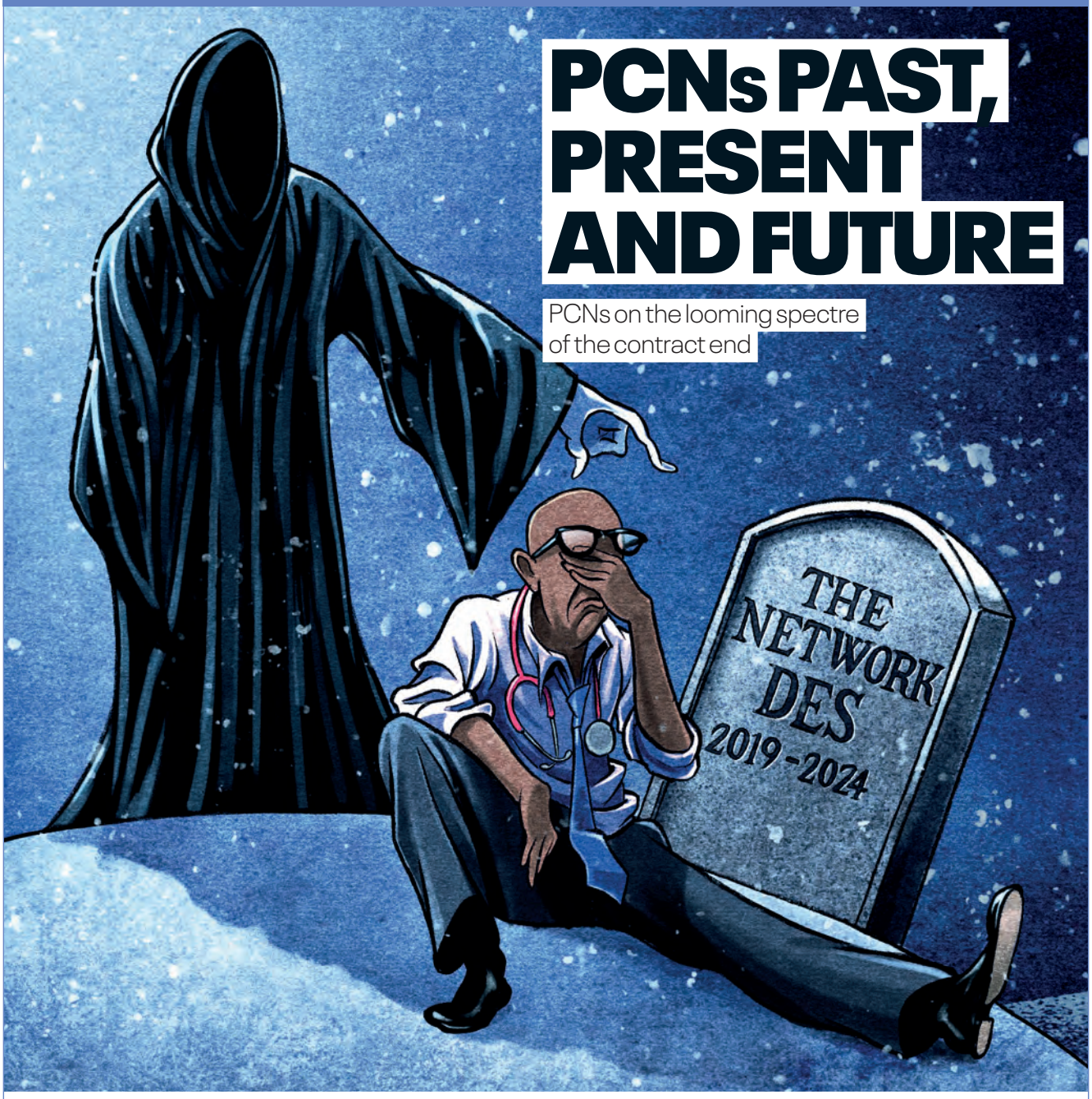
NEW LAUNCH OF THE YEAR
BRITISH SOCIETY OF MAGAZINE EDITORS

PULSE PCN
CONNECTING PRIMARY CARE NETWORKS
WINTER 2022

# PCNs PAST, PRESENT AND FUTURE

PCNs on the looming spectre of the contract end




INSIDE

# WINTER 2022







PULSEPCN

We've moved!
PCN, Cogora,
1 Giltspur Street, London
EC1A 9DD

**Email**
pulsepcn@pulsetoday.co.uk

**Editor**
Victoria Vaughan
victoriavaughan@cogora.com

**Commercial director**
Edward Burkle

**Art director**
James Depree

**Reporter**
Jess Hacker
jesshacker@cogora.com

**Editorial enquiries**
020 7214 0552

**Display advertising**
jasonwarner@cogora.com



**Delivery and subscription**
subscriptions@cogora.com



COVER: BEN JENNINGS / ALAMY / GETTY / UNP

# NHS ENGLAND MUST GUARANTEE PCNs AFTER 2024

**By Jess Hacker**

NHS England must guarantee PCNs will exist beyond 2024 to allow for long-term planning, the NHS Confederation has said.

The absence of a guarantee has left many PCNs 'hesitant to recruit permanently' using the additional roles reimbursement scheme (ARRS), which it said should be more flexible and cover training and supervision.

The organisation also called for NHS England to refrain from adding further service specifications to next year's Network DES.

The statement comes as part of a major report marking three years since the networks were established in July 2019. PCNs grappled with the Covid pandemic in their first 12 months, followed by the dissolution of CCGs and the move to integrated care boards (ICBs) in July.

There have also been think-tank policy papers 'touting reform' of the GP operating model and ballots to withdraw from the PCN contract, said the report.

NHS England must work urgently to remedy the 'unstable operating environment' PCNs launched into, it said, allowing networks to plan beyond the uncertainty that surrounds their own futures.

The report said: 'The three years since PCNs were introduced have been tumultuous, including a global pandemic, a wholesale reorganisation of the NHS, rumours of reform to the GP operating model, dwindling numbers of GPs and extremely high demand for NHS services.

'All this has caused a crisis in general practice, affecting the development of PCNs and rendering them unable to deliver on their stated aims of stabilising general practice, dissolving the historic divide between primary and community services and reducing health inequalities.'

According to the report, the Covid vaccination programme stands as proof that PCNs are 'effective delivery models' especially for reaching underserved populations, as does the accelerated progress to meet digital access targets.

And as of June 2022, PCNs have recruited 19,229 ARRS staff of the 26,000 manifesto target. The Confederation highlighted social prescribing link workers, care co-ordinators and health coaches as a 'significant plus to this gap' in GP workforce.

The Confederation also welcomed the fact that many PCN clinical directors 'matured into their roles', with many becoming primary care partners on ICBs.

Despite their achievements, however, the report says successes are often dependent on local factors, namely how well integrated the PCN is at place level and the supporting infrastructure.

## PCN CONTRACT INCREASES HEALTH INEQUALITIES, WARNS COMMONS HEALTH COMMITTEE

**By Jess Hacker**

MPs have urged NHS England to review PCN funding mechanisms to ensure they do not make health inequalities worse.

In a new report on the future of general practice, the House of Commons health and social care committee warned that significant pressures in under-doctored, highly deprived areas are compounded by 'unfair funding mechanisms' that fail to account for deprivation.

The committee found it 'particularly concerning' that funding provided via the PCN contract 'repeats this failing and risks entrenching regional variation'.

It called on NHS England to review new PCN funding mechanisms to ensure they do not 'inadvertently restrict funding for areas that already have high levels of need'.

MPs flagged that the additional roles reimbursement scheme (ARRS) does not account for deprivation, so places that already struggle to recruit may find it more difficult.

They also highlighted that the investment and impact fund (IIF) is weighted according to prevalence and list sizes but does not account for other factors, such as lower vaccine uptake among patients from some ethnic minority groups compared with white patients.

This might mean areas with a larger population of black and ethnic minority patients will need to work harder than other areas to achieve high coverage.

During the inquiry, MPs also heard that continuity of care is more difficult to achieve in very deprived areas, often because of existing GP shortages and patient populations with complex health needs.


## NETWORK DES FUNDING WORTH £37M TO BE REALLOCATED AS GP WINTER ACCESS FUNDING

**By Jess Hacker**

Sweeping changes to the Network DES will see £37m worth of funding reallocated towards direct support payments for improving core GP access this winter.

Four investment and impact fund (IIF) indicators that are worth £37m in total have been deferred or scrapped, with that funding instead allocated to PCNs via a monthly support payment from October and until 31 March next year.

It comes as part of a set of measures intended to support general practice through the winter, following the former health secretary's controversial plan for patient access.

NHS England announced the new support payment will be paid to PCNs monthly and will be based on the PCN's adjusted population.

It said: 'In line with the reinvestment commitment relating to IIF earnings, the PCN capacity and access support payment must be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients.'

To achieve this, NHS England immediately deferred three IIF indicators to April 2023, including the target for GP networks to offer patients appointments within two weeks.

And a fourth indicator, to identify and tackle health inequalities, has also been retired.

