small PCN it's easy to deliver, but not in PCNs with 10 practices
Dr Shanika Sharma

Roy We're a semi-rural area, and we seem to be struggling to do extended hours anyway, so the thought of doing both has put a lot of people off. Until 28 April, two out of five practices were thinking about opting out. I've had lots of discussions with them about the pros and cons, about PCNs doing great work, so they did decide to opt in.

Our plans are to discuss more with the federation, which is offering the service. The practices in my PCN don't wish to contribute to it, we want someone else to do it – because everyone is concerned about burnout. And even the additional roles reimbursement scheme (ARRS) staff don't seem to be keen to do anything. So, we're very reliant on commissioning [this] to somebody else. But there seem to be a couple of options in my area that are quite credible.

Robin I feel like I'm an outlier, which is a surprise, hearing everyone's positive comments about enhanced access. We have a federation that provides extended access for us at the moment, and we do our extended hours. We're talking about the options in the PCNs in our area, about how we can deliver [enhanced access] and whether we'll be able to do a fluid model and subcontract it to the federation to deliver. But to take that back in house and deliver it ourselves as a PCN in Gosport is going to be a real challenge. I think the federation also has challenges in getting →

Nobody has talked about the dilution of continuity of care

Dr Bal Duper

GPs to deliver the extended hours [and] face-to-face appointments in Gosport as well. I know we've got lots of flexibility, but that is a challenge, and recruitment is also a challenge in my area, as I'm sure it is in many other areas. If we had to do this ourselves as a PCN we would really struggle – we struggle with the extended hours we're providing at the moment. We are doing it, but it is a challenge.

Also, people have delivered the Covid vaccine programme over the last two years, and staff are tired. I'm less positive about [enhanced access], and whether we'll have the flexibility to do early starts. Obviously, we need to get patient engagement and CCG support. Are we trying to stretch our teams and clinical staff too much to deliver something that we can deliver in core hours for the majority of people?

Bal The people in this discussion are signed up to PCNs – we are enablers. But I agree, Robin – there are real big challenges with recruitment and dilution of the concept of general practice and continuity of care, which nobody's talked about. They are an unintended consequence of a lot of the stuff we're doing. And the upshot of that is the aggravation our patients are venting to us. We've got challenges in Oldham with recruitment, [but we will do it]. However, I would echo what Robin says, that there are key concepts of general practice that we need to [consider] about continuity of care, about core hours.

Seun In West of Waverley, we're semi-rural with 47,000 patients. We have what we'd call improved access here, which is run largely by our federation. We are looking at opportunities to improve on what we are offering, but there are challenges. We've talked about the GP IT systems, and workforce, and continuity. There is a challenge though, that large parts of the profession feel this has been imposed without adequate consultation. And because in primary care we're doers, we will get about doing it. But this is damaging the trust between the profession and NHS England, [a trust that] continues to be undermined with time. That will be a big issue down the road, even if we get over this hump right now.

Sajid Our federation is delivering the extended access, but we're going to change things as our PCN has decided we can deliver it better for our patients. And there's good buy-in from the practices. We run the vaccination service in a similar way, using a number of staff who aren't necessarily employed by the PCN, so we've developed a large bank of staff, both clinical and admin, who are all keen to carry on. So, we're feeling positive. There are concerns about manning space, especially on a Saturday, for 52 weeks in a year. But we see it as an opportunity. We think the funding is fair for the work. And we've got some plans together.

Victoria How will you manage workforce issues where there are challenges?

Roy Certainly everyone in my member practices seems to think they can't do any more. We're trying to consolidate that as much as we can. We've had some meetings with the federation. It doesn't currently provide extended access, but it has given us a plan of action about how it might. It has a large bank of staff in the Milton Keynes area, and we're hopeful, with more discussions, to have some of those staff to cover our area. To be honest, in my PCN everyone's scared about doing extra work, working a Saturday on top of Monday to Friday. [Perhaps] when we come to the nitty-gritty [of whether] one person can cover a Saturday [every couple of months], it might become less scary for some of the member practices.

Emma When we talk about the contract with partners and our PCN board members there's reluctance – 'I can't do any more, I can't.' But when we put it out to our wider staff, it's surprising how many people came forward

GETTY

saying they were happy to do it. We might have to pay them time and a half at the weekend but we have got the budget to do that because it is well remunerated. We found in our locality that we'll try to portion out hours per practice on patient list size. Or if people want to do more, they can volunteer. The hours that are offered at individual practice sites are usually used by their own practice population. If we're looking at doing one in six or one in eight [Saturdays] it doesn't seem that terrible. And I think that it becomes even less [onerous] when [some people ask to do] a few more hours [because they'd like] a bit more money.'

IS THE FUNDING ATTACHED TO THIS ENOUGH?

Victoria Why are some PCNs choosing to bring enhanced access in house from the federation?

