PULSE PCN
CONNECTING PRIMARY CARE NETWORKS
SUMMER 2023

YOUR PAEDIATRICIAN WILL SEE YOU NOW

PCNs deliver patient-tailored care in hubs

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PULSEPCN

Pulse 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
benguynan@cogora.com

Delivery and subscription
subscriptions@cogora.com

COVER: GETTY

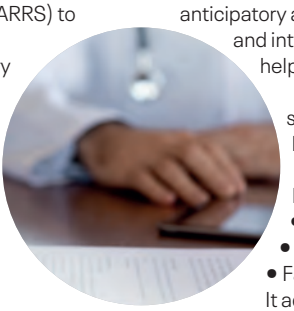
NHS ENGLAND TO REVIEW PCNs AHEAD OF 2024/25 CONTRACT

By Jess Hacker

NHS England will review the 'successes and lessons learned' from PCNs before the end of the five-year framework in 2024/25.

Announced on 9 May as part of its GP recovery plan, the review will also evaluate the additional roles reimbursement scheme (ARRS) to assess its options from 2024/25 onwards.

The review comes in response to Dr Claire Fuller's Primary Care Stocktake – published last May – which envisioned primary care organised into integrated neighbourhood teams, and called for NHS England to 'rapidly' assess the possibility.



In today's recovery plan, NHS England said the 2024/25 contract – which will mark both the end of the five-year framework and five years since PCNs were first introduced – is an opportunity to reflect on its successes and failures.

This will include assessing 'alternative approaches that can work alongside the partnership model' and opportunities to 'better align clinical and financial responsibilities' to allow primary care teams to reinvest savings in front-line services.

NHS England said of the recovery plan: 'This is the first step to address the access challenge ahead of longer-term reforms. The other two elements of the Fuller Stocktake vision of more proactive, anticipatory and preventive care delivered by multidisciplinary teams and integrated neighbourhood teams remain important and can help mitigate demand.'

NHS England said some PCNs and practices 'are successfully working on these, helping to build the learning on what it takes to implement'.

The approach, which NHS England has named Modern General Practice Access, has three components:

- Better digital telephony.
- Simpler online requests.
- Faster navigation, assessment and response.

It added: 'Integrating primary care requires general practice to operate at a larger scale either as part of PCNs or at place level, and other system partners, such as community, acute and mental health services, will need to organise care more locally to integrate with primary care.'

PCN PHARMACIST RECRUITMENT HAS 'UNINTENDED CONSEQUENCES'

By Megan Ford & Sofia Lind

Recruitment of clinical pharmacists to general practice is 'compounding the problem' of community pharmacy closures and delayed discharges from hospitals, a Government report has warned.

In early April, former health secretary Patricia Hewitt concluded in her review of the progress of integrated care systems (ICSs), requested by the Government, that national contracts – including the GP contract – present a 'significant barrier' to local innovation.

She went on to warn that 'contracts with national requirements can have unintended consequences in particular circumstances'.

'For instance, the national requirements and funding of additional roles reimbursement scheme (ARRS) roles for community pharmacists in PCNs has, on occasion, exacerbated the shortage of pharmacists, with some now preferring to work in primary care instead of community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges,' the report said.

In her report, published on 4 April, she recommended NHS England and the Department of Health and Social Care should convene a national group to develop a framework for primary care contracts.

Since 1 April, integrated care boards (ICBs) have also been delegated commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services, in addition to general practice. And, according to Ms Hewitt, this presents 'an opportunity' to make better use of the pharmacist workforce.

'The new responsibilities for ICBs provide an important opportunity, at place or system level, to integrate the whole primary care offer for communities, making the best use of staffing and premises,' the report said. She added: 'Instead of each element of primary care being treated as a separate silo, ICBs now have the opportunity – and the responsibility – to work with all elements of primary care to achieve the accessible, high-quality and integrated services that communities need.'

PRACTICES ERADICATE RACIAL INEQUALITIES IN BLOOD PRESSURE CONTROL

By Emma Wilkinson

GPs in south London have eradicated a large gap in blood pressure control between White patients and those from a Black or minority ethnic background, after a year-long project.

AT Medics Streatham PCN in Lambeth found that among their patients under 80 who were diagnosed with hypertension, there was a 12% inequality gap in blood pressure control, with 67% of White patients and 55% of Black patients treated to target.

Since the Covid pandemic, the data have shown hypertension outcomes have fallen while inequalities have grown, the team said.

The two practices in the PCN have 45,000 patients, with around 3,100 diagnosed with hypertension. They set up a centralised recall system and made use of practice pharmacists and healthcare assistants to provide education in self-care, lifestyle and medicines.

In all, 98% of hypertensive patients were recalled and had a blood pressure reading in the 12-month period and by the end of the year 87% of all patients under 80 years are controlled, they reported.

For White patients this is 86.9% and for Black patients, 87.4%. Overall the PCN has achieved 20% better control than the next best PCN in Lambeth.

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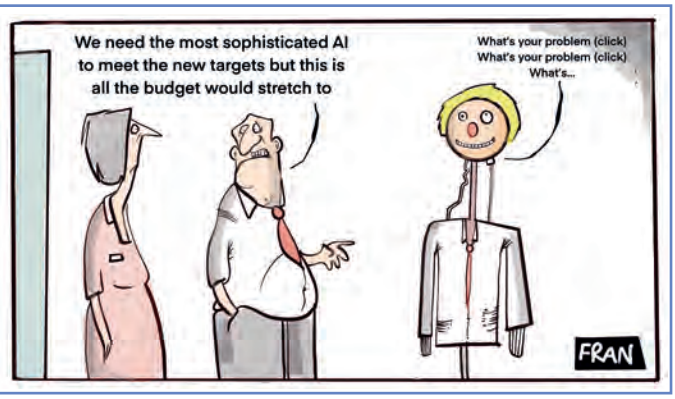

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YOUR PAEDIATRICIAN WILL SEE YOU NOW

PCNs are focusing on delivering care differently for their populations. We look at the evolution of PCN hubs and examples from across the country. *Jess Hacker* reports

A movement is gathering pace as PCNs come to the final straight of their five-year contract.

PCN hubs are in use across the country, with practices analysing their populations for problem areas and pooling staff and resources to treat them. The concept is simple: a service led by a PCN, using its collective resources, to target an underserved group or local health crisis.

The origins of this are the innovations forged in the Covid-19 pandemic, which – for all the devastation it wrought – is now regarded as a key accelerator for NHS integration.

Within weeks of the first national lockdown, GP practices had set up 'hot hubs' across at least 12 former clinical commissioning group (CCG) footprints – including North West London (NWL) and Gloucestershire – to diagnose and advise coronavirus patients in the community. By early April 2020, NHS England was advising practices without a hot hub in their PCN to identify a surgery to host one.

These Covid hubs laid the foundations of what would become PCNs' best chance to innovate and create an entirely local service for the specific needs of a PCN's community.

Now PCNs are showing they are putting their additional roles reimbursement scheme (ARRS) staff to good use and building on the tight-knit relationships made in the pandemic. As a result, integrated care systems (ICSs) are now looking to hubs as the jumping off point for the PCN's successor: integrated neighbourhood teams (INTs), proposed in Dr Claire Fuller's 2022 stocktake review.

Dr Fuller also looked ahead to solving the GP estates crisis with hubs in 'each neighbourhood and place to co-locate integrated neighbourhood teams'.

Hub is something of a misnomer. A hub is not a specific place or a purpose-built surgery, although a PCN might have one of these too. A hub is more akin to a care pathway or a specialist clinic, designed to deliver a particular kind of care.

In some cases, a hub can tackle an inequality that would be near impossible to tackle at a higher level, and its small size grants it the agility to zero in on precise barriers to access.

Where so much work in general practice and the wider NHS is governed from the top down, PCN hubs are successful because of their ground-up approach.

Child health hubs in Westminster

In the heart of the capital, PCNs in Westminster have been running a series of children's health hubs to increase access to specialist advice and ensure good quality onward referrals.