Integrated care boards (ICBs) have also been asked to identify where to allocate potential additional winter funding to GP practices and PCNs in their area, if such funding were to materialise.

PCNs are now expected to 'contribute to ICS-led conversations' on the implementation and delivery of the anticipatory care service, which will be designed by the ICSs.

GETTY / ALAMY


# PCNs YET TO COME

**PCNs know the contract is coming to an end in March 2024 but are unclear what that means. With just over a year to go we look at the challenges past, present and future. *Emma Wilkinson* reports**

The future is unwritten and in this case it's the future PCN contract that's unwritten. What will become of PCNs, how they will work with integrated care teams and the integrated care boards (ICBs) and wider systems is all yet to be worked out. But lest we see a 'vacant chair in the corner' and feel a heavy sense of humbug, PCNs must be able to look to and plan for the future to ensure the improvements they are making in their communities are sustained rather than lost.

The past year has seen PCNs face a head-spinning array of changes, from the introduction of the new PCN DES and enhanced access, and a complete overhaul of NHS structures with the introduction of ICBs and the Fuller Stocktake on the Next Steps for Integrating Primary Care. Add to that the incredible pressure on primary care even before winter hit, a revolving door of health ministers and the health select committee's Future of General Practice report, and it's no wonder PCNs are not in a position to scan the horizon and plan for the future.

Yet the current five-year contact is ending in little over a year (in March 2024) and while the Fuller Stocktake is seen as a way ahead, how PCNs will sit with integrated care teams is unclear. We look back at the key challenges in the past year, the present pressures and consider how PCNs can get themselves in the best position for the next 12 months.

**PCN past: changes to the network DES**

The network contract was updated in April, with a significant boost to funding through the additional roles reimbursement scheme (ARRS) and dramatic expansion in the impact and investment fund (IIF). The aspect that caused the biggest stir was the compulsory requirement for PCNs to provide enhanced access, which left clinical directors (CDs) carefully considering what they could realistically achieve.

Dr Sarit Ghosh, CD at Enfield Unity PCN, London, said teams were under huge pressure after the pandemic, then the vaccine campaigns and now with reactive care going through the roof.

He adds the IIF and locally commissioned services that PCNs are delivering are a lot of work. They are still training an ever-expanding workforce and trying to support practices, and with wider policy changes

BEN JENNINGS

and integrated care system (ICS) strategy, 'we have to be selective. If you tried to do everything you would probably fail.'

As a result, PCN CDs have taken a pragmatic approach to enhanced access, trying to prevent the additional appointments being swallowed up by yet more urgent care. But the new access requirements have been challenging for PCNs, which have burnt-out teams already working at maximum capacity. Some have turned to alternative options, with 40 PCNs contacting the private digital GP provider Livi.

**PCN present: winter pressures**

In further sweeping changes to the network DES announced in September, £37m was reallocated to support practices to improve access over winter. It meant the deferral of three IIF indicators and the scrapping of a fourth with the money instead coming to PCNs through a monthly support payment from October to March.

NHS England has confirmed that the support payment 'must be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients' with PCNs committing this in writing to commissioners. Two new roles – GP assistants and digital and transformation (D&T) leads – have also been added to the ARRS.

But, says Dr Yasmin Razak, who recently stepped down as CD at Neohealth PCN in North Kensington, London, the winter DES is not new. It is simply releasing some of the IIF sooner.

'I'm unsure if this will make any difference as it's only about 70p a patient and NHS England is missing the real issues.' She adds she would have liked to have seen other IIF incentives axed to free up GP time and reduce system pressures because as targets they will bring little gain.

Professor Aruna Garcea, NHS Confederation Primary Care Network advisory group chair, says the funding that's been released back to primary care is just a rebadging of the IIF. The amounts are minimal, considering what PCNs are facing. Also, there is hidden work in setting up respiratory hubs and redirecting ambulances. 'I don't think it will have a significantly robust impact on the winter threats and the workforce issues we've got,' she says.

Alongside the changes to the IIF indicators, there was also a framework outlining how ICBs should support PCNs. It tasked ICBs to scope out 'how any additional capital funding available later in the year for primary care could be used' with a focus on areas with deprivation and recruitment challenges. This had to be done by 21 October.

The framework also covers areas where support would 'help improve patient access and staff experience over the longer term, and build an ongoing quality improvement support process within primary care'. It would be paid for by ongoing system development funding (SDF) or other transformation funding.

PCN CDs say they have not heard from their ICBs about the framework. ICBs took over from CCGs on July 1 so ICBs may have had little time to consult PCNs before the deadline. Or they may already have the necessary data or don't want to overwhelm people with more engagement that they don't feel will be useful, they added.

Issues that ICBs are being asked to consider include whether cloud-based telephony is in place, what business intelligence tools practices are using, what processes have become automated and whether estates and equipment are adequate.

Professor Garcea adds there is a risk that with extra system development funding, ICBs and PCNs will not have the time to come up with a co-ordinated solution to winter pressures. This needs to be addressed for next year. 'We need to get better at planning for winter together, the ICBs and PCNs.'

Dr Emma Rowley-Conwy, clinical lead of Streatham PCN, says she has not heard from the ICS about the framework. She presumes it will filter through but says PCNs do not have the time to engage with it.

For her area, cloud telephony is well ahead. Some of the local IT issues relate to factors outside the ICB remit, such as the lack of functionality in EMIS to support enhanced access implementation.

'We need to secure ongoing funding for Accurx – licences and SMS. This is currently our most important universal tool to manage patient demand and recall, but the costs are high. Also, NHS England says that GP development fund monies cannot be used for licences. This presents a real challenge,' she says.

**PCN present: organisational and policy overhaul**

While they grapple with funding changes, new roles and preparations for a difficult winter, PCNs have had to keep abreast of key reports, policy developments and the shift from clinical commissioning groups (CCGs) to ICBs. The implications are still not fully apparent nearly six months on. This is such a big challenge for general practice that extra pots of money here and there are unlikely to make a difference, says Dr Ghosh. Long-term strategic thinking is needed, but that takes time and space.

In May, the Fuller Stocktake set out a vision for the development of integrated neighbourhood teams to drive improvement. Left as it is, primary care will become unsustainable in a 'relatively short period', said Dr Claire Fuller, the report's author and chief executive of the Surrey Heartlands ICS. It also called for a system-wide approach to managing integrated urgent care to guarentee same-day care for patients.

The Fuller Stocktake learned from good projects around the country, says Dr Ghosh, but moving to integrated neighbourhood teams is easier for some parts of the country than others. In London, there's a lot of overlap. 'Working in teams is absolutely the way to go but how do we do that without disrupting relationships?'

Although ICBs are still in a nascent phase, all 42 chief executives signed a letter endorsing the Fuller Stocktake and recognising the importance of primary care. However, they are only just starting to consider what their primary care strategy may be.

In October, the Health and Social Care Select Committee published its view on the future of general practice after a lengthy inquiry chaired by now Chancellor Jeremy Hunt. Key findings included 'extreme concern' about the decline of continuity of care, a call to return to individual patient lists and a call for NHS England to review PCN funding mechanisms to ensure they do not exacerbate health inequalities. It concluded that significant pressures in under-doctored, highly deprived areas are compounded by 'unfair funding mechanisms' that fail to account for deprivation. It was highly critical about the Government and NHS England's failure to acknowledge the crisis in general practice.

**We must give primary care its strength back – and that is continuity of care**

Dr Yasmin Razak

Dr Razak welcomes the headlines in the committee's report and says GPs had known about these issues for a long time. This should be the focus she believes, rather than the Fuller Stocktake. 'The report looks at root causes of problems – to give primary care its strength back.

'Moving acute primary care presentations to at-scale providers and out of the GP system will lead to a further loss of GP continuity, which we know improves outcomes. We need to build on the longitudinal relationship.'

In June, amidst the changes to the network DES and the Fuller Stocktake, doctors at the BMA's annual meeting voted for practices to withdraw from PCNs by next year and for funding to be moved into the core contract. That followed a warning from the General Practitioners Committee (GPC) that the PCNs posed an 'existential threat' to the independent contractor model.

More recently, details have emerged of how this might happen. The BMA has set out plans for PCNs to evolve into 'locally flexible neighbourhood teams' where local practices can collaborate. At a meeting in October, the GPC suggested that a mass exodus from the PCN DES was not imminent and there would be no point at which PCNs would close down and make ARRS staff redundant. As part of its September winter support measures NHS England also encouraged PCNs to continue to recruit, and make full use of their ARRS entitlement 'with the knowledge that support for these staff will continue'.

**PCN future**

This has been a remarkable period of flux and adaptation for PCNs, and it is difficult to know what their focus will be over the remainder of the contract and how can they can prepare for what comes next. A report published on 4 November by the NHS Confederation, Primary Care →

JON ENOCH

Networks: Three Years On, called for NHS England to guarentee they will exist beyond 2024 to aid long-term planning. It says that NHS England must work urgently to remedy the 'unstable operating environment' PCNs were launched into and allow networks to plan beyond the uncertainty surrounding their own futures. It also asked NHS England to refrain from adding further service specifications to next year's Network DES. PCN CDs will have to make tricky decisions and navigate opposing views, says Ben Gowland, director and principal consultant at Ockham Healthcare, a think-tank and consultancy that works with PCNs.