Geetha Our federation has done a great job delivering it over the past few years, however we feel our population needs [are difficult to deliver at scale], because we're quite a deprived area. We thought by bringing it into our PCN, we could serve our population better. Being able to complete a consultation on the day is one of the things we wanted to bring it back to our PCN for, because we felt some federation commissions weren't completing that. [There's also] the actual patient contact and patient care – we know as GPs that's what we relish, having the one-to-one with our own patients. So smaller was better for us.

Shanika We're a borough-wide model. Across Barking and Dagenham we've got six PCNs and we don't want all six to go in different directions with enhanced access because it's going to confuse the patients. So we're trying to design a borough-wide offer. The federation has come forward with a proposal that the PCN and the practices are quite positive about. But as Geetha says, there are differences in the PCNs and the populations and the needs of the PCNs. We need a balance. We're going for an economy of scale and are thinking about sharing a call centre with one of our neighbouring boroughs. But there are niches in a PCN that need flexibility. For example, our PCN has a very high diabetic population, so we might need some appointments to focus solely on diabetic reviews.

Sarit Our federation never delivered the extended access hubs. It was a lead practice model. The current architecture of the borough does not support much change. But I think Geetha's raised a good point – what's the main difference and the main opportunity for PCNs providing this? It is to reduce duplication and improve efficiency. This is a good opportunity to streamline pathways and give patients better access.

Seun Our plans are still at the initial stages; nothing's been agreed. [We think] this will be done at place level across the four PCNs and are working with our federation on this. I don't think there's an appetite to bring this into the PCN. [It's a big] ask in terms of providing the service and having to look after the clinical risk and governance issues. And our federation is already providing something quite good. But, again, even within the same patch, there are quite marked differences between the PCNs. Even if we're thinking of a uniform approach, we'll want to tailor to each PCN.

Victoria There is a sense that enhanced access has been imposed and this has created a negative atmosphere. How do you navigate that?

Bal There's a sense of battle weariness at the moment in general practice. Yes, I think there is a sense that this has been imposed.

I think many GPs can see the value of it. But there is also the other side of the coin, that it is imposition rather than collaboration.

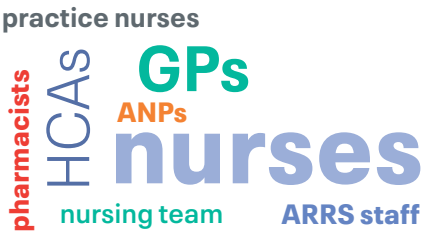
What we set out to do, three years ago as PCNs, was to try to help our practices to reduce their workload, and [the dynamic of] this is really interesting. [It's been] pushed into a PCN contract without a conversation. And that produces [resistance] in the extreme. So, for example, we get the BMA saying: 'Let's cut core hours down.' The LMC is saying: 'Let's resign from the PCNs, don't sign up.' And many of us who did the PCN stuff feel all that narrative starts to feed into negativity. I think that's really wrong because enhanced access is a really positive thing. If it had been landed in a different way, we could have done it in a positive way. We could have looked at helping GPs to manage the workload.

The other issue I've got is with workforce. I'm the clinical officer for a small provider federation and this will cannibalise our staff. I understand what is being said, that people want to take extra hours on. They'll do it for six months, or12 months, but I've been providing for services for over three years and people's resilience starts to wane as time goes on. Then as a provider, you put your rates up. And federations and out-of-hours providers are already increasing their rates. It's going to start cannibalising the workforce we need in general practice.

Seun Whether it's us in primary care or the folks at the NHS, everyone means well. The concern is that communication seems to be breaking down and that's not healthy for us, or for the patients we serve.

There's also a fundamental question here: is more access the →

WHO WILL COVER THESE APPOINTMENTS?



The most important thing to change patient behaviour is a trusted relationship, which general practice already has

Dr Farzana Hussain

solution to the problems in general practice? What data underpin this? Because what we may see in two years' time is all these enhanced access appointments get saturated.

I think we need to be smarter. Do we know the people we see? What cohorts of patients do we see the most? We sit on a load of data in primary care that we don't know about. And when we extract the data, we don't have the head space to analyse it and use it to deploy care. We need help with that, to improve care and work in a smarter way.

Farzana It's obvious extended access is here to win political votes. Access is something the Government is crazy about and always has been. East London has had something called the GP co-op for nearly 30 years, [providing] urgent care. Our federation has been doing extended access for it. But Bal's point is really important. I don't think we're going to cannibalise the workforce, I believe we already have.

If I'm a GP, if I'm a mum, why wouldn't I work a Saturday afternoon where I only have to see four patients at 15-minute intervals? Why would I be running my own practice of 5,000 [patients], having to go in when somebody's sick, when somebody's got Covid?

