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PULSE PCN

CONNECTING PRIMARY CARE NETWORKS
AUTUMN 2022

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GP PRACTICES SIGN UP FOR DESs DESPITE BMA VETO

By Jess Hacker

Exclusive More than 99% of GP practices have signed up to the 2022/23 Network Contract DES, dashing speculation of a mass PCN exodus.

Figures obtained by Pulse via a freedom of information request indicate that only 50 of the 6,452 practices in England did not sign up to the PCN DES as of 28 June 2022: a sign-up rate of 99.2%.

This marks only a marginal decrease on the previous year, when around 99.5% of practices had signed the contract, with only 33 of the 6,595 practices failing to sign.

But just three months ago in June, the BMA, LMCs and some GPs demonstrated significant opposition to PCNs at the BMA's Annual Representative Meeting (ARM), where delegates voted in favour of GP practice withdrawal from PCNs by next year.

The motion also called for PCN funding to be moved into the core GP contract and charged the BMA's GP committee (GPC) with organising 'industrial action if necessary' to oppose the new contract.

Dr Paul Evans, chair of Gateshead and South Tyneside LMC and a GP, said: 'If we weren't desperate, more practices would have the luxury of being able to turn [the DES] down. But we are in a desperate place: whole-time equivalent (WTE) numbers are falling; patient numbers, their age and complexity are rising; there's no stream of new GPs wanting to work full time to save us.'

He added that aspects of the DES, such as the additional roles reimbursement scheme (ARRS), have entrenched practices into the contract, noting that because the number of WTE GPs has fallen, practices under the DES 'are now more dependent on [ARRS staff], even if they're not capable of acting independently in many cases'.

Dr Evans said that most practices will take 'some resources versus no resource, even if they are pitiful'.

Dr Jackie Applebee, chair of Tower Hamlets LMC in east London, said that while the data show that practices have not opted out of the DES en masse, the figures do not indicate how 'enthusiastically they are embracing it'.

NON-GP STAFF COULD DOUBLE BY 2030 AS GP SHORTFALL GROWS

By Jess Hacker

The number of general practice clinical staff who are not GPs or nurses could nearly double by 2030 if current trends continue, while the GP shortfall is expected to more than double.

The workforce projections, from the Health Foundation, predict the GP shortfall will increase from 4,200 whole-time equivalent (WTE) in 2021/22 to 6,700 WTE by 2023/24, and 8,800 WTE by 2030/31, based on current policy.

To make up the shortfall, in line with current policy focused on PCNs and the additional roles reimbursement (ARRS) scheme, the number of direct-patient care (DPC) staff (excluding GPs and practice nurses) could grow from around 25,400 WTE in 2021/22 to 55,300.

The Health Foundation projections also set out an 'optimistic' scenario where DPC staff could grow to 72,000 in the same time period if 'additional policy action facilitates increased use of a bigger and broader general practice workforce team'.

But it warned that if the PCN and ARRS initiatives fail to realise their potential, with no further workforce measures beyond 2023/24, the number of DPC staff could reach only 40,000 by the end of the decade.

This 'pessimistic' scenario would also see the Government fail to deliver on its manifesto pledge to hire 26,000 additional general practice staff by 2023/34.

The projections anticipate that the Government will also fail in all three scenarios to deliver on its pledge to deploy 6,000 GPs by 2023/34.

The Health Foundation said its projections 'highlight the inherent uncertainty' in how DPC staff numbers will grow beyond 2023/24, given 'the current lack of integrated workforce planning across general practice'.

It warned that its worst-case scenario would slow the push towards multidisciplinary general practice teams after this point, with newer ARRS-funded recruits ineffectively embedded in their team, leading to increased staff turnover and vacancy rates overall.

Practices and PCNs 'need support to manage organisational and team working changes' as they become more multidisciplinary, it said, including more effective supervision and greater clarity on non-clinical work.

NHS ENGLAND TO STEP IN IF PCNs CAN'T 'SAFELY' DELIVER ENHANCED ACCESS

By Caitlin Tilley

NHS England will step in to find alternative solutions with local commissioners if PCNs cannot 'safely' deliver the Saturday and evening access required under the PCN DES, the BMA has said.

An update letter to LMCs from the General Practitioners Committee (GPC) England also claimed it has received guarantees from NHS England that PCNs that fail to agree safe enhanced access arrangements because of 'insufficient resourcing' will not be penalised.

While subcontracting would be allowed under the DES, the GPC said it had highlighted – with acknowledgement from NHS England – that this 'isn't always a viable option for every locality or region'.

The update said that NHS England had, during a recent operational meeting with the GPC, 'confirmed that where PCNs and integrated care systems (ICSs) cannot agree on safe enhanced access arrangements for the new 2022/23 PCN DES requirements because of insufficient resourcing, GPC England can escalate this to NHS England to resolve with local commissioners'.

It said 'representatives also confirmed there is no intention to penalise any PCN, or its constituent practices, that cannot agree a safe solution with the ICS'. It also said it was 'committed to working with local and regional commissioners to do everything possible to help find an alternative safe solution'.

The letter also said that the GPC asked LMCs to submit 'examples' of instances where 'PCNs and ICSs have not been able to agree', to show NHS England that the additional PCN DES requirements are 'unworkable'.

'This will then be escalated nationally for appropriate resolution,' the letter said.

Under this year's updates to the network DES, GPs in England's PCNs will be 'required to provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays' from 1 October.

Pulse has asked NHS England for comment as PCN went to press.

The move comes as NHS England rejected calls to give GPs another opportunity to opt out of the PCN DES before April next year. Pulse revealed in May that the BMA had demanded GP practices get another chance to opt out of the PCN DES.

GETTY

NOT ENOUGH HOURS IN A DAY

With the countdown to enhanced access well under way, PCNs discuss how they will find the capacity to provide the extra evening and weekend appointments for patients. *Emma Wilkinson* reports

A choppy start to the new PCN DES has left clinical directors (CDs) trying to navigate the new enhanced access service at a time of change and uncertainty.

General practice remains under huge pressure. Recent data show that GP appointments increased so sharply in May that they boosted national GDP. At the BMA Annual Representatives Meeting at the end of June, frustrated GPs voted to withdraw practices from PCNs by next year.

Clinical commissioning groups (CCGs) have given way to integrated care systems (ICSs). Looking to this new future, the Fuller stocktake described urgent same-day appointments being delivered by 'single, urgent care teams' across larger populations.

Against this backdrop, PCN CDs say they are taking a pragmatic approach to enhanced access. For those hours, 6.30 to 8pm and all day on Saturdays, the overriding message is that they will not just do more of the same.

Dr Simone Yule, CD at The Vale (BVP) Network in Dorset, said her PCN's aim is to deliver something that addresses wellbeing, prevention, and supporting 'high intensity' patients who may have low-level but unaddressed mental health needs.

Historically she notes when funding has come into primary care for additional capacity it's been swallowed up by urgent care. 'We're stuck on a hamster wheel of activity, and it could be that some of this capacity supports moving to a more proactive approach.'

Her PCN is opting for a blended model. For the evening hours it will look to the community trust, which already does some urgent care, to provide some phone triage and GP appointments. This will be under the oversight of the PCN rather than the CCG or integrated care board (ICB) so the PCN can influence the service.