'PCNs are wondering, will practices withdraw? Then the Fuller Stocktake says primary care will evolve into neighbourhood teams, so what does "evolve" mean, and is it the end of PCNs?' he says. 'We know the five-year deal is in place but not what will happen after 2024.'

He does note that in areas where integrated neighbourhood teams already operate, for example Suffolk, PCNs still operate, but voluntary, community and social care teams work alongside primary care.

Some PCNs are starting to think about the wider strategy and how to avoid losing the funding that brings into general practice. But for the most part, PCNs are just focusing on core operational demands, he says.

Most PCNs are just doing the job, he says. 'The IIF is demanding, as is the ARRS, and working in teams. And practices are starting to see value in additional roles. Their focus for the next 18 months should be two-fold: first, use ARRS funding to get the skill mix and roles they want before any contract changes; second, co-ordinate locally to work with other PCNs, the LMC and federations to ensure collective input to the ICS.

'It does feel that funding and influence will come from the ICS rather than nationally after the end of the five years. So the ability to influence the system becomes important. That's key over the next 16 months.'

But CDs are also having to accommodate different opinions among practices – whether to be proactive and propose solutions or whether to wait and see what ICSs devise. There are marked divisions, he adds.

'Some GPs are under such pressure that the idea of leaving that to another team is appealing. But there is an equally vocal cohort that is adamant that continuity of care is about seeing the same person for an urgent need because the relationship builds over time. PCN CDs are left asking, "how do I manage that"?'

Professor Garcea notes this year has been a rollercoaster for PCNs but they now need 'split-screen' thinking. As well as doing the day job, they should think about how to work successfully with ICSs. 'We're on this train and it's continually moving and we need to know what's going to happen after 2024. As a GP community we should use where CDs are strategically placed to impact on our patients and the system. At-scale working has already started in different parts of the country to deliver local and resilient solutions to help general practice. Now we need to get that right, get the joint working that needs to happen. A CD has to focus on relationships [locally] and that has to be a priority.'

Tara Humphrey, managing director at THC Primary Care, which provides project and network management and training to PCNs, says uncertainty about change is stopping progress in some networks.

'Nothing is for ever. We've seen that with the latest Government. I don't think we should live in fear because there's a lot of work to be done between now and the end of the contract,' she advises.

**"The IIF is demanding, and practices are seeing value in additional roles**

Ben Gowland

'I think that whatever the contract looks like beyond 2024, the infrastructure will stay unless something falls out of the sky. When there's lots of change and you don't know what to do, you do nothing because you're frightened of making the wrong steps,' she adds. But for PCNs, she says, it needs to be business as usual because there is enough demand in the system to warrant the work.

'There is a spectrum of where PCNs are. But whoever they are, the one thing they can control is getting into the best situation from a business point of view – culture, network agreement, finances, HR, workforce planning and IT – to be ready for the next evolution,' she says. 'While some will always have one eye on the strategic landscape, that speculation is not always helpful and can mean you lose focus.'

She says workload pressures are hard to manage but a PCN does not have to do everything themselves. In her work, she meets CDs who want to learn and are daunted but still hopeful. 'You have to able to transform into the next thing and you've got to be in a good place to do that.'

PCNs have shown resilience in the face of adversity, both past and present. Now the end of the contract is looming, casting its shadow over the coming year, and they must shore up their achievements and start on the next phase – building a larger team and links with ICBs and the wider system's needs to ensure everyone is blessed with headroom, autonomy and support.

GETTY

# WEAK FOUNDATIONS

**NHS England assures the future of ARRS staff but not the future of PCNs**

PCNs are the building blocks on which the great structure of the health and care system sits. But what foundations are they built on? An ever-changing and, some would argue, unpopular contract set to end in just over a year, a dwindling exhausted workforce, a lack of funding, a lack of estate, stretched practices. And a backdrop of revolving health secretaries, winter pressures and new parents in the form of integrated care boards (ICBs). Perhaps Matt Hancock isn't the only one who wants to disappear off to the jungle.

But PCNs haven't taken flight or even left the building (which is most probably outdated). It's actually a wonder how much some PCNs have managed to achieve.

To tackle unsustainable demand The Foundry practice in Lewes, East Sussex (see profile, page 28) has divided patients into a traffic-light system of need. This split of urgent on-the-day care where continuity is not a priority was a key recommendation of the Fuller Stocktake. While some see it as a threat to continuity, others see it as a way to preserve continuity for those that need it.

And as Professor Aruna Garcea says (Leading Questions, page 22), while she became a GP to deliver cradle-to-grave care she recognises the landscape, complexity and demand have changed and so must delivery of care.

Another feat of PCNs was the delivery of the Covid vaccination programme and how they are building on that work as discussed in our roundtable (see pages 15-20). It highlights the positive outcomes of PCN outreach. The vaccination programme shone a light on the communities that were not well served by the health system. PCN leads got out and met people in their places of worship, in town centres and uncovered significant need. But they point out that much of this work is done in their own time and is not funded.

And on the subject of funding, what are PCNs to do when the contract ends in March 2024? An NHS Confederation report, published in November, called upon NHS England and the Department of Health and Social Care to remedy the 'rollercoaster' of the past three years and guarantee PCNs' continuation.

NHS England, in its winter support measures, published in September, stated its commitment to the development of neighbourhood multi-disciplinary teams in primary care with the additional roles reimbursement scheme (ARRS) being central. It encouraged PCNs to use all ARRS funds and continue to recruit 'with the knowledge that support for these staff will continue'. But NHS England stops short of doing the same for PCNs.

To ensure this huge building remains standing, NHS England must shore up the foundations by guaranteeing the continuation of PCNs and detailing a new long-term contract informed by the profession. It must recognise the excellent work of PCNs where the conditions have been right for innovation and collaboration and urge ICBs to help create this atmosphere across the country.

It must provide a significant budget for management of PCNs and the training of the new ARRS roles and of new primary care professionals.

Only then can it build a health and care system with solid foundations.

**Victoria Vaughan** is editor of PCN

## Prescribing Information:

**ENTRESTO®** (sacubitril/valsartan)

**Important note:** Before prescribing, consult Summary of Product Characteristics (SmPC).

**Presentation:** Film-coated tablets of 24 mg/26 mg, 49 mg/51 mg and 97 mg/103 mg of sacubitril and valsartan respectively (as sacubitril valsartan sodium salt complex).