We have to implement this because it is the political narrative and it's quite easy. In fact, the remuneration is generous. But this is a way to kill off general practice. And it's a way to kill off PCNs because the only way we can deliver this is at scale and [Prime Minister] Boris Johnson will get lots of votes because we are access mad. But anybody who runs a smaller practice like mine will know patients want to see GPs. There's no evidence that extended hours initiatives have reduced core hours work. This is not going to reduce work in general practice. We don't have the GPs and we couldn't afford it with GPs. We've got ARRS roles but who is going to do the DES if they're all doing enhanced access?

WILL THE EXTENDED ACCESS IMPROVE ACCESS TO APPOINTMENTS FOR PATIENTS?

Improve

40%

Stay the same

20%

Don't know

40%

Victoria What are the benefits and opportunities of enhanced access?

Bal The first few meetings for our PCN were antagonistic. As we've moved along, relationships and partnership are working. Stronger networks with other practices could be important. This may be mini-PCN federations or practices working together.

There are lots of positives we could take from this because it's going to give an opportunity to work with other clinicians in a less pressured environment than the Monday morning when there are 50 patients. If we can work it right, it might strengthen some aspects of general practice.

Sajid We piloted a winter hub, 5pm to 8pm from December until now, which was funded separately through the CCG – and it made a huge difference. Once practices were full they were allowed to spill over into that clinic. We're just running the feedback.

We learned lots of things in terms of prescribing and setting up an electronic prescription service and there were lots of teething issues but we've worked them out and it's a big opportunity to do things at that scale. We're looking at spirometry at PCN level because it's becoming difficult to provide that at a practice level. We're thinking about training some ARRS staff to provide some services. If you get it right it benefits patients, reduces waiting times and takes pressure away from practices. Of course there's an agenda behind all of this that is putting increased pressure on all of us but there are opportunities.

Seun I see three opportunities. First, there is a great opportunity to co-produce this with patients and get the input from the people we serve on how to make this service even better. Second, it's a great opportunity for collaboration between practices. I'm lucky to lead a PCN where the four practices have similar ideas. And third, it's an opportunity to improve what we offer already and make sure not as much work goes back to the practices.

Shanika In terms of the positives, it's patient choice. A lot of young patients with chronic conditions can't attend reviews in core hours. It's the same for screenings and immunisations. So we're looking at this as an opportunity to work at a place level with our wider stakeholders, public health and the local authority. Also, we can design something that serves our population and provides more flexibility in terms of access. But it does need a lot of thinking and planning. But those are the things we're hoping enhanced access will give us an opportunity to do.

Farzana The idea of more hours and access for patients is very positive. Obviously, I'm in an area where it's not new. I particularly feel for places like Emma's, where there is a massive geography, but I'm working in an area that's a four-mile radius.

If we're going to make this successful we need to collaborate – and that's not telling practices and PCNs what to do. There's a lot of competition in the system – federations are a business, PCNs are a business and so are practices. I'm trying to find something positive – real collaboration rather than one trying to take over another because of size.

Also, we need to think about how it operates. Why is an extended hours appointment 15 minutes and a practice [appointment is] 10? We need to give patients a real uniform service. And taking Shanika's point, yes, [our] area [has] a lot of inequalities, but is it just about hours? Because we're dealing with human beings and the most important thing to change behaviour is a trusted relationship.

So I leave that as a challenge for at-scale general practice – to build up that relationship, which GP practices have done for years. I believe that's a challenge that [working] at scale cannot cope with.

AN IMPOSITION

The much awaited, or much feared, PCN DES is out and there are no surprises.

With no negotiations done with the BMA General Practitioners Committee (GPC), it has the feel of an imposed and ill-considered contract.

Most of the previous targets have been increased. The additional roles reimbursement scheme (ARRS), along with the DES is still very restrictive and micromanaged.

I won't discuss every indicator, but let's look at some interesting ones.

Faecal immunochemical testing (FIT) for colorectal pathways has been a topic of discussion in our area for a while, and is now coming through the investment and impact fund (IIF). Why? Because although NHS England and politicians want us to refer more patients with potential cancer, they have not commissioned enough capacity in secondary care. Naturally the brunt of this is borne by GPs. Although the NICE guidance is not being updated, there will be a push to do FIT tests even for barn-door referrals. Previously, I asked the CCG to get hospitals to send FIT tests out and do their own triage for referrals, but they want us to do it. But there is the potential for missed cancers and the whole medicolegal risk will sit with us. We should push for secondary care to do this as part of their triage process, not ours.

With regard to the switching of patients to edoxaban – no evidence has been provided by NHS England for why we should do this. If the reason is cost, it should be stated in black and white. GPs are not averse to having difficult conversations with patients, but we would appreciate evidence or support to facilitate them. The lack of evidence creates an ethical dilemma for clinicians.