'We don't just want to be an extension of the urgent care service; we are trying to think about wellbeing too. We have done some patient questionnaires and had a real mix of responses so we're trying to accommodate as much of that as we can.'

That includes a physiotherapist doing a clinic once a month and some social prescribers. The PCN is also considering a yoga group. Some of these decisions are driven by the shortage of GPs. They can't work 16-hour days and a Saturday as well. Dr Yule's own practice has been trying to recruit a partner for over a year.

One slight worry is that the PCN had built a good relationship with the CCG. Colleagues there understood what general practice was up against. But the move to an ICS has produced some uncertainty. 'I am slightly anxious there might be pressure to morph it into urgent care but this shouldn't be about propping up emergency services.

'I really hope we can maintain this as a wellbeing offer, and doing vaccinations and managing long-term conditions,' she says. 'It's about ensuring there's flexibility to meet patient needs but it will be dependent on the workforce we have to deliver it.'

In North Hampshire, staff shortages plus the soaring success of their collaborative vaccination service have formed the basis of the enhanced access plan, explains Tim Cooper, CD for Whitewater Loddon PCN in Hampshire.

We only scratch the surface, however many appointments we offer

Dr Laura Mount

'We're aiming to build on our shared Covid vaccination service to deliver the Saturday element. This would be six PCNs collaborating in a single space, with vaccinations, health checks and group consultations,' he says.

The PCN had already had discussions about how to make good use of the keen and engaged staff that were trained to deliver Covid jabs. 'We still vaccinate but we're also trying to do a bit more with staff who work for us, such as health checks, health promotion, all these things we couldn't do for a lot of the pandemic and don't have time for in day-to-day practice.'

The PCNs see the value of collaboration in minimising the impact of other changes as and when they come in. They would rather do that work now, he adds. A key part of that will be rigorous data collection to show what works. The problem is 'you won't see the value of much of this for another five or six years.'

Despite all the talk of modernising general practice and using new roles, this still looks like the contract from 15 years ago, he adds. 'It's time for general practice to be braver and bolder' in changing the way it operates, he says, really looking at population health management. Individual PCNs don't have the workforce to offer this, but there is power in collaboration across the 15 PCN practices, he believes.

One group session his PCN is hosting is for new parents. They were coming to the GP with feeding and nutrition questions after the decline of local health visiting services and Sure Start schemes.

'We looked at what consultations we were having and thought we should pick up people who have had a baby in the past 10 months and invite them in [for a group consultation]. The most effective aspect is the relationships that people build with each other.'

The biggest challenge is trying to create capacity in general practice, he says. 'We have staff working in the vaccination site who are new and really want to help, then there are the people in the practice who say they can't tolerate taking on any more work. We're trying to match up those two things.'

If he went to his staff and said 'congratulations you're on a rota for one in four evenings and weekends' they would all say, 'okay, we're off to work elsewhere', he says. 'We're trying to take the contractual requirement and make it work.'

In Warrington, Cheshire, there has been a difference in approach between the PCNs, says Dr Laura Mount, CD at Central and West Warrington PCN. The other four PCNs are outsourcing the enhanced access hours but hers has opted for a hybrid model in its six practices.

'There's a lead practice that has been selected because it already had a contract to provide evenings and weekend care in the CCG and it didn't want to lose those staff. It has taken responsibility for weekends and Fridays and the other practices are doing a night each during the week,' she says.

As per the specifications, her PCN has to keep a GP on site but it is also trying to offer a range of other appointments including access to a phlebotomy nurse, nurse associate and a mental health nurse. Any patient at any practice can book.

Some of the logistics have not been easy, such as the need to have a central phone number patients can call to cancel an appointment, a logistical hurdle that was surprisingly hard to solve. Dr Mount's practice also had to move from EMIS to SystmOne after realising all the practices needed to be on the same system. 'That was a huge amount of work. We had a two-week blackout where we could record things on EMIS but they wouldn't transfer over so we had to do it all manually.'

But the biggest headache has been the insistence by the CCG that they do a 12-week patient consultation because the plan involved changing location from the current extended access provider that operates from a building in the centre of town. It had to be signed off by the health scrutiny committee which only meets every three months.

For Dr Mount, this didn't seem a proportional response because the contract was ending anyway and the aim was to bring the service closer to patients. 'This is a national direction, PCNs have been asked to do this but the CCG insisted it went out to consultation.'

She makes the point that demand is so huge, however many other appointments they offer, they are barely scratching the surface.

This sentiment is shared by Dr Tom Rustom, CD at Healthy Horley PCN in Surrey who says it is like opening up an extra lane on the motorway, which will always get filled.

His PCN began doing Saturday clinics a few months ago to try to ease the massive on-the-day urgent demand. It involves a nurse-led smear clinic and a healthcare assistant doing health checks. They use weekends when it's quieter to do learning disability health checks, which can be quite important for people with anxiety, he says.

'We've usually got one or two allied health professionals, a physician associate (PA) or paramedic, and a GP as well,' he explains. 'We initially started using it as an overflow, so three or four days beforehand, we would open those appointments but we've now made it pre-bookable much further in advance.'

It has been very popular, he says, not least because patients are not seeing locums, but members of the practice team they know. The PCN was lucky in having staff who were keen to work those hours – an area he knows other PCNs are really struggling with.

'The whole governance structure is subcontracted through our GP federation, so although it's delivered by the usual people, the risk is taken away, which is reassuring.'

For weekday evenings, the plan is to have a remote GP service either managing e-consultations or doing video consultations. 'It will be a pilot scheme by a local pool of remote GPs.'

He adds there is potential down the line for other approaches, such as group consultations. 'I think at this point, with the pressures on general practice, it is really important to have extra appointments that →

patients can book into because we get hammered during the week.'

But it was clear that whatever the PCN offered, it had to be a planned service, rather than more urgent on-the-day appointments, not least because the digital infrastructure to allow enhanced access is 'woefully inadequate', he says. It is an issue that frequently pops up in PCN leader discussions on WhatsApp.

'Because we've controlled it and made it very clear what the type of appointments are, staff go in knowing what they're going to do and are comfortable with that.'

Dr Rustom was concerned when the DES first came out that it was far too prescriptive but in reality it asked what was needed, what the PCN wanted to do 'because there's no point in telling us what to do if we haven't got anyone to do it'.

In Gateshead, Tyne and Wear, the PCN looked at what practices were already dealing with. As a result, it is putting on the brakes a little. As in Surrey, the practices were already doing the required number of extra hours, though not necessarily at the specified times because previous surveys had told them their patients wanted early mornings. The practices already offer minor surgery and smears on a Saturday as a way to make best use of their limited estate.

But the data could not tell the PCN what services were needed, because nothing is operating 'as usual' at the moment.

Sheinaz Stansfield, director of transformation for Birtley, Oxford Terrace PCN in Gateshead, explains that the current period of 'special cause variation' with high waiting lists, GPs dealing with the overflow from secondary care, pressures on emergency services and rising Covid cases mean they cannot work out the real patient need.

'It's all contributing to failure demand. Our patients are being bounced around the system and are not getting what they need first time round. All that contributes to us not having real data to make decisions about a service.'

The PCN also had to contend with the fact that that provision through the federation was funded for another year and if it pulled out everything would be destabilised. Instead the PCN has worked to find a different solution.

We can't measure need because nothing is operating as usual

Sheinaz Stansfield

'We've been talking to the CCG and federation about a pilot that will tell us what the real need is in general practice. From October to March we're going to measure demand, so from April we can have conversations.'

