PULSE PCN
CONNECTING PRIMARY CARE NETWORKS
SPRING 2023

ARRS ABOUT FACE

PCNs question the scheme as they bid for underspend P6

INSIDE

SPRING 2023

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
jasonwarner@cogora.com

Delivery and subscription
subscriptions@cogora.com

COVER: JON BERKELEY

REVEALED: TENS OF MILLIONS OF UNSPENT ARRS FUNDING WILL BE LOST TO GENERAL PRACTICE

By Jess Hacker

Exclusive At least £64m of funding available under the additional roles reimbursement scheme (ARRS) this year is currently forecast to go unspent, Pulse PCN can reveal.

The exclusive investigation found that less than a fifth of that sum is set to be reallocated to PCNs, meaning that the remaining money could be lost to general practice.

Under the scheme, which is part of the Network DES, PCNs are funded to hire non-GP staff, including pharmacists, physiotherapists and paramedics, and represents a significant funding stream for general practice.

When the money is unspent, integrated care boards (ICBs) are able to invite PCNs to bid for any unclaimed funding

But figures acquired under the Freedom of Information (FOI) Act show that only around £8.77m (13%) of the estimated underspend for 2022/23 is set to be released back into primary care.

Furthermore, this money will only be reallocated in 14 ICB areas, with any unclaimed funding remaining with NHS England.

One further ICB said it 'wishes' to reallocate all of its unclaimed funding, which would add a further £1.3m if successful.

Another ICB has reallocated an undisclosed amount to 15 PCNs.

And only 21 of the 36 ICBs that provided data are inviting PCNs to bid for the money at all.

The maximum ARRS fund for 2022/23 stood at around £1.02bn.

As the fund is the Network DES's largest funding mechanism, there are concerns that any unclaimed funding represents an underspend against investment into general practice.

Ben Gowland, director at think-tank Ockham Healthcare and a former executive in the NHS, said: 'The majority of additional funds coming into general practice since 2019 have been through PCNs, and by far the biggest part of the PCN funding has been the ARRS funding. ARRS underspend therefore represents an underspend against the promised investment in general practice.'

Devon ICB has approved the most bids – accepting 61 from its 31 PCNs – granting £1.2m in extra cash for staff, despite estimating it will underspend by £800,000.

A spokesperson for Devon ICB explained that it expected a number of PCNs would not be able to recruit into the roles they submitted bids for within the limited time left in the financial year.

NHS CANNOT COMPETE WITH AMAZON AND OTHER RETAILERS FOR STAFF

By Jess Hacker

The NHS and social care cannot compete with major supermarkets for staff, including Amazon, Lidl and Aldi, and are losing workers to these international retailers, health leaders are warning.

Chief executives from several integrated care boards (ICBs) along with GP leaders have told Pulse that the wages and benefits offered by supermarkets, combined with the rate at which roles open up at new stores, have made it incredibly challenging to position the NHS and social care as a good option for work.

Currently there are as many as 165,000 vacant posts in the care sector in the UK, and 133,446 total FTE vacancies in the NHS in England.

The Association of Directors of Adult Social Services (ADASS) has now called for urgent, sustainable funding to help care services prevent highly skilled workers leaving for jobs with 'fewer responsibilities'.

Under Agenda for Change, healthcare assistants with less than two years' experience – and other Band 2 roles – earn £20,270 per year, or approximately £10.39 an hour.

And the current minimum wage in England stands at £4.81 for under-18s, and rises to the £9.50 living wage for over-23s.

By contrast, Lidl offers entry-level shopfloor staff £11.95 an hour in London – and £10.90 outside the capital – with longer-term colleagues earning up to £13 an hour.

Aldi raised its hourly rate to £11 for store assistants. And reported figures suggest Amazon pays warehouse staff an average £14.79 per hour.

Dr Peter Holden, treasurer at Derby and Derbyshire LMC, said his practice has given staff a 10% pay rise to keep receptionists and administrators from leaving the health service.

He said: 'There is a limit to how much you can give away your own income. We've given our staff a 10% pay rise to avoid losing them to Aldi. Other businesses can put the extra costs onto their prices, but we can't. We can't just turn down the heating because people have to get undressed to be examined.'