Our PCN's practices have decided to put ethics and patient safety first and we will not actively pursue those two IIF targets. If we hit them, we hit them, but not at the expense of patient care, our workload and wellbeing.

Then there is enhanced access. Confusion reigns. We wondered, do we need a GP present all the time? The contract mentions supervision could be remote. The GPC asked for clarification, and NHS England said yes, we need a GP at all times - as reported by Pulse. The way things are going we will need to have GP cover throughout our core hours from 8am to 6.30pm, then during the enhanced access hours of 6.30pm to 8pm and on Saturdays. I wouldn't be surprised if these hours move into our core GMS contract and we end up providing seven-day cover, maybe even for 24 hours.

But I am hoping practices and CCGs will be more reasonable when deciding what is best for their local needs. I suggest all PCNs do the same, and seek LMC support where they need it. Certainly in our area we understand it to mean that a GP must be available on call or via remote appointments but not necessarily physically ever-present. Practices did not even have clarity until before the 30 April opt-out from the PCN DES. To protect their dwindling incomes and because no alternative has been offered by our leaders, most have signed up. This will be sold as a huge success by NHS England.

However, with significant funding going into IIF, the only positive of the DES is that practices will have the luxury of choosing what is deliverable rather than burning out to achieve everything.

We have decided not to actively pursue two of the IIF targets

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

LEADING QUESTIONS

***Professor Jim McManus*, president of the Association of Directors of Public Health and director of public health at Hertfordshire County Council, discusses PCNs and population health management**

What's your view of PCNs as a vehicle to improve the health of their populations?
They have a very important role, but they need to understand the parameters, because they're not going to massively solve wider determinants such as housing or education. If PCNs and their partners build the right relationships, they could be a game-changer in health.

How can public health work with PCNs?
We can do the joint strategic needs assessment, preventive services and building pathways and protocols. We can build relationships with the third sector because we've got commissioning pathways. We can help you reach out to people. There's a lot of stuff we can do that PCNs don't need to revisit.

Would you advise clinical directors (CDs) to get in touch with their public health department?
This will sound very time intensive, but not by having a board meeting. Instead, sit down and have a discussion on what you want to achieve. Improving the health of the population is like creating a machine to build the services. There are cogs and parts that do different things. You need to get a working model of that system. That is best done sitting around a table talking, not in a board meeting.

One of the lessons from Covid is that we shared information and we need to keep doing that
Professor Jim McManus

Is the public health directors' link with the NHS at place level rather than directly with PCNs?
It varies. If you look at Hertfordshire, we're a massive county geographically, 37 settlements. As a team you need relationships with the multiple bits of the NHS. There are other places, maybe unitary authorities, where the geographical layouts are less complicated. I can't have a strong relationship with every PCN and pharmacy team in the county, even though I'd want it. But we do need some relationship. Most directors of public health will tell you their commissioning budget could be a lot bigger and they could commission a lot more from primary care. And we know it's effective. We know that for every £1 you spend on it, there's a £4 return from public health.

How do you think you'll work with the NHS in this new structure?
The first thing for me is how the local authority leans into the integrated care system (ICS). I think that's a corporate thing, not just a public health thing. In our area, a lot of us are leaning into the ICS as a team. The Department of Public Health (DPH) is not just interested in public health issues. We're looking at system issues as a local authority. That goes into places like the integrated care board (ICB) as well as the integrated care partnership (ICP) and then the place boards. I think you want somebody in the public health team to be leaning into the place boards. But the issue is which input is best for which bit of the system. So where does the joint strategic needs assessment input, for example? Does it input just to the ICB or to the ICP where they're planning stuff, or into place, or all of them? There are no rules on this, which is a good thing if you can find local solutions. The risk is if you don't find any solutions. The challenge we now face is how we wire what public health can bring into the ICS organism, which is a multi-system organism. Local government can do more about social determinants than our NHS colleagues. But that means you need a mature conversation across the system about what prevention means, whose job it is and the role of public health. To say it's everybody's job is not enough.

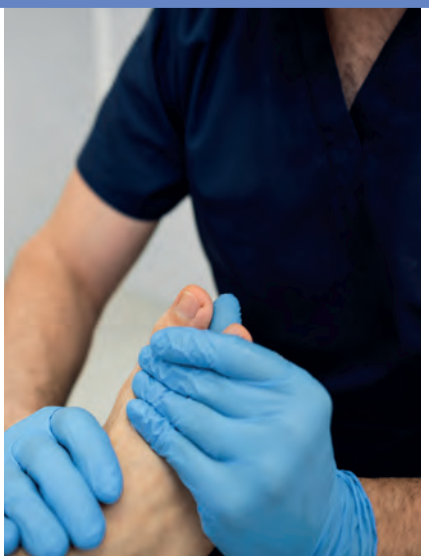
What kind of data does public health hold that CDs could benefit from but don't know about?
Public health teams have some data, but we get data from other people and we start with local authorities. Most local authorities will have lists of people who are vulnerable, need their bins collected, are known to social care or on benefits. During Covid, the areas that successfully supported vulnerable people compiled a list of lists, and contacted people for delivering things like food parcels. Now, a lot of those data streams have been shut off, and arguably we should be continuing them. Data protection issues can lengthen the process. One of the lessons from Covid is that we shared information, and we need to keep doing that. If you compare the bin list with a GP practice list, which has been done in a number of areas, it produces interesting composite results. It isn't the legislation that's the primary barrier. It is the mindset and the existence of shared secure data systems.