It ties in neatly with the Fuller stocktake, she says, and the model that is being proposed in localities. 'If 40% of people are coming with mental health problems, we will look at a mental health practitioner; if the patients are really complex we will need a complex case management approach,' she says.

'We didn't just want to do a finger-in-the-air exercise. We are already providing the hours but not all the opening times. We're going to maintain the status quo with the current providers [and also] conduct a pilot to work out what the model should be.'

She says the enhanced access service seems to be a precursor to Fuller and as such it's worth taking a step back. 'This is our opportunity to get data. Everyone is signed up to working like this.

'Nobody knows what the real demand is. We don't have the data so we're taking a pragmatic approach. It's a precursor to scaled-up general practice.'

GETTY

NO EASY FIX

The demand on primary care is immense. It's a problem that is easy to identify but difficult to fix.

PCNs were created to dissolve the divide between primary and community health services, to manage demand via extra staff from the additional roles reimbursement scheme (ARRS), find proactive ways of caring for whole populations and tackle areas such as care home residents and health inequalities, which create demand both at primary care level and in hospitals.

There are pockets of great work, as highlighted in our roundtable (see page 17). In north-east London, the focus is on pre-diabetes. In Hampshire, it's homelessness. In Cheshire, the PCN is trialling machines that monitor height, weight, blood pressure and pulse to pick up early warning signs.

But there are a number of problems. First, the benefits of population health management and preventive care can take years to come through. Preventing diabetes 10 years down the line is long-term thinking, which is not compatible with politics. Second, this work will actually increase demand by finding people who aren't attending the GP who need to. We have to meet that demand. Third, as Dr Claire Fuller, author of the *Next Step for Integrating Primary Care*, points out in Leading Questions (page 24), the scale of the demand can't be planned for. Lastly, the issue is complex as demand does not always equate to need. As Dr Kieran Gilmartin points out in the roundtable (page 22), the patients with the highest demand are 'those who shout loudest'.

Preventing diabetes 10 years down the line is long-term thinking, which is not compatible with politics

The new integrated care boards (ICBs) should tackle some of these issues. Cost-benefit analysis of population health management and preventive healthcare should be worked up to make the case for long-term resources.

ICBs should quantify demand in primary care. Efforts were being made by clinical commissioning groups (CCGs) by adapting the operational pressures escalation levels (OPEL) framework, used in hospitals. This work must spread to give primary care a cohesive idea of the pressures at each level of the system. This would help PCNs support practices and use all staff effectively.

And NHS England must embark on a public information campaign that the GP practice is not just the place you see your GP. There cannot be a public perception that the GP is always the first port of call. And the investment in the ARRS demonstrates NHS England believes this too. So alongside the ads that tell patients to see their GP if they have a cough for more than three weeks, there must also be a campaign about when it might be better to see a care co-ordinator, link worker, mental health practitioner, nurse, physiotherapist, occupational therapist, podiatrist or dietitian.

PCNs must be assured that ARRS funding will not be pulled in two years because of rising inflation, as reported in Pulse. And PCNs must be supported to recruit, train, manage and locate ARRS staff so they can be the standalone professionals outlined in our piece on occupational therapists (page 29). And of course, we must ensure the workforce is there to be recruited in the first place. It's no easy fix.

Victoria Vaughan is editor of PCN

DIGITAL DISSONANCE

The new NHS app sounds great, but it doesn't address the biggest issue: behaviour change

When the former Secretary of State for Health and Social Care Sajid Javid launched the Digital Health and Care plan earlier in the summer, he promised to 'digitally reform' the NHS. The most notable of these reforms was the new NHS app with 'an ongoing drumbeat of new features every month' and the expectation that 'by March 2025, all clinical teams in an integrated care system (ICS) will have appropriate access to a complete view of a person's health records, including their medications and key aspects of their history'.

This sounds great, but it doesn't address the elephant in the room: behaviour change.

The reform I especially enjoyed was the promise that the NHS app would be the new 'front door to the NHS'. There is, after all, an increasingly long line of people trying to access the current 'front door to the NHS' (primary care), which doesn't seem to shorten no matter how many patients we see.

To deal with this issue we have to innovate, flexing like we did at the height of the pandemic to meet patient needs. Digital plays a huge role, with online bookings, telephone consultations, video consultations and even group video consultations.

But those of you who read the newspapers may have noticed a lot of pushback because patients can't walk through an actual front door into a GP's surgery. In fact, the House of Commons had a debate in June on accessing GP services.

This would indicate that people may not be ready to use a 'new front door'.

This leads me to the enhanced access service, which PCNs are due to deliver from October and will enable patients in a PCN to access services on weekday evenings and Saturdays.

For any of you who have been involved in planning the service, you will know that IT interoperability is a major issue. Practices may use systems that don't speak to the systems of other practices or of providers. Getting all of this to link with online bookings seems to be a gargantuan task. The service specification does admit there may be issues with IT. However, some commissioners are not so forgiving, and expect something that isn't currently possible.

If we do not have the capability to meet our current ambitions and we do not have the systems to understand that, how can we build a shared record?

I do, of course, understand that the NHS needs to change the way it operates. PCNs are a prime example, with their aims of breaking down the barriers between community and primary care, reducing the workload on GPs, focusing on prevention and joining up care around the patient.

I wonder whether this was communicated across the NHS? I also wonder whether the Government will communicate the importance of digital access to patients, being honest with them about the pressure we are under and what this means for service transformation?

I would like to be optimistic about the Digital Health and Care plan. It is certainly the right direction, and the reforms could reap rewards for both the NHS and patients. That's why I hope that when the Government takes the plan forward, it brings everyone on the journey.

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

Dr Pramit Patel
is lead PCN clinical director at Surrey Heartlands ICS and board member at the NHS Confederation

PCN ROUNDTABLE

HEALTH INEQUALITIES

PCN clinical directors joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss how they are tacking health inequalities

ALAMY

DELEGATES

Dr Kieran Gilmartin
Clinical director (CD) at Fareham and Portchester PCN, Hampshire

Dr Shabnam Ali
CD at Loxford PCN, Redbridge, north-east London

Dr David Fox
CD at Hastings PCN, East Sussex

Dr Dan Bunstone
CD at Warrington Innovation Network, Cheshire

ANP Jenny Bostock
CD at Ramsgate PCN, Kent

Dr Laura Mount
CD at Central and West Warrington PCN, Cheshire

Victoria What is your PCN doing to tackle neighbourhood health inequalities?

Kieran For us, it is challenging. We're not in one of the country's most deprived areas. Fareham was classed as the second-best place to live.

However, we still have certain groups that are deprived. We have quite a high homeless population, and the area's drug and alcohol unit is located where one of the practices is, so, obviously, they go hand in hand. We've looked at how to improve the physical and mental health of these patients, especially physical health, because obviously there is lots of evidence that their morbidity and mortality is substantially higher, by approximately 15 years.

With the aid of a home visiting team, led by one of our advanced nurse practitioners, who is our health inequalities lead, we set up a project that is a weekly service, knowing the DES [requirements]. We do a drop-in clinic there for two and a half hours, but now there's [also] a chronic disease component, [including] those with COPD and diabetes who aren't normally accessing the surgery.