Analysis led by the Royal College of Paediatrics and Child Health found that 350,969 children were waiting to be seen by a consultant as of April 2022, an increase of 100,000 on the year before.

With social deprivation comes poorer access: Westminster is often perceived as affluent, but there are high levels of deprivation. According to Local Government Association analysis, Westminster has 2,399 children in working families of relatively low income. Research published by the Health Foundation in 2020 has highlighted that in more deprived areas there are fewer GPs per head, and a GP working in a practice in a deprived area is responsible for the care of almost 10% more patients than a GP in a more affluent area.

'Children in Westminster face a lot of health challenges. They deal with poverty, obesity and asthma, and we know there are real issues with gangs and county lines,' says Dr Niamh McLaughlin, a GP working in South Westminster PCN and the maternity, children and young person (MCYP) GP lead for North West London ICS.

'That's a real range of physical and social needs but we often tend to look at them individually.'

So 17 out of North West London ICS's 45 PCNs run a child health hub, a clinic staffed by a GP and a paediatrician under one roof, accompanied by a virtual meeting run by a multidisciplinary team (MDT).

If a GP has a concern about a child they have seen in practice – for example, with chronic abdominal pain or headaches – who is not acutely unwell, they will refer them to their PCN's child health hub. This is a two-hour clinic held once a month offering six 20-minute appointments. If a problem cannot be resolved at the clinic, the team can refer the patient.

"We have real issues with deprivation health problems and also gangs

Dr Niamh McLaughlin

The online MDT clinic is staffed by health visitors, school nurses, a family hub team, dietitians and child and adolescent mental health services (CAHMS) professionals. These CAHMS staff help manage patients who present with mental health concerns or eating disorders.

The hubs offer families help closer to home. As they offer a breadth of clinicians, GPs remain a part of the shared decision-making.

Working relationships between primary and secondary care are also improved.

It is important not to undervalue that working relationship. GPs, paediatricians and other members of the team are not paid for their time working in the clinics. The model relies on those staff members' goodwill. It also relies on the providers recognising the benefit of redeploying their staff.

'Much of it is dependent on the willingness of the PCN, which can see the benefits to their patients and the workforce. And also the acute trusts, which can see the benefit of redeploying their staff to work in a different way,' says Dr McLaughlin, whose PCN hub is staffed with a paediatrician from the nearby Evelina London Children's Hospital.

'Locally, PCNs naturally have an alignment with acute trusts. One of their motivations is that the hub reduces referrals to secondary care – so inappropriate referrals are reduced, and more people are seen who should be seen, which has a positive impact on waiting times. There are benefits to the system they have to consider.'

Since May 2022, routine general paediatric hospital outpatient attendances have reduced by approximately 30%, while GP attendances have reduced by around 32% as a result of children being discussed and managed through these hubs, according to data from Evelina London Children's Hospital.

Dr McLaughlin says patients with complex mental, physical and social health cases tend to benefit from the system and staff have an increased sense of job satisfaction.

'If I have a case that requires CAHMS input, for example, I have the time to speak with the clinician to make sure they have all the relevant

information for the patient. It's a much more effective and efficient way of working. I want to refer someone to the right place, and I am confident I can do that, rather than sending out three referrals and hoping one is correct. And from a system perspective, having the children seen effectively and efficiently saves money in the entire system.'

The ICS has recognised this benefit to the system too. The hubs have been pivotal in researching and developing the footprint's INTs: a model suggested by Dr Fuller as a successor or progression of the PCN model.

A spokesperson for NWL ICS said: 'The child health hubs are making a difference to children and their families. By focusing on babies, children and young people, we are supporting the wellbeing of the whole family and future healthy adults.

'Child health hubs illustrate the value of working with the primary care team, making best use of the resources in the local system. The ICS has been sharing the learning from the child health hubs with other child health teams across the country and in the establishment of INTs.'

Liverpool women's health hubs

In Liverpool, six of the city's nine PCNs have been running women's health hubs, offering a wide range of sexual health services – including fitting long-acting reversible contraception (LARC).

These hubs – each led by their PCN – were commissioned by Liverpool City Council in response to a staggeringly low rate of uptake for the contraceptive method, with the first hub launching in February 2020 in North Liverpool PCN.

'The background when we launched was pretty alarming,' says Dr Stephanie Cook, a GP in SWAGGA PCN, which runs one of the city's women's health hubs across two sites.

'Our LARC uptake in primary care in Liverpool was around 13 per 1,000 women, compared with a national average of around 30 per 1,000. And in some areas – such as where the first hub started – we had a very high number of unplanned pregnancies, with high termination and high repeat termination rates.'

Historically, LARC uptake in primary care fell drastically across the country. At its peak, the rate of LARC prescribed by GPs stood at 32.3 per 1,000 population in 2014, according to Office for Health Improvement and Disparities (OHID) data. But this rate declined to 29.2 in 2017, and fell as low as 21.1 in 2020, and never quite recovered.

Training practice staff to fit an LARC is often deemed a significant time-sink, and providers often struggle to find trainers. Where a practice does have a trained fitter, patients are often not aware of the service. LARC fittings are not big money-makers for general practice, as with any procedure that occupies a valuable room in the surgery. And these issues hit harder in places of high social deprivation.

But Liverpool's women's health hubs offer an easily accessible service for women on a cost-effective model.

Between the six PCNs, the city has women's health hubs operating out of 11 locations, the majority of which are based in a PCN member practice.

The majority of LARC fitters are GPs and nurses. The service is funded primarily by local enhanced service (LES) payments, held by the local authority, at £100 per procedure run by a GP – but the best business case is in the use of the ARRS staff.

If a PCN can recruit advanced nurse practitioners (ANPs), physician associates and clinical pharmacists – who are equally qualified to fit an IUD – into an ARRS role, the cost of staffing the hub is neutralised and the only additional cost is equipment.

Similarly, if the telephone triage can be delegated to an ARRS role such as care co-ordinators – as most hubs do –and nursing associates, this minimises cost.

Central Liverpool PCN offers its clinic at weekends, taking advantage of the enhanced access funding to cover the running costs and offer a convenient service. The PCN has three sites for its hub, including a clinic operating from its own dedicated site. With this site, the PCN is able to run five days a week, offering six slots each day.

The hub model in Liverpool has nearly doubled the number of →

LARC procedures in Liverpool over the past three years.

In 2019-20 – before the first hub launched – there were just 2,798 procedures to fit or remove an implant and IUS or IUD in Liverpool across the year. That number jumped to 5,102 across the whole year in 2022-23, just over three years since the hubs launched.

In North Liverpool PCN, as few as 15.5 women per 1,000 had an LARC fitted in 2018-19. As of 2022-23, that number now stands at 25.9 women.

And in SWAGGA PCN, the figure jumped from 20.7 women to 29.4 women over the same period.

Liverpool City Council's sexual reproductive health and HIV commissioning lead James Woolgar told Pulse PCN: 'In terms of the return on investment, one of the modelling pieces showed we could save around £80,000 in the number of patients [going to secondary care for] pessaries and some IUDs.'

'We've had a steady rise across all the PCNs ever since with an overall 150% increase in procedures in Liverpool on pre-pandemic levels. There are lots of services across the country struggling to hit even their pre-pandemic levels, let alone improve them,' says Dr Cook, who is also on the board for the Primary Care Women's Health Forum (PCWHF) which helped design the model.

But Dr Cook says the hub model 'doesn't have to be a physical space or a purpose-built, brand-new building'. Instead, these hubs are about 'pulling together and sharing your staff, your resources and linking those existing services to improve access for women'.

Dr Cook suggests the network of hubs itself has strengthened the working relationship between the neighbouring PCNs, having encouraged stronger connections between staff.

'It's been a real trailblazing service and has brought connectivity across the PCNs, which has been vital. At the end of the day, PCNs have to work together and share services and resources. The hub is a great example of that journey.'

This burgeoning relationship between providers appears to be a key indicator of success in other hubs and also ties into the push from the centre to have primary care working at scale. And it is also clinician led and patient centred.

Middleton PCN hub

The estates crisis, while not directly about workforce or patient care, is no less pressing.