Felicity Cox, chief executive of Bedfordshire, Luton and Milton Keynes ICB, said that the system struggles to recruit 'more junior roles when we're competing with shops and warehouses' that can offer discounts and attractive employment packages.

'We have a huge Amazon warehouse; we have huge number of Aldis and Lidls opening almost weekly, so there are lots of other employment opportunities and we really have to think about being an attractive employer in a competitive market,' she said.

PCNS HAVE HIRED 3,880 PHARMACISTS

By Jess Hacker

GP networks have hired nearly 4,000 pharmacists under the additional roles reimbursement scheme (ARRS).

According to figures published by NHS Digital, as many as 3,880 FTE pharmacists were working in PCNs as of December 2022, up from 3,127 in March 2022.

The dataset also indicated 2,448 care co-ordinators were working across PCNs in December, with 2,345 social prescribing link workers also in post at the same time.

Pharmacy technicians were the fourth most hired role (1,246), with the number of physiotherapists standing at 1,102.

OPEN SURGERY BY FRAN

GETTY

ARRS ABOUT FACE

As the financial year comes to an end, PCNs are bidding for the additional roles underspend. We look at the scheme's merits and what might come of the end-of-year rush. *Emma Wilkinson* reports

Speak to PCNs about local funding issues for the additional roles reimbursement scheme (ARRS) and you get a mixed bag of responses. Some have spent their slice or more. Some cannot get the staff even if they want to or can only access staff not eligible for funding. Some have regular conversations locally about how to use the money. Others have had limited communication with their integrated care board (ICB), despite trying.

This variation is also highlighted by the results of our Freedom of Information (FOI) investigation on the current underspend and plans for its allocation, which found ICBs taking very different approaches.

Our exclusive uncovered that at least £64m of the £1.02bn available for 2022/23 is currently forecast to go unspent and less than a fifth of that sum is set to be allocated to PCNs. Once again, money that was destined to be spent in general practice will seemingly be lost to the sector.

Yet GP leaders have warned clinical directors (CDs) to spend up in this final year of the contract or risk losing it. 'Do all that you can' to recruit and spend that money because once it's embedded in the system it is likely to be retained, Dr Richard Vautrey, former chair of the BMA GP Committee and CD of Central North Leeds PCN told Pulse PCN at the end of last year.

The FOI responses on ICB underspend do suggest a significant improvement on the first two years of the ARRS scheme, when Pulse revealed that up to 40% of the available funding went unspent.

Figures from NHS Digital published in January show networks have hired nearly 4,000 pharmacists through the ARRS alongside 2,448 care co-ordinators and 2,345 social prescribing link workers.

But as Ben Gowland, director at think-tank Ockham Healthcare, pointed out in response to the figures, ARRS is by far the biggest part of PCN funding, so any underspend 'represents an underspend against the promised investment in general practice'.

He also has concerns that PCNs are now starting to see the impact from the move from more primary care-focused CCGs to the 'more distant' integrated care systems (ICSs).

We have had no help from the system; the money will probably be lost

Dr Sarit Ghosh

In theory, when funding through the ARRS scheme – the part of the network DES in which PCNs are funded to hire non-GP staff including pharmacists, physiotherapists, paramedics and (most recently) digital transformation leads – goes unspent, ICBs are able to invite PCNs to bid for the surplus, as was the case when CCGs were in charge.

Yet in reality, the information provided from ICBs under the FOI act suggests that with a matter of weeks to go before the end of the financial year, only 13% of the estimated underspend is set to be released back into primary care.

The small proportion of the money that will be reallocated, according to our data, will be limited to 14 ICB areas. Any unclaimed funding remains in the NHS England coffers.

In all, 36 ICBs responded to our request for information and only 21 of those are inviting PCNs to bid for money at all. One additional ICB received no bids despite inviting them.

At one end of the scale, Hertfordshire and West Essex invited all 35 of its PCNs to update their workforce plans, and is expecting to reallocate £1.7m, despite recording an underspend of just £54,647.

Likewise, Birmingham and Solihull ICB has approved 19 PCN bids and is planning to allocate £1.3m of its £1.7m underspend. Devon ICB approved the most bids of those who replied, granting £1.2m in extra cash for staff, despite estimating it will underspend by £800,000.

It became apparent that there is significant variation in the way systems are interpreting the PCN DES. Surrey Heartlands ICB did not open a formal bidding process and instead suggested funding should be reallocated by bringing forward planned ARRS recruitment.