We're now improving the quality of their physical care as well as their mental health, and linking in with the mental health services, but specifically physical health, because that's something they don't engage with.

The biggest issue is, there are no extra finances for any of this. The DES highlights all of this but [has not attached] something to it. The assumption is, we use what's already there – and what's already there is being stretched thinner and thinner across all of the different domains. The additional roles reimbursement scheme (ARRS) was there to assist primary care but now, [those staff are]having to do all the additional stuff that's being put on us, and [have less] ability to reduce primary care workload.

Shabnam We've got a lot of issues with long-term conditions. Our team decided to take a preventive approach. It's come about as a co-production with our local system partners, and we decided to focus on pre-diabetes.

We've already got a large cohort of patients with diabetes and that's obviously causing a burden on secondary care. If we can focus on this cohort of patients to prevent them developing the disease, it may reduce the burden later on in the system.

As Kieran has mentioned, there are workforce issues. Who is going to do this work? It definitely needs doing but the bulk of it ends up falling on ARRS staff, and that pulls them out of the other work they're meant to be doing.

David In the inequalities work for the DES, we are focusing on patients with severe mental illness. We are bringing in staff employed by the PCN to assist in getting to patients who are hard to reach or difficult to engage. We're aiming for as high a coverage as possible because there are some people who just cannot get to practices.

Hastings has been deprived for many decades and we're fortunate to have a lot of third-sector organisations that have the assets in their staff, whereas the practices have very few assets in the area. We are being

Dr Candice Lim
Former CD at Kilburn PCN, north London

Chair Victoria Vaughan
Pulse PCN editor

ALAMY

"GPs have to update their knowledge regularly, but diabetes patients don't get refreshers and updates
Jenny Bostock

allowed to influence the funding in order to build them up. The grand plan is to get the third sector involved in a lot of the outreach stuff and dealing with young families and children over the next couple of years. As people are saying, general practice cannot do it alone and ARRS is not enough.

Dan We're looking at bringing in low-friction points as access is often an issue. We're bringing in a smart type of triage model. We're currently creating online access points through our hubs. This will help support the inequalities work as there is availability across the day, and for those who haven't got the internet, there are traditional access points through supported telephone triage.

The theory is that this will support increased access and availability in a self-service model, and the traditional routes will be available for those who can't access technology easily.

We've also [created] health hubs. These are basically a clinical machine that the patient stands under that [measures] height, weight, BP and pulse, and feeds this information into their medical record. It's the first stage of proactive care. We're looking at a rollout into pharmacies and potentially a couple of supermarkets. The machine is more convenient than coming to the surgery.

Jenny Ramsgate has so many areas [for] population health [work]. It has been difficult to pinpoint one in particular. We were part of a pilot for population health and because we have a large elderly population we looked at housebound diabetics, and managing them using a multidisciplinary team approach with Diabetes UK, social prescribers, clinical pharmacists, specialist nurses and healthcare assistants.

We're now looking at our housebound patients and trying to prepare them for winter. With soaring fuel costs and food issues, we're trying to get them to look at their housing for any draughty areas, to make sure they mitigate any problems, because we're worried that they are going to sit in the cold and not feed themselves.

We also have a Travellers community who have recently come to the area. They've been here about a year, about 40 to 50 of them. Nobody would register them because they don't have a proper address but we've managed to get them an address for the piece of land they are on. Another problem is that they're illiterate mostly. Most of them don't go to school. The children just help on the campsite. So, we've been going out to the campsite and getting them registered, and we've actually managed to do health checks on them.

The other thing we're looking at is [access for people who are not so digitally able]. Although digital technology is going really well, we have a lot of elderly population who have landlines. They don't have a mobile so they can't send in photos. They can't access the online services. We're trying to make sure they can get access to services as well.

Laura The biggest issue for us was where to start because the data are very old and often highly inaccurate. We tried to get data from Public Health [England] and its data are often very out of date, so we've used various data collection tools – which also caused us many problems. So, we feel anxious entering into this work because [we're] guessing →

where the priorities are in our population, [we don't] necessarily [have] the best evidence.

We also worry if we have selected the right priority to concentrate on. Then we worry about creating postcode lotteries because there might be something brilliant going on in the next PCN. [Might] our patients benefit from that? [Might] their patients benefit from our project? In the end, we just have to pick something and go for it.

We picked diabetes and our housebound population, because we did a project with care co-ordinators where they rang the housebound diabetics. The conversations with these patients were hugely long. It was embarrassing, the level of care they'd had in the last two years. They might have been having the basics, but they had so many unmet needs because they couldn't communicate with us – because the way of communicating with health has changed.

Victoria Did anyone have good data on which to base their decisions?

Jenny We had quite good data. The clinical commissioning group (CCG) had someone who supported us, because for our population health project we needed to find data. The CCG analytics people were helpful as well because in general practice we don't have that information, so it's a really big problem to collate the information and make it into something meaningful.

David We've also done a population health programme and were the first in Sussex to do it. I think those that have done that first are more confident with their inequalities projects. The data support already had a good baseline for dealing with severe mental illness work. We also had [the data] cross-referenced with the acute trust as well. We probably could have got those data ourselves as practices, and I worry that trusting all those data to external parties might not help us in the future. We need our own ability to deal with the data, or a clear organisation that will do it for us.

Victoria Would you like to see ring-fenced funding for health inequalities that is separate from the GP or PCN contract?

David When you work in a deprived area and you are short of staff, sometimes your difficulty is spending the money because you have the money but not the staff. The ARRS scheme has had some successes, but there isn't a long-term guarantee that this funding is there forever.

ALAMY

I don't see a shortage of money, I just don't see security to invest and push it

Dr David Fox

We need something that will be structurally there for the next 10 years that helps us all invest in the workforce and take the money.

I am seeing money available, but very little or structure to invest it in.

Also, I think the system is developing a language with Core20Plus where we're siloing inequality for outcomes. Really we have to go back to core funding and make it [available] over a long period through the contract – a worthwhile investment to build up teams in deprived areas in primary care. Because we can't, we haven't got the green light to do that, we are pushing more to the third sector where it's their role.

So, I don't see a shortage of money, I just don't see security to really invest [that money] and push it.

Jenny There are funding pots, but [the problem is] getting the time to know how to access the [funding]. When I worked with a CCG I was told I could access some money to help with the Travellers. But I didn't have time to research these pots of money. If the system could tell us where they are, that would be great. They're almost hidden and a secret.

Victoria How do you know if your health inequalities projects are successful? How are you measuring outcomes?

Candice It's a very good question. How do we measure qualitative changes?

We had a late start to tackling all this because of various issues, one of them being a lack of manpower, which I hear is a problem all around.

In March we started the wellbeing series, which anyone could drop into, and we captured a lot of incidents and prevalence of diseases. For example, pre-diabetes - if you don't go looking for it, you don't know it's there, and it's amazing what you can pick up by just screening.

We measured with wellbeing scales and things, but I guess it's difficult [for a patient] to quantify how happy they are from one day to the next.

What has really become apparent is that we need systems to change. That's very difficult, even with the integrated care systems (ICS), because everyone is still having individual conversations and doing small projects, which are not joining up.

I think the ICS should be playing matchmaker between all these teams to make them work for the local population.

Jenny When we did our population health projects with the housebound diabetics, it really opened our eyes. We were looking at good patient care and preventing hospital admissions from people with good HbA1c control.