In a 2022 report, the NHS Confederation urged the Government to provide ICSs with quicker access to capital funding to invest in the NHS estate, and a Pulse PCN survey with just under 200 GP and clinical director respondents found 72.8% do not have the space to house their additional roles staff.

In Rochdale, Greater Manchester, Middleton PCN's hub aimed to tackle both estates and access.

Located on the first floor of Middleton Shopping Centre next to a WHSmith, the primary care hub offers patients access to NHS services from the heart of the community. The practices benefit from the site's six consultation rooms – enough space to house the PCN's ARRS staff.

Launched in May 2023, the hub initially offered social prescribing link worker (SPLW) and phlebotomy clinics, and had three mental health staff working on site.

By the time of publication, the hub will also have an HIV service, and plans to offer broader sexual health services.

Plans are also being developed to turn one of the consultation rooms into a diagnostics centre, to offer spirometry, FeNO testing and ultrasound scans.

'We started from the same position as everybody else with a lack of estates and GP surgeries,' says Dr Mohammed Jiva, the PCN's clinical director.

The PCN was first given the space free of charge during the Covid pandemic to deliver vaccinations.

'After that, the unit went back to being an empty shell of breeze blocks,' says Dr Jiva.

The network assessed the opportunity. The location would allow for greater footfall which would improve access. Patients could attend a clinic and collect their prescription in one trip. And if the hub could offer a wide variety of services, there would be less demand and shorter waits for an appointment in the practice.

"The additional estate will let us manage more patients outside the practice

Dr Mohammed Jiva

The PCN took the concept to its neighbouring healthcare organisations and recruited three partners in the GP federation – Rochdale Health Alliance, Rochdale Borough Public Health and HMR Primary Care Academy.

Each partner contributes to the running costs with its own funds. The PCN covers costs from the investment and impact fund (IIF).

'We topslice our annual IIF achievements to keep the whole hub running, and the rest of the IIF is invested in staff and workforce across the PCN,' Dr Jiva adds.

The hub is too new to have concrete data on outcomes, but the PCN will measure its success through patient feedback. Already, Dr Jiva is keenly aware of the immediate benefit to GPs.

'With the additional estate, it will allow us to manage more patients and shorten waiting times.'

Making progress

Hub working is on the rise in a changing NHS. Major reforms last year completely reshaped the way the NHS commissions services, but PCNs are keeping an ear close to the ground, working for themselves and innovating on their own.

In a review of women's health hubs, led by the Birmingham, RAND and Cambridge Evaluation (BRACE) Centre, researchers found that the definition of a hub varied significantly, and the assorted functions were likely to confuse women, health professionals and policymakers. But it is that diversity that can give hubs the edge in providing care tailored to their populations.

'Top-down standardisation may hinder this,' they concluded. 'It is likely that a balance needs to be struck between standardisation and locally defined models.'

Where much of the NHS is dictated from the top down, PCN hubs demonstrate the success of working from the bottom up.

And that is being noticed – NWL ICB is reviewing its PCNs' child health hubs in preparation for the next phase of primary care delivery.

Ruth Rankine, director of primary care at the NHS Confederation, describes PCNs as a mechanism for clinicians to come together to understand the needs of their population because 'those services are not currently delivered and they have identified a gap' to fill.

'Although the journey is not always smooth sailing, some PCNs are already beginning to see the benefits of this integrated approach,' she says.

'The approach showcases the intelligence, tenacity and goodwill of primary care leaders and their teams coming together and navigating through the structural challenges to deliver for their patients.'

ENGAGED TONE

It's time for PCNs to shout about their successes

For the Government it might all be about access to appointments and an end to engaged tones at the 8am GP practice phone rush – as evidenced in the GP contract, the PCN DES and the GP recovery plan. But for PCNs and GPs it's about the right access at the right time in the right place. And having been tasked to serve their populations, that's exactly what PCNs are doing.

Hubs are the next step for many PCNs. Hubs in many and various forms, according to the PCN or patient need. For some it's training hubs bringing together a group of professionals in one place to work and share learning. Or a way to bring care closer to patients through a new access point. Or it's not a physical location but a way to bring together a service around a group of patients who are in need.

This issue focuses on three hubs in Liverpool, Lancashire and London (see our cover feature, page 6) – all delivering primary care at scale in different ways. For Liverpool it's a women's health hub providing contraception. In Lancashire it's increased access through a premises in a shopping centre. For London it's a children's clinic supported by secondary care paediatricians.

These examples demonstrate what primary care can do when given the chance to innovate with staff funded by the additional roles reimbursement scheme (ARRS), secondary care colleagues and the incentive to work together through PCNs and the environment created during Covid.

There is a case for delivering primary care at scale through a network of networks or integrated neighbourhood teams. Many PCNs are already working towards this, but change can also come from clinicians sitting side by side and learning from each other as pointed out in our roundtable (see page 15) on structured medication reviews – where clinical pharmacists and clinical directors give their verdict on the service.

Of course, not all PCNs are equal but it's vital to keep what's good and build on it. So PCNs must share their work to ensure any changes do not undo the progress made in the last five years.

The GP recovery plan released in May says it will review the 'successes and lessons learned' from PCNs before the end of the five-year framework in 2024/25 and evaluate ARRS to assess its options from 2024/25 onwards.

What this means for the future of PCNs is unclear. But now is the time for PCNs to shout about their successes – just as Dr Priya Kumar did with her multi-generational household home visiting pilot (see page 28). Dr Kumar sent a tweet about the project that went viral and she's now had interest from NHS England's health inequalities lead Dr Bola Owolabi. This shows the appetite for primary care success stories – and the desire to do things differently for patients. PCNs should provide plenty more examples of their innovation so the Government cannot fail to notice them. We're here to feature them.

When the review comes, the Government and NHS England would be wise not to deploy an engaged tone.

Victoria Vaughan is editor of PCN

REVIEWING THE SITUATION

Professor Aruna Garcea, our new columnist, says the recent Hewitt Review should be supported wholeheartedly

Primary care at scale offers a blueprint for providing support and services in different levels of core general practice, to mitigate pressures and preserve continuity and personalised care.

The Hewitt Review report offers a step in the right direction to address the challenges faced by primary care. At first glance, its suggestion of a contract review may seem worrying. However, we should remember that national negotiations for the next GP and PCN contracts are due this year. The Hewitt Review has supported the preservation of successful GP partnerships and has also asked for a review of local contracting with primary care. This review will allow for a more facilitative approach to support primary care to innovate and integrate, to incentivise outcomes rather than activity, and clarify financial support for integrated pathways that shift care into the community. These recommendations will allow primary care to enable different local models to deliver care.

The report recommends establishing a national partnership group to develop a framework for general practice contracts, with a focus on diversity. The report also suggests that any contract review should consider how systems can help partners who wish to operate at scale while encouraging and incentivising others to move this way.

For a long time, primary care has recognised that demand management is unsustainable and is making health inequalities worse. There is a critical need to move to prevention and health creation upstream. The Hewitt Review has clearly acknowledged the importance of primary care, PCNs and community partnerships in delivering population health management and addressing health inequalities. The review reinforces the commitment to the principle of subsidiarity and the role of place-based partnerships and bottom-up and integrated approach to care.

The need to enhance primary care is more pressing than ever, and the opportunities are plentiful. Providers and leaders across the country are recognising the urgency of organising and collaborating to establish primary care collaboratives in integrated care systems (ICSs). These collaboratives serve as a crucial platform for leaders to come together and tackle challenges at a wider system level. Moreover, they enable primary care to have a voice in the system while facilitating further integration and collaboration. Although primary care provider collaboratives are relatively new, they have already demonstrated success in mental health and secondary care for several years and are acknowledged in the review as key partners.

Funding for provider collaboratives via ring-fenced budgets would enable primary care professionals to dedicate time to building and running them. For the collaboratives to succeed across the country, this funding is vital.

The Hewitt Review offers an opportunity for primary care providers to embrace new approaches to navigate challenges and capitalise on opportunities. The Government must endorse and accept all the recommendations, so the health and care system can meet the challenges and opportunities ahead, and most importantly, act on them.