What's the difference between population health and public health?
We've complicated the language. Either we should talk about public health, or population health. My personal preference is public health because it has a 150-year pedigree. Population health management is a sub-discipline of public health that seeks to understand differential risk in defined populations in clinical services. It identifies ways to improve healthy life expectancy. Population health management started as bringing together data analytics, clinical pathways, algorithms and evidence for clinical service populations. It is not just public health done by doctors. It is a sub-discipline that crosses the boundaries between clinical public health, clinical medicine and clinical healthcare, and requires all of those to be sitting around a table, and centres on a defined clinical population. It won't change all of the health of a population. It won't prevent smoking, and we know that from the evidence. But it will massively improve lives by getting people healthier and out of the GP surgery. I call it really good data-driven clinical care. I think the language has complicated something that is about the best of primary care, the best of public health and the best of the voluntary sector all working together to get the best for patients.

WORK WITH A PODIATRIST

Clinical director and GP partner *Dr Joe Robson* shares his experience of working alongside first contact practitioner podiatrist *Richard Keating*, now a year into the role

Northamptonshire Rural PCN is a group of five practices in a rural setting. The network serves just over 50,000 patients, who can experience difficulties accessing specialist services that are located in urban centres.



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Why did we recruit a podiatrist?

The PCN recognised that a significant percentage of demand related to musculoskeletal (MSK) conditions. We felt we could manage this more effectively by developing a primary care MSK team. Our concept was an expansion of the first contact practitioner (FCP) model, with patients directed to physiotherapists or podiatrists as appropriate.

We hoped this would allow patients faster access to diagnosis, and also comprehensive and timely management advice. Ultimately, it's about streamlining and improving the patient journey. However, we also wanted to enhance the areas of expertise in our teams so we could reduce demand on GP appointments.

What did the hiring process look like?

Since podiatrists are experts in all aspects of foot and lower limb function and health, they can have wide-ranging subspecialties from MSK to high-risk foot management.

So it was important to ensure we recruited a podiatrist with the skills that matched our vision for our service. We were looking to recruit a podiatrist with a strong background in MSK medicine as we already have pathways for high-risk foot services in our area.

Key requirements for the role are:

- A BSc or equivalent in podiatric medicine.
- Registration with the healthcare and professions council.
- Evidence of being able to work at master's degree level in the practice, or willingness to undertake this on appointment.
- Experience of operating at an advanced level of practice.

The job was salary mapped between band 7 and band 8 on the Agenda for Change pay scale and posted on the NHS jobs website.

What does the podiatrist do for the PCN?

Our FCP podiatrist, Richard, has been in post for 12 months now. He spends one day a week at each practice. Receptionists can book patients directly into his diary, either as a first contact or secondary contact when a GP or other clinical staff member feels the patient might benefit. Each appointment is around 20 minutes long and the podiatrist sees, on average, 17 patients a day.

Soon after hiring Richard, we drew up criteria setting out which patients were suitable to be seen by him. In general, the podiatrist will see any foot or ankle problem for assessment.

We have found there are also benefits to using the skills of an FCP podiatrist in a more generic fashion. A recent audit has shown that roughly 30% of cases signposted to the FCP podiatrist by other clinicians were dermatology-based complaints, and around 1% of patients are offered nail surgery.

Richard will assess and offer treatments, including advice on footwear, exercise and off-the-shelf insoles. In addition, he can request investigations, including bloods and imaging, act on the imaging reports and refer the patient to secondary care providers for further treatment, if needed.

Treatments that can be provided under the primary care contract, such as toenail surgery and steroid injections, can also be administered.

What support does the role require?

Our podiatrist works mostly autonomously. However he is subject to supervision, as required under the Health Education England (HEE) FCP Roadmap to Practice, and these are duties that involve GPs. A designated GP at PCN level spends one to two hours a week with Richard to help him complete the roadmap.

Other nominated GPs work with Richard day to day, giving him a debrief at the end of each clinical session on cases outside his scope of practice until he is signed off as having demonstrated competence.

How has the podiatrist helped practices so far?

Audit is a required component of the roadmap and we hope to have hard data in the near future that show the impact the role has had. In the meantime, the patients have responded positively to this direct access to a podiatrist.