But actually, when the teams [visited the patients'] houses, they found drug hoarding – patients weren't taking their medication. There were people who were administering insulin in the same spot [each time], so there were problems with injection sites . [There was a need for] education, education, education. Patients didn't understand the importance of taking their medication, the importance of having their insulin and [controlling their] diet. Families [needed education] as well.

This work opened a huge chasm of inequalities. We only had 122 patients in our cohort, but a lot of them were from very deprived areas and had no idea how to manage their diabetes.

If you think about clinicians, we have to update on our diabetes or whatever it is every year, but these patients were diagnosed years ago and there are no updates for them.

Really what has come out of this is [the realisation that] we need to educate our patients in all aspects [of their condition] – particularly the housebound and their carers. They'd forgotten that they can't have sugar in their tea and can't eat doughnuts and all sorts of things like that. So it was really an eye-opener, but it was difficult to know what to measure because so many things came out of it.

Victoria How much do you feel this is an exercise in education and communication rather than a clinical task?

Dan The communication element is massive. [We have to] let people understand how and where they can access services. I think [patients] assume that their only source of [help] is the oracle – the GP.

[We should let them know about] ARRS roles – that they might be much better seeing a first contact physio or social prescriber because they will get much quicker answers, and probably better, and they'll get to the solutions. Education is critical to that.

[Because of] that, we've got, I hesitate to say, a communications team. We're not Google, but we've got a comms marketing-type team to get this information out there, to advertise and to promote the roles, to make people aware [of what's available].

Shabnam I totally agree with Dan. The crux of this is education and awareness. Without a good communication team, without [sending] that message out to the whole population, we won't get very far on any of our agendas. I think we do need some kind of resource allocation to that side of things.

Victoria Are care co-ordinators doing that for you at the moment?

Shabnam Yes, they are. It's the care co-ordinators that are doing this, alongside a health and wellbeing coach and the community champions that are already embedded. When we were doing the project, we felt they were best placed.

Also, [consider] who patients listen to. They listen to their own before they listen to the GP.

David Yes. We know [this] from the vaccination programme. We were in an area of low uptake [and we found] that you can put a vaccination pop-up in the most deprived part of your [area] and people won't necessarily walk across the street to go to it.

We know that access isn't necessarily the issue. You can tweet, put messages on Facebook, you can drop leaflets, and people will not go to get a healthcare intervention or check.

I think we don't truly understand this as a system. There's still a lot of work that needs to be done with on-the-ground community [outreach, otherwise] we'll just bring in another wave of something that could be a large waste of resource.

We need something on the ground. As I get told very frequently by non medics, it's the patient voice and the population voice [that matter. Those are] not a system-driven thing. →

The public health messaging needs to change, but also, we need people to understand how cheap primary care is

Dr Kieran Gilmartin

Jenny One of the issues with communication is that GP surgeries have been flooded with an array of staff. The patients don't understand what, say, an ACP is, or a paramedic practitioner, a physician's assistant, a nursing associate, a clinical pharmacist. We've got all these roles, and patients still want to see a GP. I think we need a national campaign, an advert on TV or something to say 'This is [the person] you need to [see], these are the conditions people can treat', because patients still don't understand. I'm a nurse practitioner and I get people coming in saying, 'Oh God, I wanted to see the doctor, [but] I got you'.

We need to guard against that. It requires a lot of hard work and I don't think anybody has cracked the answer yet but we remain hopeful.

Victoria Will enhanced access help with health inequalities?

David No. You can provide more access but you're not necessarily seeing the right people, the people who need access to that service.

For me to have to focus on a target is going to be a disaster. I need time to do less for [patients] that are high demand and start seeking out [patients] we've got no information on. That has got to be a major shift soon or we'll get lost in outcomes that don't matter.

Victoria Kieran, I'm assuming in an area with lower deprivation, you have more engaged, possibly demanding patients?

Kieran Yes. The problem is we've now got a culture that everything is instant. Social media, fast food, online ordering – everyone wants things now. We all know healthcare doesn't work that way and shouldn't. [We need the public health central messaging] to change, from the Department of Health and Social Care, and NHS England. [We need to tell people] 'to use healthcare when it is most appropriate' rather than 'if you've had a cough for three weeks, you've got cancer until proven otherwise, so go see your GP'.

The message is still 'go see your GP'. If they start changing the messaging and tell people where to go in the first place, [it will just be filled because] we all know that healthcare is overburdened. As we also know, £150 per patient per year is what we roughly get, but that's nothing when you think your Sky bill can be £140 a month.

People don't understand how cheap primary care is in this country. Until we get that properly out there, it doesn't matter about health inequalities because 'those who shout loudest get' – and that's the problem.

GETTY

CHAOS THEORY

Has NHS England now realised how undeliverable and pointless this DES is?

The PCN DES is in full swing. NHS England is sitting pretty as hardly any practices have resigned from the DES. So while they are sipping Champagne in their ivory towers, feeling smug, practices up and down the country have no choice but to clutch the crumbs being thrown at us.

To compound this further, the Government has decided not to award GP partners the 4.5% pay rise that is being given to salaried GPs and the wider healthcare sector. It must be down to the terrific five-year contract that had no clauses or caveats for emergencies like Covid. What top negotiators we are.

Despite this kick to the guts, we soldier on and the flavour of the month is enhanced access. PCNs up and down the country spent hours understanding the nuances of GP supervision, then had to grapple with how they're going to deliver this, while undertaking huge amounts of patient feedback. No worries, it didn't take up practice resources; we just missed a few rounds of golf.

To add to that, NHS England has provided us with the support and reassurance we desperately need: it will step in to support PCNs that are struggling to deliver enhanced access. Alas, there is no support for practices struggling to deliver their core contract.

If PCNs cannot deliver enhanced access on their own, they can collaborate, federate or do whatever it takes to forward the political agenda.

My question is this: has NHS England now recognised how undeliverable and pointless this whole DES is as it is now providing advice on how to make it workable? The answer is 'yes'. Now, if the Fuller Stocktake report is to be taken as policy, NHS England wants to transform PCNs into neighbourhood teams.

In our PCN, we did provide a functioning plan, but the system can't decide whether it wants to move towards more digital appointments or more face-to-face appointments. So we bat away the arbitrary figures being thrown at us and proceed in the best way for our patients.

On another note, how many people have heard of the balancing mechanism? There is confusion about whether this is actually operating or not. As far as I understand, it means that if, God forbid, the GP partners make a lot of money for working every God-given hour, vaccinating people in a pandemic and forsaking a family life, NHS England can deduct money from PCNs and contracts. But if GP incomes fall because of inflation, PCN additional roles reimbursement scheme (ARRS) funding could be diverted into core. Has this been agreed? I'm confused. We will not know until year-end accounts.

What happens to PCNs like ours, which have spent almost 100% of the ARRS budget? Is it advisable not to recruit via the scheme as the money might come into core funding? No one knows.

It seems the Government is against any income coming to partnerships.

I think the biggest problem is, whatever is thrown at us, we make it work, and we will make the DES work as well – but at what cost?

So, there is no clarity about whether PCNs are fit for purpose or if this balancing mechanism is operating. There are concerns about the future of the partnership model. I wonder what the desired outcomes are for the policy of chaos?