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

Professor Aruna Garcea
is clinical director for Leicester City and Universities PCN and chair of the NHS Confederation's PCN advisory group

PCN ROUNDTABLE

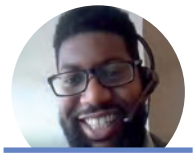
STRUCTURED MEDICATION REVIEWS

Clinical directors and PCN pharmacists gave their verdict on structured medication reviews when they joined Pulse PCN editor *Victoria Vaughan* to discuss the service

ALAMY

DELEGATES

Saran Braybrook
Clinical director and lead pharmacist, Forest of Dean PCN, Gloucestershire



Elvis Sanwu
Deputy head PCN pharmacy, central London healthcare federation, Westminster, London

Dr Bal Dupa
Clinical director Oldham PCN, Greater Manchester

Dr Dan Bunstone
Clinical director, Warrington Innovation Network PCN, Cheshire

Dr Paul Bowen
Clinical director Middlewood PCN, Cheshire

Dr Kieran Gilmartin
Clinical director Fareham and Portchester PCN, Hampshire

Victoria How has the structured medication review (SMR) and medicines optimisation service specification worked in your PCN and benefited your practices and patients?

Saran I worked in primary care for 30 years as a pharmacist, so I have some issues with this whole idea of an SMR. It's just a new name for something that's been going on for years. I like patients to have their medications reviewed in a meaningful way. That might be a quick update for some patients, and something really complicated for others. If you've got pain patients, you'll probably have a number of encounters through the year. I'm not a big fan of the SMR introduction as part of the DES, but that said, it suits its purpose, doesn't it?

It has helped facilitate the recruitment of pharmacists into the PCN because if you're going to hit your targets and get some points, you need to have staff to do it.

At year-end we have got success in all the SMRs. I would have died of embarrassment if we hadn't as we've got a lot of staff focusing on it.

But it brings its own challenges. Some of them were great. The care home ones should have been really effective. But we took a view locally that we wouldn't do the pain management SMR because it was pointless – there were too many patients. We didn't even bother with it.

Having said that, we've got about 30 to 40% of SMRs on that category. It wasn't that we didn't bother at all – we do what we normally do. We didn't hit the target because it was a stupid target.

Elvis I agree. A real medication review should be thorough. We know that NICE guidance says they should be structured. It said it in 2014. So SMR is really just a term for us to do a piece of work that was assessed in a particular way as part of the investment and impact fund (IIF).

One of the interesting things that did come up is an aspect of standardisation. We cover quite a few practices where historically the medication review quality wasn't up to scratch. [The SMR] really did help and a lot of patients showed appreciation. Also, some patients hadn't had a medication review for absolutely ages. That was quite useful.

Paul I felt it posed a risk of eroding the continuity with the GP. And was it a SMR or a structured condition review? And was it actually more of a holistic review of the greater need?

Because you can review the conditions, but not review the person. It potentially eroded the role of general practice and didn't use the skills and experience of our pharmacy colleagues appropriately. That was partly because it was unclear from the start what the true objective of the SMR was. Was it about safety of medications, which is incredibly important? If it was about safety, focusing on medication was better than focusing on conditions. But it was also about reducing inappropriate referrals. It was aiming to be more proactive and therefore reduce GP demand. It was about upskilling. It was trying to do too many things with a relatively small amount of funding for too many patients.

Bal All general practice agrees you cannot continue your care of your patient without an SMR. It's like the old concept 'refer and forget'. You do the SMR and you forget. I've got some amazing bright pharmacists who

Chair Victoria Vaughan
Pulse PCN editor

ALAMY

are just sitting looking at a computer screen. They could offer so much, it's detrimental to their personal and professional development.

The two big areas I would [use] the SMR for are the interfacing of secondary care discharging and intermediate services. If we could start with those, we would make major transformational services. [We could] start with an SMR before the patient is discharged from hospital. If we did that, we'd change the face of general practice.

I think 90% of it is a good idea because it focuses our mind on an important area, but unfortunately it's become habit and rote. It's causing barriers and I'm not sure what the success of it is.

Victoria How did you receive the changes to the Network DES that removed the IIF indicators for the SMRs and what impact will they have?

Kieran The changes proved that the targets and everything they set were a waste of time. We all know that medication errors is a big area. But when you think [there were] 1.04bn prescriptions items 21/22, and there were around 43,000 medication errors that were classed as serious, that's a small percentage of the total – it's ridiculously low. But it's an area to improve.

"The IIF changes proved the targets were a waste of time
Dr Kieran Gilmartin

Most of those errors are in the communication links where things fall between secondary care, primary care and community pharmacy because there are too many touch points. Removing it from the IIF completely was about the only good thing that was done. [As was] allowing our teams to get qualified in the areas they need to get qualified in to understand general practice as a whole, to get training they need, to take the workload that is appropriate as they train and qualify.

We started using clinical pharmacists in a very different way even with these crazy SMR targets. We concentrated on the clinical work [even though we missed out on] some of the funding. But in the grand scheme of things, the funding wasn't that much anyway because we've gained in the other areas that were more realistic and more achievable, and stuff that we were used to doing anyway.

We're focusing on the clinical context of doing SMRs on the right population, the highest risk population, those that are discharged from hospital as Bal said. All of those are getting reviews because we know a lot of the failure is there.

A lot of those [people] end up in care homes, so it links in with our home visiting team. That's the big thing we've noticed – having control over the different groups of staff who are in those areas that we've never had before. It's invaluable.

Victoria Does anyone feel that this change destabilised their clinical pharmacy team in any way?

Paul Quite the opposite. The NHS central team doesn't dictate to the Christie Cancer Hospital how a new cancer specialist should work to →

We want to deal with everything patients need, especially after hospital discharge because they often aren't told what's happening

Saran Braybrook

achieve better outcomes for cancer patients. Yet [it's thought that] the best way of managing general practice in a stressed environment is to dictate who does the work through the additional roles reimbursement (ARRS) scheme, and also how they should do it, and what a meaningful outcome or measure of success of that is.

We're seeing that with other elements in the contract as well including access targets. It's time [to put more] trust in the profession. I know this is said [a lot] through negotiations that the BMA general practitioners committee (GPC) is having at the moment. But [they should] hold us to account on meaningful outcomes that we all agree are reasonable signs of quality and safety.

And [they should] allow us to work with our pharmacy colleagues and other ARRS staff to achieve those outcomes in flexible ways. I'm a single partnership, I've got so much autonomy in terms of the ability to work with all my clinical colleagues and non clinical colleagues across 160 staff. We've got huge potential but [these structures mean] we were held back [from] doing the things we really wanted to do and using people's skills most appropriately.

So yes, I feel freed by the lack of it.

What worries me is that it's still in the letter of the contract. To what extent will they still performance-manage us without those targets? If I cannot prove I am doing an SMR, how can I assure NHS England that I should be paid? I'm sure my pharmacist and GP colleagues aren't twiddling their thumbs, but it is important that we have a way of assuring the centre that we're doing the work.

Dan Our pharmacists help us support the population health management stuff, [for instance] all the patients who haven't had their BP correctly controlled during Covid, and all our COPD patients. They work with the teams to do that first cut after working out that patients are on the correct medication and everything's happening correctly. That's key for us.

It's the thing the NHS doesn't do particularly well – sowing a seed now to have a plant in 10 years' time. We all talk about the prevention agenda, but we are not enabled to do it [against] the backdrop of access at all costs.

Victoria What's been the benefit of having clinical pharmacists in PCNs and more available to practices?

Saran We need to remember all PCNs are at different levels of maturity. Our PCN has only recently got pharmacists within the last 18 months. Some [of our] practices still don't have them or have got remote pharmacists. It's still very new and this will allow us the time to really rethink the priorities.

When patients call, for whatever reason, we [would like to] deal with everything they need in one go. Like Bal says, with discharge patients, often there are lot of issues that haven't been dealt with. We'll be able to deal with that and that will help our access, the phone calls to the practice, [and] the GPs. Most of all it'll help patients because they'll have someone telling them what's going on, and otherwise they probably won't know.