Primary care colleagues also report that they feel under less strain. They no longer have to deal with common conditions like plantar fasciitis, which frees them up to focus on problems that require their specific skills.

In addition, colleagues have also found that taking a more team-oriented approach has benefited their learning.

Richard has developed a good working relationship with local orthopaedic and podiatric surgery departments, which have reported they are happy with the conservative care patients receive prior to their referral.

Dr Joe Robson is CD at Northamptonshire Rural PCN and a GP partner at Greens Norton and Weedon Medical Practice, Towcester, Northhamptonshire

Richard Keating is an FCP podiatrist at Northamptonshire Rural PCN

DEVELOP A PRESCRIPTION ORDERING DIRECT SERVICE

***Dr Neil Paul* offers advice for PCNs thinking about developing a pharmacy prescription ordering direct (POD) service to save costs and reduce medicines waste**

Increasingly, PCNs and groups of practices are looking to identify opportunities to work at scale and increase efficiency.

One interesting option is a pharmacy prescription ordering direct (POD) service, to share the management of repeat and acute prescribing requests. A POD enables patients of participating practices to call a central dedicated number and speak to a trained adviser, or use an online form, when needing to order a repeat prescription. In other words, it's a team of people who process some or all of the prescriptions on behalf of multiple practices.

The size and expertise of the team bring numerous benefits. First, there is huge variation between the way practices handle prescription requests. Some handle them all within 24 hours, some take three days or more. At request stage, some put a huge amount of work into ensuring safety, quality and cost saving, while others issue the prescription and carry out medication reviews whenever they can. PODs are a single team handling prescriptions, which should improve standardisation and reduce variation between practices, also cutting down on medicines waste.

PODs can also save money, increase profits and reduce the bureaucratic burden on managers and GPs. They can reduce staff turnover by improving training, and ease pressure on reception staff because fewer calls will be made to practices.

Several areas around the country already have PODs, such as Kent, the West Midlands, Sussex and Norfolk. If your PCN is considering adopting this model, the following tips might help.

1 Think about funding
Additional Roles Reimbursement Scheme (ARRS) funding for pharmacists and pharmacy technicians could cover much of the staffing costs for a POD, although money will have to be found for management costs. It might be reasonable to use any relevant PCN funding, such as DES funds or other pots like primary care development funding.

Remember that when employing staff, you need to be mindful of VAT liability. Seek advice from your accountant.

2 Define your purpose
Decide on the main aims and objectives. Are you aiming to increase efficiency, or profitability, or raise the quality and robustness of prescribing methods? Do you want the POD to include structured medication reviews and medicines use reviews?

3 Consider starting small
Some PODs offer specific services only, such as repeat requests from nursing homes or requests from patients that are housebound, frail or elderly.

4 Alternatively, do you already have a prototype POD in place?
If you have PCN-level pharmacists working on behalf of all your practices, there may be an opportunity to discuss how to expand and grow their service.

5 Engage with practices
Explain how the scheme will benefit them. Look at what each practice does now and learn from the best. You don't need all practices to engage with this. The service can involve just two or three at first.

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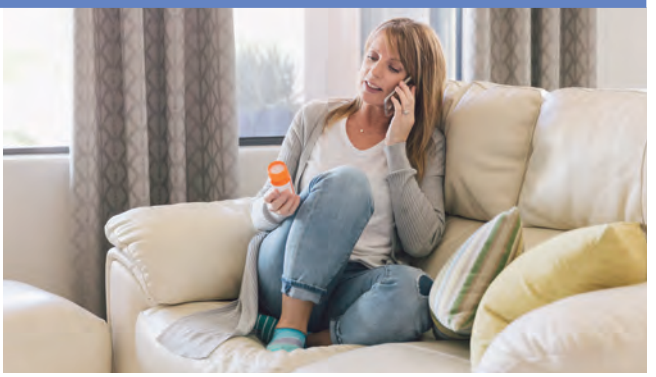

6 Assess what workforce is needed to run the POD
Should practices lend their ARRS staff or should they resource it with funds, so staff can be employed centrally? Think about creating a project management role for the POD since practice managers are already busy.

7 Agree how the POD team can access support
If a team member needs help from a GP or other clinician, do they need to call on the patient's registered GP, the on-call GP, or the last GP that saw them? You need to agree on processes that work for all.

8 Think about data sharing and IT
Ideally, staff need access to all patients from all practices.

9 Decide on a location for the service
You may need a new site for the team if there is insufficient space at a single practice. Alternatively, if you use a distributed model, you will have to consider how that will be managed.

10 Check agreements
Can your PCN DES agreement cover this new service? Set up a memorandum of understanding for all the decisions. Include tie-in periods, to prevent a practice pulling out and halting the service.

11 Communicate with the public
You may need to allay patients' fears, for instance that the scheme is part of a takeover from the private sector.