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

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

***Dr Claire Fuller*, chief executive at Surrey Heartlands Integrated Care System and author of *Next Steps For Integrating Primary Care* shares her insights on PCNs with Pulse reporter Caitlin Tilley**

Do you think PCNs are proving to be a success?

In some places they are and some they aren't. At their best, they're incredible. And at their best people are already delivering the integrated neighbourhood teams, as outlined in my report *Next Steps For Integrating Primary Care: Fuller Stocktake*. There is nothing in this that I think is new. What we've done is describe multiple places around the country where it is happening. Many places are delivering a lot of this stuff already.

Where it hasn't worked, it will be for particular reasons. It's the whole inverse care law – the areas that are most deprived have the fewest people working, and we need to do something different.

The thing that's powerful about the letter accompanying the report from the integrated care system (ICS) chiefs is the understanding about the development of practices and PCNs and the evolution into neighbourhood teams. It's our job to help that happen.

What challenges do PCNs face?

When you've got multiple practices that are doing one session here, one session there, it isn't a great way for people to work, because they don't get the sense of neighbourhood or team. With any change programme, the biggest threat is that everyone is exhausted and overwhelmed. The idea of trying to do something different, even though it will improve the way we work and deliver care, is really hard. So it's up to us as ICS chief executives to give people protected time and space and the right expertise to do that.

I think in the past, we expected people to do this kind of thing in the evenings, and [say] why have you not done it? Nobody can work like that. The places that have been successful have had the support and the time to make changes. It is absolutely incredible the things that have been delivered and the improvements to communities.

We don't properly record our demand. We need to get better about demand capacity planning

Dr Claire Fuller

Do PCNs destabilise general practice?

I think it's the opposite. I've seen, increasingly, practices are merging across PCN footprints. But I think what we're describing is an evolution from PCNs into neighbourhood teams. You need more people than just a few of the additional roles reimbursement scheme (ARRS) [hires] to do all the work that we need, which is why it's important that we bring in other partners in the voluntary sector, the primary care and secondary care sectors and the community to create those bigger teams.

I think if stuff is working, [we shouldn't] mess with it. Where we've got great leadership, leave it alone. Let people get on and deliver. But there are lots of places around the country where things are not working. That's where ICSs need to come in and help rather than just watching.

Is the ARRS proving to be a success?

That's really interesting. When I started this process, all the chief execs said 'The ARRS roles, they're terrible, they're so inflexible'. But when you get the numbers, there are now thousands of new people working in general practice than before. [At our meetings we found] there is more flexibility then we thought there was. We've had a bit of regional variation in the way forms are filled in, but there is greater flexibility. Why would we think it was a bad idea to have extra people working? Perhaps we're not using and supporting them in the right way, but I think it's incredible having that many more people now working in general practice.

What support do you think PCN clinical directors (CDs) need and how much protected time should they have for leading PCNs?

More than they've got at the moment. In Surrey, we increased the [protected] time and I'm fortunate to have the fabulous Dr Pramit Patel. He sits on my executive team and has the primary care leader role, and has extra time from me to bring together all the PCN CDs. He runs a primary care transformation board and does a lot of development work with the CDs. This is why the letter signed by all 42 ICS leaders is so powerful, because it's a commitment to primary care leaders: that we need to give them more time. We need to help them do this, give them the right skills and the right protection. That may come from the ICS, it may come from other organisations, but there's a real understanding that we can't ask people to upend their model on very limited time when they are already exhausted.

I think there are some capabilities that we don't have in general practice routinely. All other NHS organisations do demand capacity planning, so they can tell you how many people they've got working, what work they are expecting, and how many people they need to do that. We don't even know what we do, do we? We don't properly record our demand, and not everywhere knows who is working. We need to get better about demand capacity planning, so we can create a baseline of the activity we're doing. Then when things get worse, we can add capacity. It's the e-rostering that hospitals take for granted. We should be working with them: and they want to help do that. If somebody can only come in 10am to 2pm, term-time, Tuesday to Thursday, let's have them in. But at the moment, a lot of places aren't able to have that flexibility.

What do you think should happen when the current planned funding comes to an end? Should it continue past 31 March 2024?

Because the report is a stocktake, I didn't ask [those we interviewed]. One thing we did talk about, though, was bundling funding together, and a commitment to work towards that. Instead of being so rigid it would be for local systems [to say] we've got this amount of money, what is the best way to spend it locally?

That, to me, would have a massive impact.

WORK WITH OCCUPATIONAL THERAPISTS

***Libby Brown* and *Melanie Larkin* are occupational therapists in London and are training as first contact practitioners. They explain how they can ease pressure in primary care**

What is occupational therapy?
Occupational therapists (OTs) help people perform routine tasks like self-care, work and leisure activities that have become difficult because of ill-health or life circumstances. This includes teaching new skills and adapting the home environment. We work with patients of all ages with physical or mental health issues for weeks or months, depending on their needs.

What qualifications and skills do you need to work as an OT at a PCN?
For entry-level OT jobs you need a degree, Bachelor's or pre-registration Master's. But in primary care, OTs need to be experienced – at least five years post-qualification – because we're working with undifferentiated diagnoses.

Our portfolio needs to have evidence of different clinical skills to demonstrate we are able to work in a primary care environment, which is not typical for OTs. For example, at our PCN, an OT would need broad experience working with a range of complex health conditions and in the community. We need to feel comfortable working alone as well as in a team and be able to cope with uncertainty. Having a high level of clinical reasoning is essential, as is being open to change as roles keep evolving. Building relationships is also key, so strong interpersonal skills are required.

These skills are covered in Health Education England's (HEE) *Roadmap to Practice*, which outlines that OTs who want to be in a first contact practitioner role need to demonstrate a range of skills at Master's level. This is the equivalent of Level 7 in the Royal College of Occupational Therapists (RCOT) career development framework.

As well as subject-specific understanding, the required skills include:

- Being able to use initiative and take responsibility.
- Solving problems in creative and innovative ways.
- Making decisions in challenging situations.
- Continuing to learn and develop professionally.
- Being able to communicate effectively.

We are working towards the role via the portfolio route. The pay scale is equivalent to Band 7 in Agenda for Change.

What is your routine at the PCN?
Neither of us is attached to one particular practice. We work across all four practices in the PCN. We start the week with an online team meeting. We then do telephone triage with our patients to see if they need help. In some cases, we schedule a home visit. Then we'll write up an assessment for the GP records, in which we'll raise any red flags. We also liaise with community services and practice teams.

We work autonomously, managing our own caseload. We receive supervision in line with our Health and Care Professions Council (HCPC) registration and support from GPs and managers in the PCN.

How do OTs bring value to PCNs?
We are able to unpick what the patient's problem is, and why they are not able to manage their health and other activities. This comes from assessment in the patient's own environment.

For example, one of our patients with diabetes and thyroid problems was repeatedly going to the hospital because her blood results were out of range. Assessing her at home uncovered the cause: she was taking her medicine at irregular times because of poor vision. We were able to tell the GP and community services and arrange for a telecare medication dispenser and support from social care. Once that was in place, the patient's thyroid function and diabetes management improved. Without this information, the GP may have tweaked her medication to no avail – because this was not a medical issue.

We also add value to the PCN by working with the wider community. For example, we have conducted sessions with elderly people and staff at day centres on how to prevent falls and how to get support. There isn't much awareness about this. We have also provided sessions for medical students about occupational therapy as an emerging role in primary care.