[I don't think we know] the value of pharmacists and pharmacy technicians. When the national data come out for the dashboard, we'll know we've done lots of SMRs and stuff, but we ought to be asking patients and engaging more.

Elvis The SMR aspect of the IIF last year was unclear in terms of the objectives. That may reflect the uncertainty of what is expected from clinical pharmacists in general practice as a whole. You will find in various different places, different pharmacists are doing very different things.

When pharmacists come into general practice it's different from other areas. They need to understand the way teams work. They need to understand the priorities of general practice as well.

Obviously, one of the key things is to broaden their knowledge in general practice, [over] a whole breadth of conditions, and to a fairly deep level as well. And so that does take time. There is a Centre for Postgraduate Pharmacy Education (CPPE) pathway that allows pharmacists to improve their skills and gain clinical examination skills as well, over a period 18 months. But that can feel like eternity for practices that are in dire need of pharmacists. It could probably be quicker.

Paul We've now adopted a personalised list approach, so our pharmacists and our pharmacy techs work alongside us to proactively review medications in a virtual way, in advance of a patient's annual review, before we see or speak to them. That works very well.

That's nothing about working at scale. If anything it's the opposite of working at scale. It's a colleague who's skilled and knowledgeable about the medications sitting with me and upskilling me, [while I] look at the conditions side of things. It's got huge potential. The national thing is about working at scale, [but] working at scale is not always the most efficient use of our team.

Our pharmacists have said they're lucky, because they work alongside one group of GPs in the same practice, with the same policies, the same procedures, the same clinical record. I recognise we're relatively lucky from that point of view.

Saran I love Paul's example because you work at these targets and things develop as you go along. I found one of the best ways of doing care home reviews was to put a summary in the notes ready for whoever is going out [to visit]. We are moving towards a more holistic approach.

The SMR was almost a red herring because sometimes we're at our best when we're all doing bits and pieces [that are] then put together. We're feeling our way because there isn't any defined way.

And following on from Elvis, the national pathway is shocking. It's appalling. It's a waste of time from my perspective. From what I've seen, pharmacists that don't have much experience [are] trained to be little doctors, which is not what we need. And speaking as an experienced clinical pharmacist who's just done the pathway, it's a slog and a waste of time. So we don't have a pathway or training that helps pharmacists learn how to work in a general practice, which is interesting for me at this stage in the fifth year of the DES.

Victoria Has anyone figured out a better way of supporting pharmacists in their PCN?

Saran It's about networking. I'm working across a massive geographical area and we're recruiting when a lot of places can't, because people

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want to come as they can see we've got a big team. We have a monthly networking meeting. We work together, we put support in. Everyone's different.

I did think when I started this, 'any pharmacist and any technician could fit into these roles'. But after a couple of years, we've just had one pharmacist leave for a hospital job where they will be better supported. It's quite an isolated, vulnerable role for pharmacists at this stage while our training doesn't support it.

To pick up Bal's point, I'd like to see pharmacist roles where the hospital pharmacists also work in a GP practice, because then they can see the trauma they cause by writing something stupid on the prescription. Equally, if a primary care pharmacist had to work in hospital, they'd understand why it's so hard and why discharges sometimes come out with nothing helpful.

We need a more integrated approach, for instance, at our community hospitals. Nurses put patients on a dosette or monitored dosage system (MDS), with no pharmaceutical assessment. The patient medicines supply comes under the care of the practice and any willing local community pharmacy. MDS is difficult to stop once started and It sucks up so many resources that should be reserved for patients that need it to keep them independently living at home. Often all that's needed is a medicines review and deprescribing. MDS is not what the patient needs long term but is a quick way of getting them out of hospital into primary care, but it eats up a lot of resources in the wrong way.

Bal We're into the fourth year of the DES. ARRS roles are in place. We're hearing that ARRS funding will continue [in 2024 and beyond]. And yet, we still have a central diktat of what a clinical pharmacist should do – the national pathway. I didn't even recognise the job description for a clinical pharmacist in the DES. I don't know who wrote that. We're talking as if they're transitory things that we'll do this year because next year the real stuff's going to happen. We need to move on from that.

My challenge back to you, Saran and Elvis, is to ask what is your own profession doing about it? It's not for me to tell your colleagues what the support structure for a clinical pharmacist is. The profession needs to recognise that you're not transitory. That conversation [doesn't seem to be] going on in the pharmacy world either.

"Working at scale is not always the best use of our team

Dr Paul Bowen

Saran I agree Bal. It's a problem for our profession because primary care pharmacists are a very small percentage. We're never going to be the priority and we're the ones that are sucking the life out of the other two areas where pharmacists work. I'm not sure we're ready to do that yet. I'd like to see our NHS workforce be planned and thought through. [I'd like us to] do integrated training together, pharmacists and GPs. That's how it worked in hospital clinical pharmacy.

I trained in hospital 30 years ago, and clinical pharmacist means something different to me from what the DES says. It means someone's that's got an accredited clinical diploma or extensive experience working in the hospital or maybe supervising primary care.

I think it's coming, it's not there yet, it's just a matter of time. I love your idea about thinking long term and that this is not transitory. We need to get that into NHS England.

Victoria How do you fit in with the wider NHS, with the medicines optimisation teams at integrated care boards (ICBs), hospital pharmacy and community pharmacy teams?

Kieran We've had a pharmacy team for the last four years and it is building up those links, especially with community pharmacies, and between pharmacists and pharmacy techs in the PCN and community teams.

Obviously there are fewer pharmacies because they're closing in droves. We've got three pharmacies closing in our PCN area.

Hospital [pharmacy] is trickier because they are still siloed. They're still located in one area in most hospitals as part of the churn →

I want to create a hub so pharmacists in each PCN can work together, share knowledge and cross-pollinate

Dr Dan Bunstone

of discharges. The medicines optimisation teams in the old clinical commissioning groups (CCGs) are now in the ICBs. Some of that work is being pushed in our direction, and every time I kindly push it back. Because at the end of the day, that's what they're there for. They're not doing clinical work, they're just reducing the budget for the prescribing budget. That's the only thing I've ever seen in 20 years of being a doctor.

Dan The PCN team link with the place-based medicines management team. They have regular monthly meetings because there's a theoretical overlap. They work around that to create common goals. Some of the SMR stuff and care home work that the local medicines management team want to do is wrapped into a realistic piece and pulled together.

Victoria What's the possibility, the capacity and the potential for this service? What could you achieve with what you've got now for the future health of your patients?

Dan I'd want to create a hub so that pharmacists in each PCN will work together, cross-pollinate and share their knowledge. They will have targets to meet. They'll support through triage, [and] some of the forward-facing patient activity – dealing with minor ailments, dealing with more complex problems, and of course, dealing with specialty areas too, [perhaps] menopause or hypertension. And ultimately [they will] help us to manage long-term conditions more proactively, and better. At the moment, if you look at hypertension, it's not being managed perfectly, and that's because we're having to deal with other areas first.

Elvis Following on from Dan, we actually have an e-hub. We're still bringing it together but there will be a pharmacist doing triage and acute stuff. It will take work away from practices, but also [it creates] job satisfaction for the pharmacists as well. There's career progression and variety. That's important as we're thinking about pharmacists coming into general practice and we've got to keep them there, otherwise we [will] have the same issue we've got with GPs. We need to think about retention.

Paul My concern is this: while we need to focus on increasing and improving the offer of general practice in medications and pharmacy services, we can't do it in isolation. It's no good having fantastic SMRs for some of our most frail, complex patients, yet not have enough nurses simply to take their blood pressure. We have to look at the bigger picture. Alongside those pharmacists, we also need all the other clinical staff that can make a just-about-managing service into an excellent and fully optimised service.

Saran I want to work in more personalised and focused [patient] care. The NHS keeps telling us to sign up to shared decision-making. It's time the NHS management signed up for shared decision-making learning, because it needs to stop giving us targets to put people on statins that they don't want. We need to listen [to patients]. And the NHS management needs to listen.