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

PULSE Intelligence

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FINDING NEW ROADS TO WELLBEING

***Dr Amit Sharma*, clinical director of Earley+ PCN in West Berkshire, explains why his network is focusing attention on providing quality mental health support**

The rising demand from patients for mental health support, much of which GPs did not have the time or training to address, led our PCN on the outskirts of Reading to focus on this issue.

We are located in an affluent area with low unemployment and good schools, which is attractive to families and those wanting to live outside London where housing is more affordable.

Our demographics show an even split between men and women. The population is largely white British but with many other ethnic groups well represented – Indian, Pakistani, and Chinese. Our average age is 38 years, which means that as a practice we are not funded as well by the GP contract.

We looked at population health management data, which identified us as a practice with the highest proportion of adult mental health patients compared with others locally – approximately 16% of our adult population. A significant proportion of the working population has a depression or anxiety diagnosis, or both. A large part of our work has been to demedicalise the issue. By partnering with One Front Door (OFD), part of Citizens Advice, we began helping patients to address their social, emotional, physical and practical needs instead of giving a prescription.

Our approach came from the sense that much of the poor mental health we saw was from lifestyle and non-medical causes. Patients wanted to get better, but did not know how to go about it. So we referred our patients to OFD , which signposted them to local organisations and charities.

Also, we employed three health and wellbeing advisers (HWAs) to help patients to engage in their own wellbeing with a holistic approach, providing strategies and choices to help them avoid the need for medication in the first place, or to reduce their need for it over time.

Clinical director
Dr Amit Sharma

Practice
Brookside Group Practice

PCN
Earley+ PCN

Location
West Berkshire

Number of practices in PCN
2

Number of patients in PCN
30,500

PCN hires (ARRS employed)
3 health and wellbeing advisers/ coaches
1 pharmacy technician
2 clinical pharmacists
2 physician associates
1 first-contact physiotherapist
1 advanced practitioner

Recruiting (ARRS roles still to fill)
Mental health practitioner (adult and child), nurse associate, two to three more physician associates this year

PATIENT FEEDBACK ABOUT THE SERVICE

- **'The service is a lifeline for people who don't necessarily know where to turn. I appreciate the way you dealt with me, you listened, were empathetic and took the time. I am still worried about the future, but I don't feel quite as frantic, scared and despairing.'**
- **'I wish I had accessed support like this 15 years ago. It feels like I have been on a hamster wheel that was never ending and now I'm free.'**
- **'Alongside the talking therapies and self-help guides, these sessions helped my mental health enormously.'**
- **'Now that I have been doing the right exercises for a while, I can see the difference they have made in reducing my back pain. That has not only helped my physical wellbeing but also my mental state as I feel I am finally doing something that is taking me in the right direction and has given me a lot of hope.'**
- **'These sessions have given me options for how to deal with my health anxiety in a more proactive way, which in turn has helped my emotional and physical wellbeing.'**
- **'I felt I genuinely mattered during the sessions. From the much-appreciated information you provided, I obtained very useful tips on jobhunting techniques that ultimately led to me getting a job. The fact that the job is something I love doing is a great bonus too.'**

Our HWAs have completed mental health first-aid training, social prescriber-plus training and a health coaching course.

Between October 2020 and April 2021, 475 of our patients were helped by OFD. They were largely aged between 30 and 54. The majority needed help with health and community care support, which includes support specific to Covid guidance. They also needed help with finance (benefits and debt), employment and housing.

We also have a full time MIND wellbeing worker seconded to the practice who has become an integral part of the team. And we have two physician associates who specialise in mental health, who conduct mental health reviews with patients who are on regular medication and those with severe mental illness.

We offer coaching sessions for our patients with the same HWA for a duration of three to six months. The frequency of appointments is agreed between the patient and the HWA. In addition to this, our team has also conducted educational webinars in partnership with NHS talking therapies about managing anxiety.

Help for anxious parents

We identified that a significant proportion of our on-the-day and emergency demand was from anxious parents who were not confident about where to go or what to do when they were concerned about

From left: PCN manager Sarah Simpson, CD Dr Amit Sharma, physician associate Tanya Ali

their children's health. So we created a live virtual group consultation for anxious postnatal mums to educate and give them confidence about where and when to access healthcare support.

Taking help to the community

As part of a community approach, our HWA team ran a health and wellbeing fair to bring together patients and local organisations and charities who wanted to support people's wellbeing. There were 15 organisations including Link & The Friendship Alliance, Christians Against Poverty, Involve, Healthwatch, Earley Community Centre, Reading Men's Shed and, of course, OFD. About 70 patients attended and discovered what was on their doorstep to help them improve their mental health and overall wellbeing.

How it's working

Our HWAs are providing 90 hours of HWA work for the PCN's patients. We also have a full-time wellbeing worker from MIND.