**Indications:** In adult patients for treatment of symptomatic chronic heart failure with reduced ejection fraction. **Dosage & administration:** The recommended starting dose of sacubitril/valsartan is one tablet of 49 mg/51 mg twice daily, doubled at 2-4 weeks to the target dose of one tablet of 97 mg/103 mg twice daily, as tolerated by the patient. In patients not currently taking an ACE inhibitor or an ARB, or taking low doses of these medicinal products, a starting dose of 24 mg/26 mg twice daily and slow dose titration (doubling every 3 - 4 weeks) are recommended. A starting dose of 24 mg/26 mg twice daily should be considered for patients with SBP ≥100 to 110 mmHg, moderate or severe renal impairment (use with caution in severe renal impairment) and moderate hepatic impairment. Do not co-administer with an ACE inhibitor or an ARB. Do not start treatment for at least 36 hours after discontinuing ACE inhibitor therapy. Sacubitril/valsartan may be administered with or without food. The tablets must be swallowed with a glass of water. Splitting or crushing of the tablets is not recommended. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. Concomitant use with ACE inhibitors. Do not administer until 36 hours after discontinuing ACE inhibitor therapy. Known history of angioedema related to previous ACE inhibitor or ARB therapy. Hereditary or idiopathic angioedema. Concomitant use with aliskiren-containing medicinal products in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 $m^2$). Severe hepatic impairment, biliary cirrhosis and cholestasis. Second and third trimester of pregnancy. **Warnings/Precautions:** Dual blockade of the renin angiotensin-aldosterone system (RAAS): Combination with an ACE inhibitor is contraindicated due to the increased risk of angioedema. Sacubitril/valsartan must not be initiated until 36 hours after taking the last dose of ACE inhibitor therapy. If treatment with sacubitril/valsartan is stopped, ACE inhibitor therapy must not be initiated until 36 hours after the last dose of sacubitril/valsartan. Combination of sacubitril/valsartan with direct renin inhibitors such as aliskiren is not recommended. Sacubitril/valsartan should not be co-administered with another ARB containing medicinal product. Hypotension: Treatment should not be initiated unless SBP is ≥100 mmHg. Patients with SBP <100 mmHg were not studied. Cases of symptomatic hypotension have been reported in patients treated with sacubitril/valsartan during clinical studies, especially in patients ≥65 years old, patients with renal disease and patients with low SBP (<112 mmHg). Blood pressure should be monitored routinely when initiating or during dose titration with sacubitril/valsartan. If hypotension occurs, temporary down-titration or discontinuation of sacubitril/valsartan is recommended. Impaired or worsening renal function: Limited clinical experience in patients with severe renal impairment (estimated GFR <30 ml/min/1.73$m^2$). There is no experience in patients with end-stage renal disease and use of sacubitril/valsartan is not recommended. Use of sacubitril/valsartan may be associated with decreased renal function, and down-titration should be considered in these patients. Hyperkalaemia: sacubitril/valsartan should not be initiated if the serum potassium level is >5.4 mmol/l. Monitoring of serum potassium is recommended, especially in patients who have risk factors such as renal impairment, diabetes mellitus or hypoaldosteronism or who are on a high potassium diet or on mineralocorticoid antagonists. If clinically significant hyperkalaemia occurs, consider adjustment of concomitant medicinal products or temporary down-titration or discontinuation of sacubitril/valsartan. If serum potassium level is >5.4 mmol/l discontinuation should be considered. Angioedema: Angioedema has been reported with sacubitril/valsartan. If angioedema occurs, discontinue sacubitril/valsartan immediately and provide appropriate therapy and monitoring until complete and sustained resolution of signs and symptoms has occurred. sacubitril/valsartan must not be re administered. Patients with a prior history of angioedema were not studied. As they may be at higher risk for angioedema, caution is recommended if sacubitril/valsartan is used in these patients. Black patients have an increased susceptibility to develop angioedema. Patients with renal artery stenosis: Caution is required and monitoring of renal function is recommended. Patients with NYHA functional classification IV: Caution should be exercised due to limited clinical experience in this population. Patients with hepatic impairment: There is limited clinical experience in patients with moderate hepatic impairment (Child Pugh B classification) or with AST/ALT values more than twice the upper limit of the normal range. Caution is therefore recommended in these patients. B-type natriuretic peptide (BNP): BNP is not a suitable biomarker of heart failure in patients treated with sacubitril/valsartan because it is a neprilysin substrate. Psychiatric disorders: Hallucinations, paranoia and sleep disorders, in the context of psychotic events, have been associated with sacubitril/valsartan use. If a patient experiences such events, discontinuation of sacubitril/valsartan treatment should be considered. **Interactions:** Contraindicated with ACE inhibitors, 36 hours washout is required. Use with aliskiren contraindicated in patients with diabetes mellitus or in patients with renal impairment (eGFR <60 ml/min/1.73 $m^2$). Should not be co-administered with another ARB. Use with caution when co-administering sacubitril/valsartan with statins or PDE5 inhibitors. Monitoring serum potassium is recommended if sacubitril/valsartan is co-administered with potassium-sparing diuretics or substances containing potassium (such as heparin). Monitoring renal function is recommended when initiating or modifying treatment in patients on sacubitril/valsartan who are taking NSAIDs concomitantly. Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with ACE inhibitors or angiotensin II receptor antagonists including sacubitril/valsartan. Therefore, this combination is not recommended. If the combination proves necessary, careful monitoring of serum lithium levels is recommended. If a diuretic is also used, the risk of lithium toxicity may be increased further. Co-administration of sacubitril/valsartan and furosemide reduced Cmax and AUC of furosemide by 50% and 28%, respectively, with reduced urinary excretion of sodium. Co-administration of nitroglycerin and sacubitril/valsartan was associated with a treatment difference of 5 bpm in heart rate compared to the administration of nitroglycerine alone, no dose adjustment is required. Co-administration of sacubitril/valsartan with inhibitors of OATP1B1, OATP1B3, OAT3 (e.g. rifampicin, ciclosporin), OAT1 (e.g. tenofovir, cidofovir) or MRP2 (e.g. ritonavir) may increase the systemic exposure of LBQ657 or valsartan. Appropriate care should be exercised. Co-administration of sacubitril/valsartan with metformin reduced both Cmax and AUC of metformin by 23%. When initiating therapy with sacubitril/valsartan in patients receiving metformin, the clinical status of the patient should be evaluated. **Fertility, pregnancy and lactation:** The use of sacubitril/valsartan is not recommended during the first trimester of pregnancy and is contraindicated during the second and third trimesters of pregnancy. It is not known whether sacubitril/valsartan is excreted in human milk, but components were excreted in the milk of rats. Sacubitril/valsartan is not recommended during breastfeeding. A decision should be made whether to abstain from breast feeding or to discontinue sacubitril/valsartan while breast feeding, taking into account the importance of sacubitril/valsartan to the mother. **Undesirable effects:** *Very common (≥1/10):* Hyperkalaemia, hypotension, renal impairment. *Common (≥1/100 to <1/10):* Anaemia, hypokalaemia, hypoglycaemia, dizziness, headache, syncope, vertigo, orthostatic hypotension, cough, diarrhoea, nausea, gastritis, renal failure, acute renal failure, fatigue, asthenia. *Uncommon (≥1/1,000 to <1/100):* Hypersensitivity, postural dizziness, pruritis, rash, angioedema. *Rare (≥1/10,000 to < 1/1,000)*: Hallucinations (including auditory and visual hallucinations), sleep disorders. *Very rare (<1/10,000):* Paranoia.

**Legal classification:** POM. **Marketing Authorisation Numbers, quantities and price**: Entresto 24 mg/26 mg film-coated tablets £45.78 per 28 tablet pack (EU/1/15/1058/001); Entresto 49 mg/51 mg film-coated tablets £45.78 per 28 tablet pack, £91.56 per 56 tablet pack (EU/1/15/1058/002-003); Entresto 97 mg/103 mg film-coated tablets £91.56 per 56 tablet pack (EU/1/15/1058/006). **Date of last revision of prescribing information: May 2021**. MLR ID: 129646. **Full prescribing information (SmPC) is available from:** Novartis Pharmaceuticals UK Ltd, 2nd Floor, The WestWorks Building, White City Place, 195 Wood Lane, London, W12 7FQ. Tel: 01276 692255.

**Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard Adverse events should also be reported to Novartis via uk.patientsafety@novartis.com or online through the pharmacovigilance intake tool at www.report.novartis.com. If you have a question about the product, please contact Medical Information on 01276 698370 or by email at medinfo.uk@novartis.com**

PCN ROUNDTABLE

# WORKING WITH THE COMMUNITY

**Primary care leaders joined Pulse PCN editor *Victoria Vaughan* to discuss how they are working with communities and building on the lessons learned from the Covid vaccination programme**

ALAMY

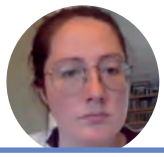
## DELEGATES

**Dr Andy Brooks**
visiting fellow at The King's Fund, GP in Surrey

**Dr Manraj Barhey**
clinical director of Medics PCN, Luton, Bedfordshire

**Nicola Hall**
transformation programme lead, Coventry and Warwickshire

**Riyad Karim**
Assistant director of primary care, Enfield, London



**Alexandra Kerswell**
project manager, additional roles reimbursement and childhood immunisation in central London

**Chair Victoria Vaughan**
Pulse PCN editor

**Victoria Following the work done in the initial phase of the Covid vaccination programme, PCNs are forging links with faith groups and the voluntary community and social enterprise (VCSE) sector. Can you outline the work that is going on in your areas?**

Riyad My role is to support primary care in general. With regard to Covid, it's been increasingly collaborative in focus, working with PCNs, the GP federation, the VCSE sector, public health, acute and community providers. Many were concerned about the disproportionate impact of Covid on black and minority ethnic (BAME) communities.

Enfield council public health team provided regular figures so we had a data-driven approach to that group, looking at vaccine uptake by age, sex, ethnicity, geography and language spoken. That helped to inform how we engaged with communities by locating vaccination pop-ups at mosques, churches and women's centres, for example.

We also mobilised trusted faith and community and clinical leaders because it was clear that underpinning vaccination was the need to engage with the community on health inequalities, particularly with the black African, black Caribbean community. That ensured that when we did webinars and community engagement, we focused on particular languages or ethnicity groups.

We're continuing that work into childhood immunisation, using trusted voices and trusted leaders in the community and clinical leaders.

Alexandra When Covid vaccinations were launched, we worked closely with our volunteer networks, not only as a workforce but also by acting as prime examples of why to get a vaccine. By volunteering at the sites, they became spokespeople for it, which was really interesting to see. We had staff who were administrators, who were anti-vaxxers at the very beginning but then by seeing herd movements, began to say: 'Actually, I'll do it'. They went on to speak out in newsletters and their local communities.

Our social prescribers initially worked on site, and so they had all the information and could speak with confidence. We had marshals from learning disability charities, which helped when patients came through the doors.

We moved the site around once pop-ups were established into local places of faith. We had a bus and we put a call out to anybody and everybody who had ideas and wanted to be involved. Because everyone had been behind closed doors for so long people jumped at the opportunity, which was amazing to see. There was a real strong sense of community, especially in the first few weeks.

That has continued as some of the volunteers that still work at our vaccine sites are people who attended to get a vaccine.