We need more focus on systems, too. We've plonked pharmacists into primary care. We need to make sure we enable pharmacists to work at the top of their licence and change our workflows. We could do things more effectively in primary care if we work around the patient, and around what they really need and want, instead of what the NHS target is.

I'd like to see more integrated roles across community services, across hospitals and community pharmacy. [Then] we'll all see, and we'll stop offloading our problem patients to each other, and we'll start managing them in a different way. And I'd like to see a workforce plan. One that will actually take us all together and, particularly for the pharmacists, take them from their early years into training. They'll get supervision in lots of different areas. They'll have career development.

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ACCESS ALL AREAS

Dr Sian Stanley, our new columnist, considers how to fulfil the demands for more access

All roads lead to increased access. The word on the street was this would come via the PCN DES but to our absolute horror it has come through the GP contract.

The contract changes have left me considering how a PCN could help practices weave in the capacity and access improvement plan, and protect practices.

I know some GPs have issues with PCNs. I don't think PCNs can be a cure for everything, but I am considering ideas that may help practices fulfil the contract requirements without being drowned in work.

We have set up a minor illness hub which allows our additional roles reimbursement scheme (ARRS) team to work at the top of their licences while getting supervision and support from a GP consultant, who is a GP trainer financed with investment and impact fund (IIF) money.

The hub operates in the afternoons at one of the town-centre practices. The appointments are available for same-day use for face-to-face appointments and e-consultions. The practices have a share of appointments across the week according to their list size. A larger practice will have on average an additional 50 appointments per week. The intention is to expand and contract the service depending on demand, so in the summer the focus could be long-term conditions management, while winter will focus on acute respiratory conditions. During the Strep A outbreak last year, the minor illness hub was quickly transformed into a sore throat service. When we've had surges in Covid we have converted to a hot clinic.

Have I spilt the atom with this idea? Well, no.

Have I created infinite access to primary care? Well, no.

But we have explored a new way of working and increased the number of appointments we can offer. Then we can create a safe space for patients and clinicians, allowing senior clinicians to focus on more complex care. The patient feedback has been excellent and the ARRS team enjoy working in the hub as they have dedicated supervision. Our ARRS team has varied backgrounds with different experience, and some members need a lot of supervision. Such supervision can be draining on a practice, so the PCN hub is a way of providing appointments without increasing the burden on practice teams. We have some registrars working there too who get a lot from the experience.

Don't get me wrong. As a GP, I like a cheeky verruca presentation, but is it a good use of my time? For years, I have been wrestling with how I am best deployed. Sometimes while exploring the verruca other issues come to my attention. A minor presentation helps me get to know patients better and I know this is appreciated. But GPs are on the endangered species list so I am sad to say my verruca days are gone.

Working at scale is a popular concept and there are merits to working in this way. We've found that if it is fair and we all play by the rules, we can make it work. I know this is like nails down a blackboard for those of you who feel that investment should only flow into the practice model but creating capacity must be a good thing for everyone.

ONLINE
Read more blogs at pulsetoday.co.uk/pcn

Dr Sian Stanley
is clinical director of Stort Valley and Villages PCN, East of England CD Representative, NHS Confederation and a GP partner in Bishops Stortford, Hertfordshire

LEADING QUESTIONS

Lord Victor Adebowale*, chair of the NHS Confederation, shares his thoughts on health inequalities in England with senior reporter *Jess Hacker

Can you give an overview of the current state of health inequalities in England?

Health inequalities in England were already stark before the Covid-19 pandemic. The rising cost of living will have further impact on people's mental and physical health.

The Covid-19 pandemic increased public awareness of this. The impact of the pandemic, both directly and indirectly, was greater for people from minority ethnic groups, children and older people, people on lower incomes, and disabled people.

The rising cost of living means rising rates of poverty. Around eight children in a class of 30 are being brought up in poverty. Poverty in communities means cold homes, meals being skipped and people taking the cheapest route to feeling full – often foods high in fat, salt and sugar. This has a negative effect on health. And 'money worries' isn't just a glib turn of phrase – cost-of-living pressures are having a significant impact on the nation's mental health too. One adult in four in the most deprived areas of England is experiencing moderate to severe depression.

The term 'health inequalities' has become more prominent in policy in recent years. Why is this?

General practice clinicians have long seen how social determinants of health affect patients. Factors like where we were born, where we work and the air we breathe all contribute to our health. This is health inequalities in action: the unfair, avoidable and systematic differences in health between different groups.

It's not just clinicians who understand this. The unequal impact of the Covid-19 pandemic showed the public, the press and policymakers across the political divide that it's not just our individual choices that affect how healthy we are.

The NHS Long-Term Plan has reducing health inequalities at its core, and PCNs form a key part of this. Lots has happened since 2019, but the aim and direction of travel are laudable. We need to make sure we don't lose momentum, we keep what has worked well (such as PCNs) and continue to translate policy into action.

What is expected of general practice in regard to health inequalities?

General practice is expected – not mandated – to be a part of a PCN. A specific PCN service is tackling neighbourhood health inequalities, and excellent progress has been made, especially with annual physical health checks for those on the learning disability register.

Future contracts must give PCNs the ability to focus on what matters for their communities and what primary care does best – caring for patients in their communities. We need to go back to those core aims and learn from primary care about what works and what does not.

Future contracts must give PCNs the ability to focus on what matters locally

Lord Victor Adebowale

Are PCNs the best vehicle for addressing health inequalities in primary care?

We know that the only way to address health inequalities is by addressing capacity issues. The longer they continue, the worse health inequalities will become.

The rising demand and declining GP numbers mean that primary care needs to work to benefit from economies of scale and meet demand.

PCNs are one example of this, federations are another, as are primary care provider collaboratives and networks of networks. A merger of practices is also an example of this.

We cannot say a thing is the 'best vehicle' without knowing what the other options are, but PCNs were introduced with an objective of addressing health inequalities. Since 2019, when they started, they have contended with a lot of extraordinary events – the pandemic, the Covid vaccination programme, rumours about their future when they had barely got started, but they have achieved a huge amount in this time. Their services are up and running, thousands of additional roles reimbursement scheme (ARRS) staff are in place and they led the vaccination programme, which did a great deal to reduce health inequalities. Their outreach initiatives, from buses to everyday conversations, were remarkable. They have a lot to commend them.

Is the NHS sufficiently focused on reducing inequalities?

When I speak to NHS leaders, I hear resoundingly that they are focused on and committed to reducing inequalities.

The NHS alone cannot 'solve' health inequalities - central policy change is needed too. NHS leaders were looking to the health disparities white paper to address the national, structural causes of health inequalities. This white paper was shelved last summer, and has now been folded into an upcoming major conditions strategy.

Policy must be translated into action and this requires capacity. At present, in primary care – and all across health and social care – demand is outstripping supply. It's difficult for the NHS, both management and clinicians, to do what's needed to reduce health inequalities when they're understaffed and demoralised. In primary care, the annual funding increase in the GP contract is nowhere near inflation. And investment – and permissions – to improve estates have not been forthcoming. A fully funded workforce plan and investment that at least keeps pace with inflation, as well as vital capital investment, would help alleviate these pressures.

As well as this, GPs working in a challenged area should be paid a premium, and all training exam costs should be covered if they then work in the NHS for a minimum of three years. This would help retention and the recruitment of GPs and relieve a lot of pressures primary care currently faces.