We asked our colleagues for feedback on our work, and GPs told us they now spend less time on their consultations. They also felt the patients we work with present less frequently in a crisis situation. And they have more information about their patient's context.

What support do you get from the PCN?
We have regular meetings with the clinical director, PCN managers, pharmacists, health and wellbeing coaches, social prescribers, care co-ordinators and HCAs. We are encouraged to raise any learning points because the PCN fosters a learning environment. We also have a weekly session with GP trainees and conduct joint visits with them.

We have access to the Community Education Provider Network (CEPN) and also an external OT who supervises us, in line with the HCPC requirements. We are also in touch with other OTs through the RCOT.

Practices in the PCN regularly invite us to their social events, which helps us maintain a good relationship with them.

Can you offer any advice for PCNs looking to hire an OT?
During the hiring interview, it would help if PCNs discussed the patient group OTs will work with. OTs work in a number of areas, but in primary care the focus is mainly on frailty, mental health and vocational rehabilitation. PCNs need to recruit OTs with the right experience.

Libby Brown and **Melanie Larkin** are OTs in Tower Hamlets, east London

PULSE Intelligence

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FORM A COMPANY

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

Most PCNs set up as either a lead or flat practice model. But many are now finding this problematic, particularly when sharing staff, and are considering a limited company (corporate) business model. And PCNs that operate as a super-partnership or in a federation are equipped to deal with a growing amount of legal and employment issues.

What key problems can a company model overcome?
The main issues relate to tax and staff liabilities.

1 **VAT**
While healthcare services are classed as VAT exempt, the sharing of staff around the network (including medical staff) is usually subject to 20% VAT unless a practice is operating below the £85,000 registration threshold. HMRC indicates that this applies to the Clinical Director (CD) role too. This is a complex issue, but a PCN operating a limited company can be structured to benefit from a VAT relief called the cost-sharing exemption, by operating a cost-sharing group.

2 **Liability**
A network with a lead practice structure is not a separate legal entity. It is a group of practices that are jointly and severally liable for what happens in the network. So all the practices – and therefore all the partners – are trusting each other to share the network's legal and financial responsibilities. The main concern is that if a PCN needs to make staff redundant, the cost will fall on individual member practices. But if a company is employing the workforce the costs come out of the assets of the company – so there is less risk of destabilising individual practices. Also, it's possible that PCNs may not be a permanent fixture – an issue that should not be ignored.

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

4 **Tax on PCN surplus?**
If a PCN is not a legal entity it has no mechanism to report its taxes, except through its member practices, with each practice needing to report its share of the surplus through its own accounts. Creating a company offers options for the PCN to shelter some of the profits at corporation tax rate instead of partners' marginal tax rates of 40-45%.

What are the pros and cons of a corporate model?
The advantages of the corporate model include:
- It limits the liability for the practices and partners.
- It mitigates the VAT issue relating to shared staff.
- Staff can be engaged on consistent employment terms.
- The CD can be employed by the company, solving the VAT issue.
- Sheltering some of the unexpended PCN funds from tax.
- A company is the only way a network can hold an APMS contract.

The disadvantages include:
- The cost of setting up and running the PCN company as an extra entity – preparing and submitting accounts and running a payroll.
- The company may need separate CQC registration.
- Transferring staff, following Transfer of Undertakings (Protection of Employment) (TUPE) procedures, can be onerous.
- Access to the NHS pension is not automatic.

GETTY

Why is TUPE important?
When moving the workforce into a limited company, companies must follow TUPE regulations, which ensure employees retain their terms and conditions and keep continuity of employment. Because of this, a number of PCNs have decided to form a company now, even if they operate below the VAT registration threshold, to avoid needing to transfer a larger number of staff at a future date.

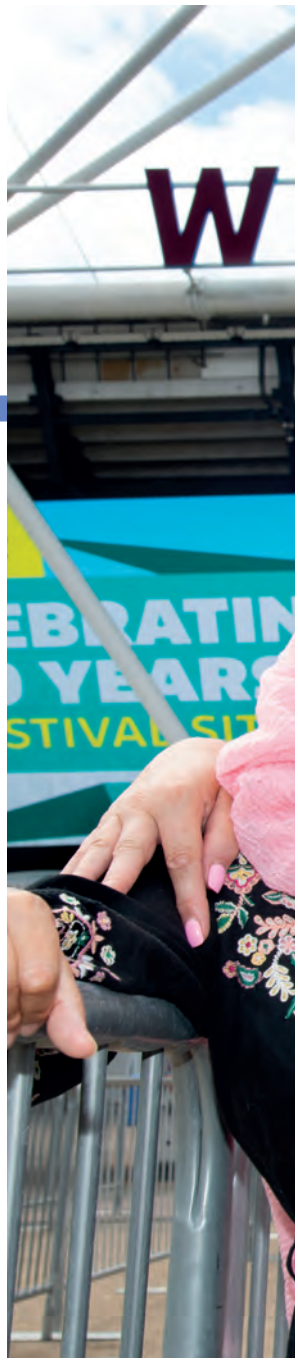
What about pensions?
PCNs using limited companies could not originally access the NHS pension scheme, but they can apply for this under a temporary direction/determination order, which currently lasts until 31 March 2023.

Next steps
The next steps include:
- Forming the company with the correct legal structure and paperwork.
- Transferring staff from the PCN (with TUPE and consultation).
- Arranging access to the NHS pension scheme.
- Other admin such as opening a bank account, arranging contracts of employment and exploring CQC registration.

Specialist advice is usually needed for these tasks. However, the long-term benefits outweigh the short-term effort.

James Gransby is vice-chair of the Association of Independent Specialist Medical Accountants and a partner at RSM UK Tax and Accounting Ltd. This is an update to his article published in PCN Spring 2021

AIMING TO REDUCE KNIFE CRIME



***Dr Farzana Hussain* leads a knife crime reduction programme in Newham PCN, north east London. She explains how it's working in her community**

Knife crime is a significant challenge in urban areas. Latest figures from the Office for National Statistics (ONS) show there were more than 47,000 serious offences involving a knife in England in the year up to March 2022. Of these, 275 resulted in a death. London alone sees just under a quarter of these offences, with a death toll of 75 recorded in the year from March 2021 to March 2022.

At our practice, The Project Surgery in north-east London, which has a list size of 5,000, we have lost three teenagers to knife crime in the last eight years.

While this number may seem small when set against the ONS data, in our context it is more deaths than we've seen from childhood cancer, which is a leading cause of child mortality here.

Figures show that since 2011 there have been between 10,000 and 16,000 offences in London per year that involved a knife or sharp instrument, with a peak in April 2019 to March 2020 just as PCNs came into operation in July 2019.

We wanted to undertake a project that was wider than just a health model and identify young people aged 11-18 at risk of knife crime who we could proactively help at an early stage.

Our project, Identifying Risk Factors to Reduce Knife Crime in our Young People in Newham, began in March 2021. We used social media (Facebook, Snapchat and Instagram) to try to encourage young people in Newham to come forward for help as we know teenagers do not attend GP practices much.

We employed a specialist young persons' link worker from West Ham United Foundation, a voluntary sector organisation linked to the football club, who has really connected with our young people and can direct them to various activities tailored to their needs – which include signposting them to tennis lessons or football practice and giving them personal mentors.