Manraj When we were tasked, as PCN, to set up vaccination centres, we hit the ground running and had lots of input. But regular monitoring showed that the uptake in certain communities was low. We were approached by local leaders so GPs put together little video clips encouraging vaccination.

We put some of the local clinical leaders on local radio. A community




**We've done a couple of visits to the Sikh temple to check blood pressures – a couple of years ago that was unthinkable**

Dr Manraj Barhey

ALAMY

vaccination hesitancy group was set up very quickly. We were asked do an outreach clinic at the local Sikh temple and the mosques.

We found if we used our local leading clinicians and religious leaders, advising people to have the vaccination, and showed them on video having the vaccinations done, the uptake improved considerably.

In Luton, one of the lesser-known factors is that a lot of unregistered patients are here illegally. I remember the first trip to our local mosque. We had about 200 patients turn up that weren't registered with any practice, the people with no papers. They all wanted their vaccination but they had nowhere to go because they weren't registered. We had a similar experience at the Sikh temple. Very quickly, we built close relationships with the local religious institutions. That's carried on. They're asking us: 'Please can you come and do health checks and blood pressures and so forth?' Obviously, the Government's amnesty on unregistered patients helped, so we were allowed to just vaccinate and there were no questions asked.

**Victoria This idea of trusted voices and using your volunteers as advocates – can it be applied to delivering other services in primary care?**

Manraj Absolutely yes. We're getting demands and requests, saying, 'Please come back to our Sikh temple', and 'Please come to our mosques' to do health checks and education and so forth. The downside is this is all out of hours and there's no funding for it. We've done a couple of visits to the Sikh temple and the throughput is amazing. All the people turn up wanting their blood pressures and blood sugars done and so forth, but the common theme is poor access to primary care.

The topic of discussion has moved on to less common things. We've done something at the local Sikh temple on autism. A few years ago, you wouldn't hear of these sort of things at a Sikh temple - it's had a really positive impact.

Alexandra Yes, just to reinforce what Manraj was saying, in our area, it has enabled us to move quicker with things like polio, and the work that I'm doing with our pilot on childhood immunisations, which involves working closely with the community to improve uptake using community settings. We're trying to apply the same approach in building up conversations about vaccinations for children, getting people talking about it and feeling confident to talk about it. The more people we can reach with correct information and the more people we can train to articulate it appropriately, the better healthcare and access become.

Covid was a fantastic opportunity because things were made a lot easier, especially with access to information and working together. Some red tape became a bit orange, so you could get around things much quicker. That was really good, but before that, in central London, our PCNs had been working with the voluntary sector and communities, in terms of engagement and training, with people such as carers' networks. They'd come in and offer training at practices. We had the learning disability charities. We had an initiative called Pride in Practice. Opening these doors to these trainings, [which] weren't mandatory but were things that improved relationships and referrals and →

**Many people think they understand diversity issues but our work has shown we need a lot more engagement locally**

Riyad Karim

built on how they could be referred into – that led to social prescribing.

We also have volunteers that work in the GP practice gardens. If patients feel like their practice is theirs, they know the staff, they belong there, they're more likely to engage appropriately with it.

Andy Nationally, we wanted lots of people to be vaccinated but there wasn't a target. Lots of stuff came from the bottom up, which I think [makes the success] really interesting. The cultural stuff and the soft stuff was really important, and it focused on one-to-ones. All the individual success stories add up to population bases rather than a top-down approach.

There's also capacity and capability – as Manraj was saying, this was done outside core stuff. It was people putting in effort, which is great – but if it needs to be extended, it's going to require significant capability and capacity.


There is also a potential that we underestimate the risks of more complicated [tasks] and therefore require even more capacity. While the effort that went into [the vaccination programme] was significant the task was straightforward.

Riyad In terms of legacy work we discussed about how particular MDT groups we've used during Covid vaccination can now be used for polio and childhood immunisations. One of the things that became clear, particularly when we worked with our black Caribbean and black African communities, was that we needed to invest more in programmes to address health inequalities with the communities.

In response to a community consultation, we commissioned a specialist organisation called the Caribbean & African Health Network (CAHN) from Greater Manchester, using inequalities funding, to set up this programme for Enfield Primary Care. It was intended to address health inequalities and was overseen by our communities director. It delivers a one-hour session of culturally appropriate education, training and support, designed for Enfield Primary Care staff and other healthcare professionals. It's free for Enfield practices and is endorsed by CAHN, and has been quite transformational for practice managers.

Many [practice managers] have said they thought they'd understood diversity but [this has] shown that they need to know the local population more and need to be engaging more – which is mind blowing.

Manraj The PCNs do tackle health inequalities, or are certainly trying to, in terms of finding CVD, hypertension, cancer and so forth. Having learned lessons from the vaccination programme, we have used some of our additional roles to look at aspects where we can try to help.

As an example, we're doing a lot of work on hypertension case-finding and CVD risk. We've got our physician associates doing the actual work, taking blood pressures and so forth. We've got care co-ordinators getting the data and we've got our social prescriber and health and wellbeing coach targeting various communities that we know are at risk. It's their day job now to build up their relationships with local communities. Occasionally we have to do things out of hours in terms of education but we must not forget that PCNs are an enabler to tackle some of these health inequalities and carry on some of the work we've established from the vaccination centres.

**Victoria The VCSE sector is also working with PCNs to provide support in areas such as mental health. Can you outline how that's working for you?**

Nicola In Coventry and Warwickshire I'm part of the community mental health unit at Rethink Mental Illness, supporting the transformation in local areas. Also, I'm the local lead for Coventry and Warwickshire working with the PCNs, particularly the social prescribers and the mental health liaison workers and link workers. I've been developing multi-agency MDTs. There are lots of organisations that attend – housing, social care, secondary care, psychology, the police and probation. A common theme in primary care and the voluntary sector is the level of complexity of some of the cases we're working with – that either aren't getting through access hubs into secondary care or are on huge waiting lists and therefore are relying on primary care and the voluntary sector.

These multi-agency MDTs are bringing all the partners together to work through some of the complexity and [develop] a fast track into secondary care for the patients who should have got through the access hub. Also, [it is helpful to] bring together the professionals to work in an aligned and co-ordinated [way] as patients are working with so many different professionals they almost become their own care co-ordinator trying to align all the different types of support. Multi-agency working is really about providing this aligned support, which is being delivered throughout PCNs in Coventry and Warwickshire.

**Victoria Alexandra and Manraj do you have multi-agency MDT teams for your PCNs and someone co-ordinating this?**

Manraj The short answer is no. One of our biggest frustrations is that there are lots of good pieces of work going on in the community but we don't actually know about them.

Let me give you a couple of examples. We set up a health check in our local Sikh temple and while we were there they were saying, 'Somebody's contacted us from public health and they're coming in a month's time', which was the first I'd heard of it. I went along to the

ALAMY / GETTY

event and I asked the people doing the health checks 'Where do you record the data?' They said, 'We just put it on some bits of paper somewhere'. It wasn't going to the practices or PCNs. The work is going on but not being co-ordinated. The information isn't being recorded centrally. We need a lot more co-ordination between the big stakeholders, public health and community trusts so we can tap into them and work alongside them rather than reinventing things.

Alexandra We're fortunate in central London that our GP practices and the PCNs were working in these. Sadly there isn't one individual with an MDT hat and there are multiple teams – name a target group and there is an MDT [for it] somewhere.

One of the things that was identified recently with my childhood immunisations project is that family navigators weren't involved in some of the children's MDT meetings and they want to get involved. It's by having these conversations in pilot projects that [we get] the people involved that should be.

There's no resource for this. It is purely funded by the passion of the individuals. If we look at primary care, the amount of time that is volunteered beyond individuals' roles is phenomenal.

At the moment one of our focuses is high-intensity users. There are a couple of different projects going on and we're drawing on volunteers and the community to take responsibility for high-intensity users. At the end of these pilots we will hopefully show they have had an impact.

One of the pilots is a demonstrator that is identifying pools of people that are accessing services or [might] access more services. We've got about 900 young people across the borough that we're going to be targeting to make sure they are better supported in accessing healthcare and are being socially prescribed.

However, one thing that we are at risk of doing, especially in central London, is having nowhere to socially prescribe to.

By increasing all this access and awareness, the services are floundering because their funding isn't as strong as it used to be and they don't have the provision.

**Victoria Nicola, how is your MDT funded?**

Nicola My funding comes from the charity's aid foundation to support the transformation. Basically my role has three prongs: I work with the voluntary sector; I sit on all the transformation boards; and I co-ordinate and develop MDTs. Sometimes there's an assumption that if you →

**Sometimes there's an assumption that if you refer a patient to a service, they get the help. But they might just join a waiting list**

Nicola Hall

refer a patient to a service they are actually getting that support. In fact, that patient may be on a huge waiting list or that service may have gone – this is an area where the MDTs can definitely help.

**Victoria How do you make the information on community provision more available to PCNs?**

Andy One of the things I found really helpful as a GP is not having to be aware of what the services are. What I try to convey is the patient's need rather than deciding [what service they should go to]. Then the experts who have a directory can [direct to the most appropriate place].