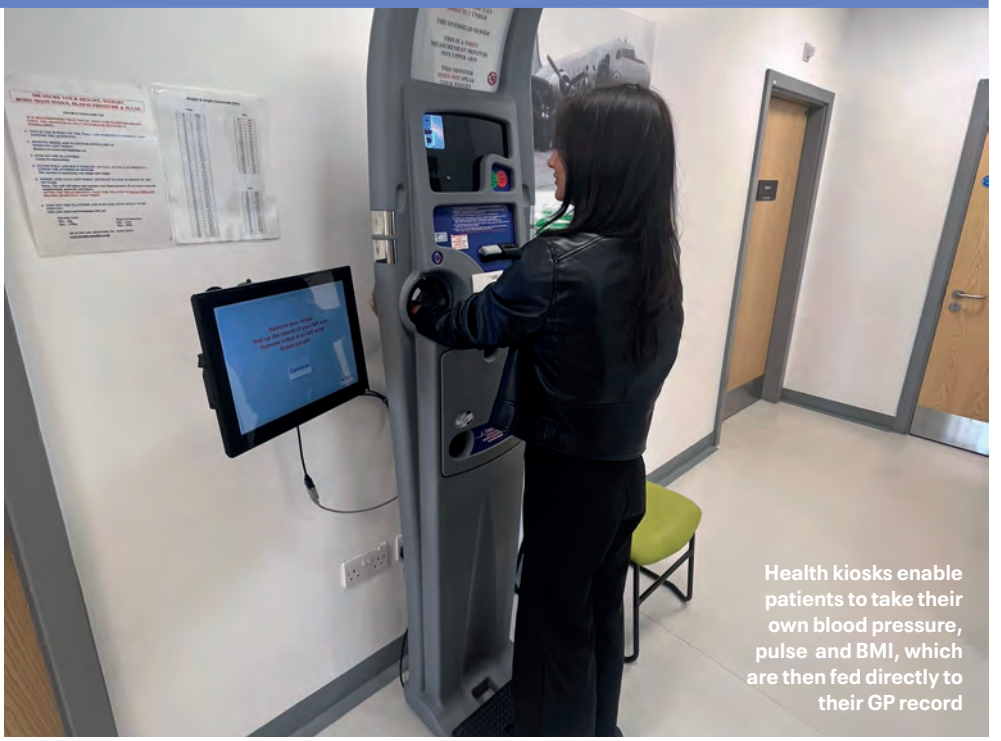
SET UP PROACTIVE CARE FOR HYPERTENSION AND COPD

An initiative in Cheshire focuses on patients with hypertension or COPD. *Dr Dan Bunstone*, clinical director of the Warrington Innovation Network PCN, explains how it works

This pilot in Warrington, Cheshire, aims to support patients with hypertension or COPD to minimise their risk of hospital admission and significant health events such as heart attack or stroke.

It is jointly funded by our PCN and Etc Health, which is part of the telecoms provider BT Group. Etc Health has created an app for patients to upload clinical data that can be viewed by our clinical teams. This gives us a remote monitoring platform to actively assess, monitor and treat patients. The app is not yet generally available. Our team is helping to refine it and it should be ready for download soon.

Seven practices are involved in the project. We have rolled it out across the whole Warrington Innovation Network (WIN) PCN.



Health kiosks enable patients to take their own blood pressure, pulse and BMI, which are then fed directly to their GP record

Aims

We knew that the burden of disease would become untenable unless we invested in future health.

In Warrington, respiratory conditions, including COPD exacerbations, are the largest driver of A&E attendances. Up to 47% of COPD patients experience at least one exacerbation per annum and the likelihood of another increases with each occurrence.

By proactively monitoring and holistically managing our COPD patients, we aim to provide increased support when they need it. We can spot when their condition starts to deteriorate – often before they've spotted it themselves – enabling rapid treatment and quicker recovery.

Hypertension is a significant and direct risk factor for heart attack and stroke. Optimising our management of the condition is incredibly cost-effective and helps us prevent hundreds of heart attacks and strokes each year across just our integrated care system (ICS).

We know that blood pressure control nationally needs improvement, and Covid-19 has exacerbated this. We aim to identify patients with hypertension who would benefit from closer intervention and risk stratifying. We offer them the Etc Health app, which enables patients to upload details to be viewed by our clinical teams.

Through a combination of holistic and medication changes, we support them to achieve good blood pressure control. The aim is to engage more effectively with patients who previously have been harder to reach, as we can see when readings are submitted and follow up on any gaps. It helps with adherence and goal setting and is a significant driver for behavioural change.

Methods

For both long-term conditions, we are taking a hybrid approach that combines remote care with in-person support as needed.

We use a risk stratification tool created by UCL Partners,[1] which is clinically validated and very effective. It enables us to direct care towards the patients who most need it, so care is delivered where it is effective instead of on a 'fair shares' basis.

We have also created health kiosks in the seven PCN member surgeries, which were purchased by the PCN using GP transformational funding.

Health kiosks enable patients to take their own blood pressure, pulse and BMI, which then feeds directly to their GP records. This is used as a single-point test to identify patients who may need greater intervention. We run searches to pick up readings submitted that week.

Patients who are flagged are offered the app and their clinical observations are monitored for two weeks.

For COPD, we monitor oxygen saturations and pulse rate. For hypertension, we measure blood pressure and pulse rate.

Our clinical team then monitors the patient inputs. Remote monitoring is incredibly efficient, and we can offer intensive management with micro-interventions. We can see when patients become unwell and react early. We can spot missed readings and remind the patient to upload a new one. And we can ask how medication changes are being tolerated. →

Etc Health has created an app for patients to upload clinical data that can be viewed by clinical teams

Patients are pre-emptively booked into follow-up appointments with a prescribing nurse or a clinical pharmacist so that changes can be made to their medication as necessary. The patient can also have sessions with a healthcare assistant or pharmacy technician, who will work through lifestyle advice.

Outcomes

Over the course of the project, we will see at least 1,000 patients, and we hope to see even more. This will be a mixture of more acute COPD patients and patients with a known diagnosis of hypertension in whom treatment has yet to be fully optimised.

Feedback from patients has been overwhelmingly positive. They love the proactive care and feel safe and supported in their medical condition. For hypertension, we are able to significantly impact our patients' management. We anticipate that over the next six to 12 months, the project will prevent 10 heart attacks and 20 strokes[1] with reduced hospital admissions.

For COPD, we have registered about 100 patients across our PCN who have a diagnosis and are at risk of hospital admission. We have proactively managed their care, supported them to optimise their health when they feel well, and quickly managed their care when they deteriorate.

Ultimately, this improves quality of life, helps our patients feel supported, and reduces unplanned attendance at both the GP surgery and hospital. We are supporting hospital discharge by preventing the initial admission.

With support from our integrated care board (ICB) team in Warrington, we are using 1,250 oxygen sats machines that the NHS purchased to support Covid management and we aim to increase that number.

Patients input their oxygen saturation readings to be monitored by our clinical team. If readings show deterioration, the clinical team will contact the patient to ensure all is well, and where appropriate will arrange assessment and follow up. Our experience is that early intervention and support of this kind is valued by patients – simply knowing that someone is actively looking after their care is much of the help they need.

We also have Bluetooth-enabled devices for both pulse oximetry and blood pressure, but as we already had the surplus oxygen sats monitors, we wanted to rapidly mobilise them for our patients.

We've also collaborated with the local authority to provide the additional support of social prescribers and signposting, which has proved very effective. And we are supporting COPD patients who have been identified as experiencing fuel poverty, tackling the problem now before we hit winter 2023.

Also, we'll have made a start on the long process of changing the culture of health in our PCN. Instead of patients seeking care when they feel unwell, they will be contacted before they become ill. This is the power of collaborative working and digital technology.

The future

The NHS needs to balance the problem of in-year demand with supporting the future, which is one of the focuses of this project. By supporting COPD patients, we increase efficiencies by preventing A&E admissions. By supporting blood pressure management, we prevent heart attacks and strokes.

The ultimate aim is that our patients will always have access to the Etc Health app, to track their results and get support for improving health behaviours. The partnership with Etc Health is also allowing us to test and innovate digital products.

We hope to increase the breadth and depth of the project by sharing ideas with the other PCNs and supporting a full rollout across the other PCNs in Warrington.

We also hope to increase the number of long-term conditions we can support. Heart failure and diabetes are the two we are considering next, and possibly also frailty.