Practices and two local secondary schools have been given a simple screening tool, which we devised with the practices, public health and schools to identify these young people. Some common themes are emerging – early mental health issues and relationship-building issues.

Our link worker has a full caseload of young people who would not have had any contact with services previously as they are not 'sick' enough for Children's Adolescent Mental Health Services.

We are evaluating the young people's experience with the service and also the experience of our link worker.

The project is part of a national health inequalities programme called Complete Care Communities. We are one of 46 demonstrator sites across the country. The programme focuses on the needs and health inequalities in different populations. We are the only knife crime project.

We were funded £40,000 for one year by the integrated care system (ICS) in north-east London as part of the national programme. We are measuring success by the collaboration between schools, public health and primary care, and also the caseload of the link worker. Now, as the project is so successful, our ICS will continue to provide a small amount of funding.

Our link worker is funded through our PCN additional roles reimbursement scheme (ARRS) but the project does not meet the service specification of tackling health inequalities as it is far more

PCN
Newham, north-east London

Clinical director
Dr Saravanan Chellappan

Programme's senior responsible officer
Dr Farzana Hussain (former CD)

Practice
The Project Surgery

PCN
Newham central 1

PCN Location
Newham, north east London

Number of practices in PCN
7

Number of patients in PCN
68,000

PCN hires (ARRS employed)
1 adult link worker
1 child link worker
3 pharmacists
3 physican associates
1 pharmacy technician

Recruiting
Care co-ordinator
Health and wellbeing coach

COMPLETE CARE COMMUNITIES

The Complete Care Community programme is delivered by Healthworks with NHS Arden & GEM in Warwickshire, with clinical leadership from Professor James Kingsland OBE. It is a national programme that supports PCNs to identify and reduce local health inequalities. The programme encourages local networks to adopt a systematic approach to addressing the wider determinants of health inequalities including using data to inform action.

There are 46 demonstrator sites across all seven NHS England regions. The programme receives funding from the National Healthcare Inequalities Improvement Programme at NHS England and supports Core20Plus5, the national drive to reduce healthcare inequalities.

From left: Dr Farzana Hussain, practice manager Emma Forrester, link worker Ruby Williams

holisitic and includes the wider determinants of health.

The PCN ran regular meetings, especially in the initial phase, to co-design the simple screening tool that admin staff could use to identify young people who were at risk. GPs also identified at-risk individuals using their patient knowledge and hospital letters – such as a young person who attended the emergency department with a hand injury from punching a wall.

The relationships between the two secondary schools, the PCN and public health are really strong as we are all invested in a shared purpose. We also want to engage young people themselves in co-designing the next stage. We want to link up with the hospital, which has link workers for young people who present with non-fatal stabbings, and we want to link up with the London violence reduction unit.

The national programme will be evaluated by the National Institute for Health and Care Research.

> **GPs have been able to identify some at-risk patients using hospital letters and their patient knowledge**
>
> Dr Farzana Hussain

The outcomes we are aiming for are:

- More connection with GP practices so that young people can feel confident to access mental health and sexual health advice as well as physical health advice.
- More knowledge for young people to know what to do if they are getting involved in gangs and to know how to participate in other activities such as sports.
- A safe space for young people to talk in confidence to a link worker .

We want to embed this project so that it becomes a normal part of practice and use it as a template to look after all age groups with a lens wider than physical health.

We aim to identify themes and learning across all 46 sites in the Complete Care Communities programme, which are all doing different projects to tackle health inequalities.

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

PROACTIVELY WORKING AS A SYSTEM

It's Penny here, from the primary care support and strategic intelligence unit (PCSSIU), with another packed edition of the newsletter.

Sharp-eyed readers will have noticed that the PCSSIU, formerly the primary care support and strategic integration unit, has had a change of name. This important change reflects the completion of our integration journey and a new focus on intelligence in primary care commissioning.

The first action of the Sackwell & Binthorpe integrated care board (S&B ICB), when it came into statutory existence in July, was to order an immediate review of the names of directorates, operating divisions and strategic commissioning units. This work is progressively ongoing, and our expectation is that it will be culminatory towards the year-end. We'll advise you of the final outturn in subsequent newsletters.

Linda Marshall, chair of the strategic naming review and refresh (SNRR) group, would like to thank primary care colleagues for their tireless work putting up posters and handing out questionnaires.

Meet the system leaders

Although the ICS has been running in shadow form for two years, July marked the point we started working in earnest. We celebrated with a Meet the System Leaders Day on 27 July. Patient representatives, PCN clinical directors (CDs), practice managers and the extended primary care team had the opportunity to network with deputy director of finance Selina Sayed and senior contracting manager Ken Moss.

All the attendees who completed the feedback form agreed the event had been 'interesting' and/or 'quite informative'. Delegates reported a 13% increase in their perception and knowledge of ICS aspirations and ambitions, based on surveys taken before and after the buffet lunch.

Amanda Pritchard made a short video presentation thanking front-line colleagues for all they do and pledging full support to ICS leaders.

The NHS England chief executive promised that NHS regional directors would be checking in with them regularly to find out where robust, targeted support was required.

A stronger voice for primary care

As we move at pace towards fully integrated working at scale, primary care colleagues have expressed concern that their 'voice' could get lost. The ICS has put in place decisive steps to ensure this does not happen.

These include fulfilling the statutory obligation to have at least one primary care representative on the ICB. It is equally important that we deliver enhanced voice at the levels of neighbourhood and place and that leaders develop the active listening skills to 'hear' it.

As Dr Claire Fuller memorably observed in her ground-breaking review, 'only by collaborating can we work together effectively'.

An important part of my team's role will be to maximise the opportunities for collaboration, from multidisciplinary cross-fertilisation at practice level to the introduction of distributed leadership models in PCNs. As networks of PCNs evolve, we will see blended leadership models emerge, with primary care and place leads matrix-working to ensure neighbourhood workstreams are harmonised with place-based initiatives and flow seamlessly into the overarching systemwide strategy set by the ICB and/or the integrated care partnership (ICP). As you can see, questions about how and where decisions are taken or who's in charge are much less relevant. Instead, leaders should ask themselves 'How did that make me feel?', 'Which leadership behaviours should I work on?' and 'What have I done today to build meaningful relationships?'

Working together as a network – tips for success

The success of working together as a system will be built on the success of working together in subsystems. At every level, people, clinicians and citizens will collaborate to design new models of commissioning, care, co-production, governance and general practice.

The NHS Leadership Academy, NHS Horizons and the RCGP have teamed up to produce a series of quick guides on:

- Collaborative stances, preferences and styles.
- Thinking spaces – and how to furnish them.
- Resilient behaviours of happy teams.
- Holding productive conversations.

Are you sitting comfortably?

If you're squirming uncomfortably as you read this, it may be because you spend too long sitting down. A recent study found the sedentary lifestyle of GPs may be putting their health at risk, causing a range of problems from lower back pain and cramp to early retirement.

Last month, the ICS brought together primary care leads, CDs and physiotherapists to address the problem. The resulting Healthy Sitting Initiative (HSI) includes recommendations on sitting with purpose, positive posture and how to adjust swivel chairs. It will be supported by a social media campaign urging GPs and other practice staff to 'find time to stand' and 'stay mobile, stay well'. Do look out for it.

The HSI action group is meeting again this month to consider how the adoption of a John Lewis model in general practice may promote the adoption of more tasteful décor and softer lighting in primary care.

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