Manraj There's something to say about building [community provision] into the local structure. We've got a place for health inequalities, which is funded by the integrated care board [ICB].

For example, we have social services, public health and the mental health trust and it's built into the governance structure so that they are aware of what's going on, which can be fed back to primary care and other PCNs.

**Victoria What would help you capitalise on working with the VCSE sector?**

Manraj We need shared data because we find that different stakeholders use different systems. They can't talk to each other. The data Public Health provides is usually out of date and again, it can't simply be transferred to GP systems.

Also, [it would be good to] share knowledge of the resources available to us. Half the time, we don't know what's going on in our own neighbourhood. We need to get on with this and actually do things.

I've been [at] clinical commissioning groups (CCGs) and, prior to that, primary care trusts (PCTs) for so many years and I'd like to see outcomes and results. I think PCNs are a huge opportunity to [tackle] bite-sized chunks with measurable outcomes fairly quickly.

PCNs can be a huge resource for workforce. They can tackle health inequalities directly and we can measure our own data. From the more strategic point of view I like the phrase 'fusing strategies'. If you look at the local police strategy and where the most stabbings and burglaries take place, it almost mimics health inequalities maps. They're all targeting resources to the same area – so let's all join forces rather than work in silos.

Alexandra We need investment – not only in the services themselves but in people that help develop and oversee it. We've got lots of investment in things such as social prescribers and care co-ordinators. These roles are good and useful but there's nobody to manage and direct them. Some investment in supporting the networks is needed – and that goes beyond just PCNs and the GPs but into the wider community with volunteers to continue the legacy work that Covid brought.

There was a really interesting psycho-social phenomenon during Covid that hasn't been seen for a long time. Although there was an increase in mental health problems from isolation, there was a decrease in certain types of mental health problem because people engaged in things they enjoyed where they live.

ALAMY

It would be helpful to have investment in a workforce that can look at that, pull it together and learn from it.

Riyad The structure is important but underpinning that is the level of coproduction and relationships. [We need to] build trust, internally and externally with all the stakeholders in a borough.

Also levels of deprivation must be accounted for – and I would hope that funding will be prioritised on the basis of deprivation in the area.

Certainly during Covid, hyperlocal funding was allocated on that kind of basis. That helped to co-ordinate and target vaccine promotion.

It's important to recognise that across England, we're in the transition model. We have ICBs – they're in transition as prior to that there was a CCG, which was a primary care-led organisation. Now we're moving towards a multi-professional integrated care system and an organisational structure.

It's important for me to amplify the impact of primary care and PCNs. We're not clipboard commissioners and we haven't been for the last two or three years. [This is all] about partnering and partnership working and ensuring we help and support primary care in this transitional process. Looking at the Fuller Stocktake, that's going to be very important in the future, in the promotion of integrated neighbourhoods.

Above all, it's all about building relationships and trust – as we've been saying all along.

# BAD PARENTS

PCNs are now just over three years old. Most three-year-olds walk, fall over and get up again. We do not normally expect them to run marathons. In the NHS long-term plan of 2019, the ambition for our new baby was as follows: 'for the first time since the NHS was set up in 1948, there will be a creation of fully integrated community-based healthcare'. Yet in the PCNs' short lives, we have expected practices to come together to become one delivery unit, work in partnership with multiple organisations – often competing for resources – and embed and supervise more than a dozen new roles. There has been little support and often more top-down demands.

Despite this vast expectation, PCNs have delivered the most successful vaccination programme in the history of the NHS and many have worked innovatively to tackle difficult wider health issues such as the incidence of knife crime in young people. This project was undertaken in my own PCN, and it came on top of the day job of hitting impact and investment and DES targets.

So has the delivery of the vaccine programme led to big hugs, praise and treats for our toddler PCNs from the doting NHS parents? Unfortunately not. PCNs have been sent to bed early with the threat of no supper. Since the pandemic, the negative narrative about lack of GP appointments and reduction of face-to-face appointments has painted GPs and their teams as deliberately obstructive and lazy. There has been little support for practices, which are, of course, the foundations of PCNs.

And now we are morphing into another entity – integrated neighbourhood teams. It is unclear to me how another restructuring will solve any of the issues.

The unanswered question for me is this: what is the purpose of PCNs?

Are they here to sustain practices? This is clearly not happening as patients registered with small lists or in areas of deprivation are not benefiting from the additional roles reimbursement scheme (ARRS) staff who often work in a large practice, and in affluent areas. This is widening health inequalities.

Are PCNs here to tackle population health and work with communities on wider determinants of health and prevention? This does not seem to be the message from our Integrated Care Systems (ICSs), which are struggling to keep people out of hospitals. The focus is not on primary and community care. This is a different reality from the objectives of the long-term plan.

If PCNs are to succeed, we need to define what we are asking of primary care – which must include general practices as the foundation. We have to focus on priorities that will make largest impact. If we try to do everything, we will achieve nothing. We must have an equal voice in the large ICS boards and brave dialogue with our acute trusts. We will need a united primary care voice – which can be hard to achieve with the infrastructure of primary care being disparate, independent organisations. All this requires listening, humility and relationship building, which takes time.

Finally, we must remember that PCNs are not like human three-year-olds who often need direct instruction. Let's have adult-to-adult conversations with all members of PCNs, not just the clinical directors, and let us have a break from restructuring and work on a shared purpose to serve our communities.

**PCNs have been sent to bed early with the threat of no supper**

**ONLINE**
**Read about Dr Hussain's knife crime project at pulsetoday.co.uk/pcn**

**Dr Farzana Hussain**
is a GP and former clinical director of Newham Central 1 PCN in east London

# LEADING QUESTIONS

***Professor Aruna Garcea*, clinical director for Leicester City and Universities PCN and chair of the NHS Confederation's primary care network advisory group, shares her thoughts about the next steps for PCNs**

**What do you think PCNs should be doing about the Fuller Stocktake?**
For our PCN members, the Fuller Stocktake represents the next stage for primary care. It is about neighbourhood teams and system working. Our PCN members want to support and design how it can be implemented using their knowledge, skills and experience. Our network is creating design groups and trying to translate it into a detailed approach that PCNs and primary care can take to their integrated care systems (ICSs). It is something we need to embrace because we're still fighting fire and not planning for resilience, and the Fuller Stocktake is about resilience.

**How do you think PCNs should work with integrated neighborhood teams?**
It's about developing new functions that didn't exist in core practice before. If you think about personalised care planning, population health management, trying to meet increasingly complex needs in the community, the lack of social care, the impact of the wider determinants of health and changing political climates, you need to create different solutions. Neighbourhood teams are the ring around the PCN. They are working relationships with our health and social care partners. From that we create multidisciplinary teams (MDTs) or micro-teams around patients, to push the personalised care agenda for patients that need it. But neighbourhood teams are also a platform for us to integrate and share care across a wider team, which we have done with our MDT working in cancer and safeguarding.

**I believe in continuity of care and we must show patients that this can be given by the wider team**
Professor Aruna Garcea

But neighbourhood teams would be a lot more formal – a place where we are living that integrated leadership and that integrated team. One size does not fit all because every geography is different, every PCN and its relationships with providers is different. We'll find that creating neighbourhood teams to drive that part of the PCN and community work will feed into place, because the missing gap in the ICS is place-based working, and it's lacking in general practice at the moment.

That's the next step. We need to form teams and they should have a strategic position at place level to drive solutions.

**Fuller also considered issues of urgent care versus continuity of care. How do you think it should be approached?**
As a GP I came into this profession to look after my patients from cradle to grave. I believed in continuity and the benefits of the continuous relationship. However, I recognise that we have challenges that are threatening the very essence of the NHS, never mind general practice. We have worsening health inequalities as a result of the social care burden, the changing political landscape, the cost-of-living pressures. The umbrella cover of general practice has morphed, and there is an increasing complexity in general practice. Providing continuity isn't as simple as it was 20 years ago. So I absolutely agree we need continuity of care with a provider. My challenge is that it may make sense to split away urgent episodic care that is non-complex. That will help relieve capacity so that I can focus on continuity of care with micro-teams, as I described.

I do believe there's a space for continuity. I believe it involves personalised care planning and a risk stratification approach. I think patients should always have a continuous relationship with their practice because that's their home for health and wellbeing. But I think we also need to take our patients with us in the multidisciplinary approach of new primary care and reassure them that they're getting appointments with the wider care team because these guys are best suited for their need at the time. Also that we are maintaining continuity because we have data continuity through the electronic patient record and we have care continuity as a team in the practice.

**What do you want to see from the Government and NHS England when the contract ends in 2024?**
PCNs have been restricted in their development because of a restricted contract, and it's been front loaded. We end up with a lot of demands that have been gradually withdrawn over the year. The contract is constantly being interrupted in its application. What I would like, as a representative of our members, is to tell policy-makers that our PCNs want to have more autonomy, more flex, more influence at place and neighbourhood and to determine local solutions for their communities, backed by the principles of the DES, instead of the DES being prescriptive. I'd like to see how we're going to improve estates. I'd like to understand how the additional roles reimbursement scheme (ARRS) will come back into the contract so we can be reassured of keeping these staff so we can plan long term. We're in short-term territory at the moment, so it's impossible to be strategic.