Dr Dan Bunstone is clinical director of Warrington Innovation Network (WIN) PCN, medical director at Etc Health, BT, and chair of the NHS Confederation's PCN data and digital design group

Reference

1 UCL Partners. Size of the Prize: Preventing Heart Attacks and Strokes At Scale

RAN A MULTI-GENERATIONAL HOME VISITING PILOT

***Dr Priya Kumar* outlines how four PCNs in Slough, Berkshire, are joining forces to create a multi-generational household home visiting project**

NHS Frimley integrated care board (ICB) covers a diverse area across the three counties of Surrey, Berkshire and Hampshire. Of its five places, Slough has the highest levels of deprivation and more than 150 languages are spoken in this region. The town's four PCNs – SPINE, LOCC, SHAPE and Central Slough Network (CSN) face significant challenges to achieve the same health outcomes as neighbouring networks. There is a ten-year life expectancy gap with the rest of the ICB region and a four-year life expectancy gap compared with the England average.

In addition, 13.9% of Slough's population lives in multi-generational households, a fact that was highlighted to us during Covid, where we focused on communicating how to reduce the spread of infection in these households.

We have further explored this concept and our local immunisation team was keen to address the low levels of herd immunity for general childhood illnesses and childhood vaccination uptake in Slough. The majority of practices in Slough were below the 87% QOF target for pre-school boosters despite the best efforts of the practices. Feedback from parents suggested they were not opposed to vaccination per se but that other factors, perhaps work schedules or caring responsibilities, were preventing them taking up the offer of routine immunisations.

This planted the idea that we could target multi-generational households that had outstanding immunisations for home visits and use the opportunity to do other health checks that family members might need.

Methods

The programme was funded by the local vaccination board, who wanted to address the stark inequalities in uptake within the pre-school booster cohort. We identified all the multi-generational households with children who had not had their pre-school booster and were up and running a week later.

The immunisations list was matched in the practice records to identify other household members who had outstanding health checks including medication reviews, QOF indicators, pre-diabetes and blood pressure checks, severe mental illness reviews, adult immunisations, breast screening, cervical and bowel screening.

Each PCN was tasked with organising and arranging the visits for the households on the lists. Families were called in advance and visits arranged for those happy to take part. We advised them that all members of the family would be reviewed in one visit and practices arranged many of the visits after 4pm to ensure all the children were at home after school.

The hour-long home visit was done by two staff members, and a variety of different professionals were involved, including GPs, nurses, healthcare assistants, pharmacists and physician associates.

Outcomes

Initially, we identified 145 households. In total 103 households were visited and 68 more pre-school boosters were given by the end of the QOF year, within the space of two weeks. Through this approach, we were finally able to achieve some of these targets with those residents not engaging through the traditional routes of primary care.

We quickly realised we could achieve much more than we initially thought by visiting the family home, understanding the patients' home environment and social situation. We were able to complete most of the outstanding checks as well as booking appointments at the practice for follow up where needed. This included QOF check-ups as well as social prescribing referrals and encouragement to engage with national screening programmes.

While the aim of the pilot was to boost our childhood immunisation uptake, it soon became clear that home visiting was also important for the 40 to 60 age group.

This is usually the cohort we struggle to reach in general practice because of the pressures of daily life. In one example, a 39-year-old gentleman had missed his pre-diabetic check-up for the past two-and-a-half years. By visiting him at home at the right time we were able to take his bloods and complete the check as well as discussing important secondary prevention advice with him. His wife also asked if we could offer smoking cessation advice, highlighting the importance of the peer support element within the household.

Another example was a household where a woman had seven children. We did the immunisations that were needed, including 12-month immunisations and flu. Given her situation, she hadn't made time to have her cervical or breast screening. We booked her

From left: senior practice nurse Ruth Rehmat, Dr Priya Kumar, Aiden Duncombe, facilities driver and assistant for East Berkshire primary care at Kumar Medical Centre, Slough

appointment and the following week she came in for her smear test. By reaching out to these residents, we were able change the narrative, which meant they were empowered to self-care and engage in their check-ups.

It was fascinating for me as a GP to visit these homes. The conversations I was having with the family as a whole were much more meaningful. Families appreciated we had taken time out of our day to visit them specifically and said they were more likely to invest in their own health and wellbeing in the future.

Furthermore, some residents did decline the offer of the home visit, but they engaged with us at practice level and we were able to complete the necessary checks.

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Future

Given the success of the pilot, we are extending this project to multi-generational households (with more than five people) with individuals who have less than 40% QOF indicators completed as of 31 March 2023 with the majority of these households in the Core20plus5 cohorts. We have been able to automate the household lists through the Connected Care platform, which is an integrated dataset across primary, secondary, social and urgent care activity across the system to identify all outstanding check-ups in the household. We have now identified 441 households with approximately 4,000 individuals that fulfil these criteria.

As well as visiting, we will also connect families with social prescribing teams, community development workers and the voluntary sector if required and offer our digital buddies programme for those who have digital accessibility needs. Information packs have also been created to inform families of the support available in out of hours, apps such as healthier together, getUbetter, the Slough wellbeing website as well as directing them to the local GP website for further support.

The aim of phase two is to improve prevention and health outcomes of the disengaged families. There could be a variety of reasons for their lack of engagement, which are out of their control. We want to move from a reactive to a proactive way of accessing health. My hope is that this will be rolled out widely to reduce the health inequalities gap and improve life expectancy, especially those in the underserved communities.

Dr Priya Kumar is Slough health inequalities lead and finance lead at SPINE PCN in Berkshire
As told to Emma Wilkinson

TIM KAVANAGH / UNPX2

ACCENTUATE THE POSITIVE: POLITICS IN PRIMARY CARE

Our new columnist, health journalist Andy Cowper, guesses how primary care might feature in the upcoming General Election battles

The political climate for PCNs is getting hotter. After the local elections showed the Conservatives doing badly and Labour doing well, the rhythm of health policy and politics will accelerate as we head to the next General Election.

Will the pre-election debate accentuate the positive for primary care and PCNs, as the song goes? Well, there is no clear policy challenge from any major party to the concept of greater integration of health and care services, and more preventive care. And networks are crucial to this.

The Hewitt Review, by Norfolk and Waveney Integrated Care Board (ICB) chair and former New Labour Health Secretary Patricia Hewitt, preached the integration and prevention gospel. It recommended funding for prevention should be increased. It also called for a new framework and funding baseline for prevention work to be agreed by autumn 2023, with all systems reporting their prevention investment by 1 April 2024; with a 1% increase in spending on prevention from NHS system budgets over the next five financial years.

No commitments have followed from the Government.

For PCNs, the recent GP contract update announcement of the new investment and impact fund (IIF) brought the Government's commitment to improving GP access into sharp focus. The IIF will fund PCNs an average of £11,500 a month in 2023/24 to improve access.

Pulse editor Jaimie Kaffash wrote that the contract papers for the Network DES also reveal there will be just six weeks to develop plans to improve access for a share of a further £74m – around £60,000 per PCN per year. The target is to see 85% of patients within two weeks of an appointment request. NHS England then added a whole seven weeks to this timetable. PCNs may now submit access plans to their integrated care board (ICB) by 30 June.

Some obvious thoughts: getting a GP appointment within two weeks may be all that's deliverable. But it shows how bad access has become. Also, this is not going to reduce demand. People who need healthcare will carry on trying the GP 8am phone lottery, before heading to a walk-in centre (if they still have one) or A&E. And these are not significant sums of money. Good luck to all 1,250 PCNs in finding a GP for £60,000 a year, and making £11,500 a month go far on access improvements.

So what is the opposition promising? Labour's Wes Streeting stepped away from his performative policy pyromania in his speech at The King's Fund, emphasising that previous discussions about an end to GPs' independent contractor status were not a policy position. He floated Labour's vision for a 'neighbourhood health service' in which ICBs would lead local delivery and reform. He outlined the party's plans to use money from abolishing the non-domiciled tax status to train more clinicians, health visitors and district nurses, and double the number of medical school places. He avoided putting a number on the extra GPs because even if Labour wins, none of the new training cohort will be fully qualified by the end of that five-year term.

Governments can do things: oppositions can announce things. It's obvious that the doing plans will not improve primary care access. It's optimistic to think Labour can turn things around. Primary care is stuck in the middle.

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Andy Cowper
is the editor of *Health Policy Insight* and a columnist for the *BMJ* and *Civil Service World*