Between July 2021 and January 2022 we have had 391 new patient referrals. There are more than 1,000 patient contacts per month. The approximate case load per HWA per month is 50-60 patients.

Very few of our GPs are now seeing patients with mental health or emotional wellbeing issues. We can ensure our patients are being seen by the most appropriate members of our team.

> **We hope there will be fewer patients who need medication for anxiety and depression**
>
> Dr Amit Sharma

Looking to the future

We hope that in the future, more patients will find the help they need outside the GP practice, through self-care, connection and engagement with community and non-medical support, or through counselling and wellbeing coaching.

We hope there will be fewer patients who need medication to manage anxiety and depression and that there will be better support for patients who are in need.

We want to improve the sharing of information and collaboration with secondary care for more complex patients.

We are also looking to expand into working with children, young people and their families. And we are aiming to improve links with social workers, health visitors and community nursing along with exploring, identifying and addressing key health inequalities in our community by working with population health and by collaborating with key local organisations.

To achieve all this, we will need the right funding and personnel, investment in our practice sites and greater collaboration with other local organisations.

We are committed to doing this for our patients as we know they value the service, and it has helped our PCN practices function better by getting the appropriate care to these patients and freeing up valuable GP time.

PAUL STUART

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

A BEACON OF HINDSIGHT

Hi again, primary care fans. It's Penny here, from the Sackwell and Binthorpe ICS primary care support unit.

I've just spent a great couple of days getting to know some of you at Pulse Live and I'm going back to the office with plenty of food for thought.

The highlight of the event was an interview with Jeremy Hunt by Jaimie Kaffash, the editor of Pulse. Some of you may remember Jeremy as the longest-serving health secretary in history. It's not often you see people in power admit to their mistakes, but Jeremy was candid about the GP workforce crisis, acknowledging that he 'could have done a bit more to help'. He said he was also 'very sad' about junior doctors.

Because no one has time to read Pulse, especially as we push on with our popular extended hours plan, I have summarised the interview below.

A small miscalculation

Jaimie Kaffash You promised 5,000 more GPs. What happened?

Jeremy Hunt You don't make promises as secretary of state to have 5,000 more doctors or 50,000 more nurses or whatever unless you really mean it and have an inkling about how you're going to do it. With hindsight I think that was a miscalculation.

But it wasn't a number we plucked out of the air. The McKinsey team put months of research into it and concluded that we needed exactly 5,000 more GPs, which was the number that Comms agreed 'felt right in headlines'. We got the headlines but not the doctors, mainly because of a few unforeseen factors that I now bitterly regret not foreseeing.

JK And what were those factors?

JH How could we have predicted that because there were already too few staff dealing with a growing workload, some GPs would decide to go part time or retire early? How could we have known that NHS England, an organisation with a fabulous track record of supporting primary care and some brilliant service specifications at its disposal, would be unable to turn the situation around as fast as we'd hoped? Or might even, in a way that I now recognise to be entirely my fault, make matters worse?

So, there was nothing wrong with our plan. It was just that we didn't really have one. If you ask me what I regret most, that's in the top 10.

Making general practice magical again

JK So, what needs to be done?

JH The time for empty words has passed. We want GPs to be at the heart of the future in a very real sense. I want to bring the magic back into general practice in the same way Paul Daniels used to make every Saturday night magical when I was a boy.

Some people ask me if it's right to expect practices to open on Saturdays when they're already struggling with capacity. I always reply that, like Martin Luther King and [former NHS England chief executive] Simon Stevens, I have a dream. Or I turn the question around and ask them: why does Tinkerbell come back to life in Peter Pan? Is it because of the great team in ICU? No, it's because a hard-working GP made a timely referral and the children chose to believe in fairies as hard as they could. I take full responsibility for not believing in them harder myself during my time in office. We need to keep believing in general practice, however tough it is at the moment, and then everything will have a future in the very real sense I referred to earlier.

JK How disappointed are you to see the amendment defeated that would have compelled the Government to publish workforce figures regularly?

JH This is something I continually reproach myself for and I know it is a huge disappointment to Simon Stevens.

Now that Simon is no longer running the NHS, where he was obviously in no position to do anything about it, it's great to see him campaigning on workforce issues for several hours a week in the House of Lords.

Simon and I have talked about this, and we have both reached the conclusion that wisdom has a strange way of following events. Regrettably, sometimes it comes too late to do what in your heart of hearts you always knew needed to be done but were too consumed by the day job to do – whether that's standing for party leader or securing an important knighthood.

Last words

Penny here again. It's always inspiring to see our political leaders acknowledging that they don't get everything right first time. Your primary care support team is also committed to shining the light of hindsight on the challenges you face on the front line.

In my next newsletter we'll set out the opportunities for PCNs to contribute to the Sackwell and Binthorpe integrated care strategy, and how you can meet the expectation to 'get involved'. I'm sure you're as excited about it as I am.

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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