And also I'd like a recognition of the support that we need with IT, with intelligence and with leadership.

**What impact is this having on ARRS in a PCN?**
Because it's so stop and start we're always having to mitigate. There are PCNs that are having to think about redundancy planning in case there is a problem [with ARRS]. And this also affects the patients, because they are used to a level of access that didn't exist before.

There is also quality and safety to consider because these staff are providing a huge amount of safety, particularly our pharmacists and social prescribers in terms of supporting those that are vulnerable at home. There are lots of softer consequences from that uncertainty, in terms of services that we're providing.

I am keen to have that negotiation, get clarification and make sure there is a bottom-up approach this time round.

# HIRE A DIGITAL AND TRANSFORMATION LEAD

**Digital and transformation leads were added to the additional roles reimbursement scheme (ARRS) in September 'to optimise new technology and other initiatives' across PCNs. *Dr Neil Paul* explains the role**


It probably shouldn't have been a surprise when NHS England told us we could use additional roles money on a digital and transformation (D&T) lead – one per PCN, maximum band 8a. This seems a reasonable response to the complaint that we have struggled to get innovation implemented and this is a way of pushing the accelerate button.

NHS England has said these roles must use data to: improve patient access and staff experience; support population health management; understand the 'type and intensity' of training needed; facilitate clinically led innovation; make sure practices are using the latest technology to offer more phone lines; monitor their call response times; and offer support with the NHS app which, since November, helps patients review their test results.

**Should you have a D&T lead?**

While it sounds attractive, remember the original aim of the additional roles reimbursement scheme (ARRS) was to reduce the workload of the GP. Perhaps its unstated aim was to get more patients seen. We were encouraged to adopt new clinical roles in primary care that had been piloted but hadn't taken off widely.

A good question for a PCN is: 'Are you going to get more value from this D&T lead than from, say, an advanced clinical practitioner?'

To be worthwhile, the role must deliver value to practices and patients. It should not end up trying to promote top-down solutions that the PCN or practices don't support, or filling in spreadsheets to 'feed the beast'.

**Consider splitting the role**

The role is advertised as 'digital and transformation', and while these are linked, they could be separate tasks with overlap.

The digital side of the role covers everything from data analysis to strategic planning. The transformation side covers building relationships with the wider system and facilitating working between practices.

You don't need to have one person that does it all. Decide what is important and hire accordingly. My PCN is thinking of having two people working half time – one delivering the digital and the other transformation, with significant overlap.

Think about sharing with other PCNs. Many PCNs work closely with others, perhaps in a federation.

**Who to hire**

The role is quite high level but the D&T lead shouldn't spend their life in meetings. They should help practices deliver their GMS and PCN work and look at what help is needed by practice managers, PCN managers and partners. It is a lead role – it is not about admin nitty-gritty like updating smart cards and changing printer cartridges. Of course, you may have suitable internal candidates who have primary care IT expertise and experience is key – and may be hard to find in outside candidates.

I would be wary of taking on ex-clinical commissioning group (CCG) staff who are displaced and looking for work. Some may be excellent and have the right skills, but many won't understand the operational pressures of primary care and may struggle to know who they are serving or may not have the right IT background.

Some PCNs are wondering if they can nominate their existing PCN manager to be their transformation lead and fund them from this pot. I understand the thinking, but would be cautious about this. Will you get more work done? This role is about adding capacity.

However, this approach might free up DES and leadership money to spend on something more flexible that doesn't have to follow the ARRS rules, including more clinical director or GP time. I know some managers are attracted to this option as there has been a statement that ARRS funding will be guaranteed whereas leadership money may not be.

Using third-party suppliers may be an option. The scheme was originally meant to fund employed posts, but many PCNs have outsourced other roles to charities, federations or companies that have the right skills. However, there is a danger that they will assume the role is to take part in meetings instead of going to a practice and actively trying to improve the lives of staff. Also, there is a worry that outside contractors won't understand primary care, but many are bright people with interesting skills and could bring valuable expertise. However, they may be used to higher wages than 8a level.

I've seen lots of negative comments on forums about the role of D&T lead. As I've stated, the key, if you are using this role, is to make sure they add value to practices. In my PCN I'm confident that we can develop the role so that it will.

The role can be useful to help practices and clinicians, so think carefully what you want the D&T lead to do and make sure you get the right person. Also, think about sharing the person with another PCN.

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



GETTY

# HIRE SOCIAL PRESCRIBING LINK WORKERS

**As the social prescribing workforce is expanding in primary care, *Dr Pipin Singh* explains why the role is valuable for PCNs**

We have seen a big increase in austerity, childhood poverty and social deprivation over the past 10 years. It is widely recognised that a significant percentage of GP consultations are due to social problems such as housing, financial and employment issues.

Social prescribing allows patients to be directed down a path that takes account of all these social factors and formulates a holistic plan that can have a positive impact on their physical and mental health, as well as their role in society.

**What are the requirements of the role?**

The social prescriber works in a GP practice and, with the help of clinicians and the administrative team, identifies patients who would benefit from a holistic overview of their care.

They should work within the multidisciplinary team (MDT) providing psychosocial interventions such as setting goals, signposting to other organisations, agenda setting, setting boundaries and promotion of self-management.

The social prescriber should be trained in promoting motivational change and recognise the stages of change that patients go through.

They also need to be empathetic, sensitive to patient needs and have good communication skills in order to extract information that will help manage the patient. They should be trained in safeguarding and be alert to information that should be passed back to the primary care team or escalated to the appropriate agency.

A social prescriber also should be knowledgeable about the geographical area they serve, work well in the primary care team and be comfortable attending meetings and sharing information as needed.

NHS England sets out the minimum requirements for a social prescribing link worker employed by PCNs, in the NHS England Network Contract DES service specification.

**Getting the best out of your link worker**

**Help them to help you** Invite your social prescribing link worker to regular MDT meetings. This is the best way for them to identify patients they can help. This will also help the social prescriber identify what other agencies are involved and whether their involvement may duplicate work or cause extra steps or inconvenience for patients.

**Encourage regular communication** Presence at team meetings also encourages sharing of information and the likelihood that the service will be used, as it helps other healthcare professionals in the team identify needs and potential support available. It will also enhance relationships with other team members and break down potential barriers to communication.

If you do not have a regular MDT meeting, ensure you introduce the link worker to your team or directly to individual team members. It is important that everyone in your team is aware that there is a link worker available, particularly care navigators whose roles may partly overlap.

**Co-ordinate with PCN colleagues** It is important to co-ordinate with other member practices where link workers are employed across a PCN. For example, if MDT meetings at different practices are held the same day, a link worker could be invited at least once a month, or where there are multiple link workers they can be assigned to different practices.

A regular (monthly) newsletter via email, highlighting case studies with positive outcomes, is also useful to keep up their profile and share knowledge and information about the service.

GETTY

**Have clear referral pathways** This can be through email, task or referral form. It is also important to have a clear and formalised process for the link worker to communicate back to the referring clinician. Also remember when referring to use the code 'referred to social prescribing service'.

**Make sure they feel supported** There have been concerns that social prescribing link workers feel undervalued and lack support in their new PCN roles. One survey conducted in 2020 found 30% of link workers were considering quitting because of a lack of clinical supervision or support. Most of them were based in general practice.

I suspect much of this was down to poor understanding of the support and skill they can provide, so that teams are not referring patients appropriately. It is vital your link workers are invited to MDT meetings and kept in touch with the rest of the team.

It may not be necessary to have a formal supervision process, but it is important your link workers have a clinician they can speak to, or the practice manager, to discuss any queries or concerns. In addition, encourage link workers in a PCN to meet regularly to discuss cases and support each other. This could involve a group on social media, such as Facebook, WhatsApp or Twitter.

You could also encourage them to join an organisation such as the National Association for Link Workers, to network with other social prescribers to share experience, knowledge and training opportunities.

**Dr Pipin Singh** is a GP partner and trainer in Wallsend, Tyne and Wear

# FORGING THE WAY

**Foundry PCN in Lewes, East Sussex, is gaining notoriety for its success in managing urgent demand in primary care and was highlighted in the Fuller Stocktake. Clinical director *Dr Philip Wallek* explains how his PCN is approaching patient demand**

Demand and capacity are huge challenges in primary care. While I would never say we are meeting our patient demand I can say that our approach allows us to feel in control and plan for it.

By segmenting our patients into three groups and funnelling them to different types of appointments with the appropriate member of our staff – fully using the additional roles reimbursement scheme (ARRS) – we've created a matrix to manage and adapt to our patients' needs.

**Patients**

PCN patients are coded according to a traffic light system.

- Green – generally well patients who access care infrequently and for whom continuity is not a priority, but need ease and speed of access.
- Amber – patients with ongoing conditions for whom continuity is important.
- Red – vulnerable patients with complex and ongoing needs for whom continuity is crucial.

We have created teams to support these patient groups.

Green team, an evolution of our acute team, works from our urgent treatment centre providing on-the-day and advance-booked appointments. They are paramedics, GPs and first contact physiotherapists.

Patients in this group are more likely to prioritise speed of access, which can be provided by any competent clinician. They still have a named GP to track any documentation, but they won't necessarily see that GP. We offer some choice of clinician if they book in advance.

**Clinical director**
Dr Philip Wallek

**Practice**
Foundry Health Centre

**PCN**
Foundry PCN

**PCN location**
Lewes, East Sussex

**Number of practices in PCN**
1

**Number of patients in PCN**
28,500

**PCN hires through additional roles reimbursement scheme (ARRS)**
1 social prescriber
2 community paramedics
2 pharmacists
1 pharmacy technician
7 care co-ordinators
1 data transformation lead
2 mental health practitioners

**Recruiting (ARRS roles still to fill)**
1 pharmacy technician

## BACKGROUND

**Foundry PCN works in five sites in Lewes, Sussex. There are three practices, an urgent care centre and a former practice now used as managerial headquarters. Having been part of the National Association for Primary Care's Primary Care Home programme, the area was ready to capitalise on the opportunities brought by PCNs. With the 2019 PCN launch the three practices, which already shared management and nursing staff, merged finances in 2019 under one GMS contract and merged clinical systems in 2020. It was a huge cultural shift to operate at a larger scale.**

**We developed a vision of how to improve the care for patients, as the status quo was not sustainable. We brought together all the staff from the practices to study a small sample of patients and discover their experiences of healthcare by looking at their records and speaking to them. This highlighted problems in our systems and created a vision to improve care. We have continued this culture of improvement involving all staff.**

**Losing the identity of the original practices has been hard for longer-standing members of staff. We have worked hard to create a new positive brand – Foundry PCN – which staff are proud of. This has been reflected in our staff survey and also in our ability to recruit. We filled our recent GP vacancies with excellent candidates. The journey has been difficult but we feel it has been worthwhile and look forward to the future.**

Amber and red patients are registered with a usual GP and are grouped into micro 'continuing care teams' to help maintain continuity. The practice teams are multidisciplinary, including nurses, GPs, care co-ordinators, pharmacists and social prescribers.

Making the most of our additional roles has required a cultural shift. Receptionists and care co-ordinators have, where appropriate, offered patients alternatives to a GP appointment. Patients have started to realise the benefits in terms of continuity and specialist knowledge.

**Appointments**

We provide access via econsult or telephone booking. Receptionists filter queries as appropriate to community pharmacy or to our administration and medicines management team. All urgent on-the-day requests for the acute team are given a telephone appointment and are then seen face to face if needed. Advance-booked appointments are offered within two weeks and also in a month to try to improve continuity and offer patient choice. On-the-day green appointments are 10 minutes, advance-booked green appointments and all amber appointments are 15 minutes. Our red appointments are 15 minutes with GPs and these patients have further time with care co-ordinators, social prescribers and nurse specialists for both reactive and proactive care.

Proactive care is offered by our nursing and pharmacy teams including GPs when needed. We invite patients for long-term condition reviews to manage their needs in as a few appointments as possible.

By looking at patient groups and appointments we can track what's going on and adjust our focus. Using evidence from data analytics, we are able to intelligently respond to demand and adapt the design of our

Front left: PCN clinical director Dr Philip Wallek and the Foundry PCN team

services, which informs recruitment and deployment of staff.

Dementia patients were identified as a high-attending group with complex needs. We created a dementia team with a care co-ordinator and nurse specialist who have become the first point of contact for reactive and proactive care. They ask the usual GP for advice or a medical review when needed. This has both improved care, reduced urgent problems and saved GP time.

**Urgent treatment centre**

We formed a partnership with Sussex Community Foundation Trust to run an urgent treatment centre (UTC) in May 2020. With funding from the Friends of the Lewes Victoria Hospital, we expanded the minor injuries unit. The PCN provides medical supervision from 8am to 8pm seven days a week for an urgent care practitioner-led walk-in service, which also receives telephone triage from 111. We run our green service at the UTC and combine this with our extended hours service and the urgent treatment contract. This benefits both organisations and improves access for patients. The weekend GP shifts are offered to our PCN GPs as extras, which offers them flexibility and improves continuity for patients.

There were challenges in creating this UTC partnership. It has taken time to establish relationships and standard operating procedures but both parties feel it has been a success.

**Outcomes**

The South, Central and West Commissioning Support Unit looked at our data and found that our top 5% of frequent attenders only use 30% of GP consultations compared with 40% elsewhere. We have reduced the number of 'avoidable' appointments from 9% to 6.5% in late 2021, whereas other primary care services report an average 27% of appointments are 'avoidable'. We provide around 1,800 GP appointments per week, which suggests we save 370 GP appointments a week.

> **There were challenges in creating the urgent care partnership, but the effort has paid off**
>
> Dr Philip Wallek

We try to ensure that every clinician is working to the top of their capabilities, with the right clinician seeing the right patient at the right time. This improves staff satisfaction and patient care and saves money.

We are currently working with Kent Surrey Sussex Academic Health Science Network to create an independent assessment of our service redesign to help others to understand the benefit of our approach.

**Future**

We started our journey of merging three practices in five sites in 2015 and hoped to have a new building to be a hub for healthcare in Lewes. Because of planning issues this has been delayed but we hope it may be ready in 2024. The delay has enabled us to look more carefully at how a larger organisation can still offer continuity and the benefits of smaller teams. We have a commitment to always strive to improve. One innovation is a workforce management platform including data analytics that we are using to continually assess and improve our approach that we hope other PCNs may also find useful.

THE SACKWELL AND BINTHORPE PCSSIU BULLETIN

# TOWARDS NEIGHBOURHOOD TEAMS

Greetings, emergent integrated neighbourhood team members. It's Penny Stint again, with your regular update from the primary care support and strategic intelligence unit (PCSSIU).

As you know, the Sackwell & Binthorpe integrated care board (ICB) is fully committed to rolling out integrated neighbourhood teams across the system before the end of this year.

These were the main recommendations to come out of Dr Claire Fuller's report Next Steps for Integrating Primary Care earlier this year. The neighbourhood team is a 'team of teams' or network of PCNs responsible for:

- Developing a sense of shared purpose.
- Creating alignment.
- Fostering collaboration.
- Driving integration.
- Improving outcomes.

Dr Fuller's report set out a clear vision and strategy. It is now up to individual neighbourhoods to fill in the operational details including:

- How it will work.
- How things are paid for.
- Who's in charge.
- Where the money will come from.
- How we recruit the workforce.

Right now, we have exhausted staff and practices that are overwhelmed with work. That's because they're spending too much time seeing patients when they could be in meetings designing a better way to work.

With any big change programme you need to have the courage to say we need to do something differently.

It's the job of PCNs working with integrated care systems (ICS) leaders to imagine what 'different' might look like.

The role of the ICS is to support you to help you to make time for change.

We are developing a suite of practical resources, including:

- Why You Have More Space and Time Than You Think (primary care quantum physics mythbuster).
- The Shared Purpose Builder (step-by-step guide to proactive visioneering).
- Setting Your Team Up for Success (top tips for managing large-scale change programmes, with a foreword by Lord Lansley, architect of the 2012 NHS reforms).

**PCNs, neighbourhoods and places**

There has been some confusion about the difference between these concepts. A PCN is a group of practices serving a population of between 30,000 and 50,000 at neighbourhood level. An integrated neighbourhood team encompasses more than one PCN, so is bigger than a neighbourhood but smaller than a place. A place encompasses PCNs and neighbourhoods as well as one or more secondary care trusts. Neighbourhoods could evolve to become places but only if other neighbourhoods move in to fill the resulting gap.

I hope that clarifies the situation.

**The S&B primary care heatmap**

I'm sure you'll be pleased to hear that primary care is to get its own heatmap, an alert system to show which practices are under pressure similar to the operational pressures escalation level (OPEL) system used to flag up problems with hospitals.

A similar system trialled at S&B – the practice early warning system (PEWS) – will give the ICS and the national team advance warning about hotspots.

Practices will report whether they are cool, tepid, warm, hot or nearing boiling point. Those close to vaporising (the highest level of alert) will trigger a range of support measures from the ICS. These may include additional resilience training, help to try harder, strong encouragement from the ICB or a personal visit from the director of performance and recovery at the regional team.

We remain fully committed to preventing general practice from burning to a crisp.

**PCNs make incredible progress**

I always like to end this update on a positive note, so the last word goes to Dr Fuller. Asked if she felt PCNs were proving a success, Dr Fuller said: 'It's absolutely incredible what some areas have managed to achieve.' Acknowledging that it's too early to say what those achievements are, she said there were promising signs that NHS England would soon know.

It's not surprising that PCNs sometimes worry about minor obstacles along the way, such as potential non-existence after 2024. But neighbourhood teams promise a more integrated future than ever for general practice.

My team will continue to engage with you with meaningful offers of support as we embark on the next leg of the journey.

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

## OPEN SURGERY BY FRAN