Ultimately, in this scramble to make sure money is spent, there are fundamental flaws in the ARRS funding stream, say PCNs.

Putting in a bid – if that is an option – is one thing. Being able to fill the roles in time is quite another. Difficulties with recruitment, rigidity of the permitted roles, and the last-minute panic leave little room for long-term planning. And after the 'worst ever' winter the health service has seen, PCNs have little headspace to think strategically.

Ruth Rankine, director of primary care at the NHS Confederation, points out: 'While many of our members have been able to access the ARRS underspend and recruit more staff, the funding is short term and has often come too late to have maximum impact this winter, which has been a theme across the NHS.

'While any additional income in primary care is welcome, this still doesn't address the historical issues that primary care has had with recruitment for certain roles.'

She adds: 'Targeted support for those areas would be welcome, along with innovative approaches to addressing the capacity gap.'

Beccy Baird, senior policy fellow at The King's Fund think-tank, says variation in the ability to recruit is a real problem for PCNs and she would rather see ICBs offering support to PCNs to overcome those problems and help them spend the money in the longer term as well as getting the roles properly embedded.

In some areas, she says, recruiting pharmacists is really hard. In others, mental health workers are particularly difficult. One size does not fit all and support from the ICB is key, she adds.

'If you can't recruit pharmacists, who can you recruit and what can we help you with? How are ICBs going to make an impact with this money, because it's really important to everybody that we use the money.'

If PCNs are not submitting bids, ICBs should be asking why, she says.

It's not just about barriers to recruitment. There are other areas that PCNs are grappling with – such as having enough estate to house any new staff. There is also the issue of having the time to do the recruitment, training, supervision and integration with existing teams.

'For me, that's an ICB job – to work with PCNs and say what would it take, what do you need to be able to recruit these roles. They're important, but just having them isn't enough. You also need to be able to implement them properly.'

This should be a collaborative process between the ICB and PCNs because 'no one wants that money lost, everyone wants to improve GP access', she adds.

JON BERKELEY

That support for primary care in ICBs is massively variable, she explains. Some areas, such as Sussex, have invested in primary care infrastructure but in other areas it simply does not exist.

'How the ICB will support primary care is a wider question than just the ARRS roles but fundamental,' she adds.

Dr Sarit Ghosh, CD at Enfield Unity PCN in north London, is among those who have had limited communication on the underspend. He fears the money will just be lost.

'We have had no direction on this from the local system. We suspect the money will be clawed back by the centre,' he says.

Dr Brigid Joughin, CD of Outer West Newcastle PCN, says in her ICB of North East and North Cumbria there is a large underspend and they have been asked to submit bids with no advice about a limit.

The main problem is that it's so last-minute.

'There are few roles that we can get in post within three months. It is very frustrating.' She adds that it could be used to bring forward ARRS they have budgeted for in the following year.

'But as it's unlikely we can get anyone started before April, I'm not sure we can use any of it,' she says.

One option the PCN has considered is to ask a voluntary organisation it already uses for link workers if it can redeploy someone to get an 'extra three-months' worth' but that is probably all it can do.

It has been suggested there is likely to be an underspend again next year. 'So we could employ on top of budget for next year and hope there will be underspend again to continue that additional role into the next year.'

As previously reported by Pulse PCN, some areas feel limited by the roles on offer and would prefer to hire other staff, including nurses. One CD for a Dartmoor PCN noted: 'We see a lot of practices – particularly smaller practices – say they can't use an ARRS role and would rather opt for a doctor or nurse. That's probably where you're getting underspend.'

Dr Nicholas Jackson, CD at Selby PCN in North Yorkshire, says ARRS underspend is a constant source of angst for him and the PCN manager.

'The constraints on the staff groups and the recruitment environment mean that it has been almost impossible to come anywhere near using our allocation.

He adds: 'Locally, I think there is one small PCN who has done so and the rest of us are watching tens or hundreds of thousands of pounds going back into NHS England baselines.'

Earlier this year, Dr Jackson approached NHS England centrally to ask whether the underspend could be released to fund winter resilience schemes, because 'we predicted both a really difficult winter, and a reduction in the sums available to support winter access due to the pay award'.

'That fell on deaf ears but seems a very short-sighted decision now,' he says.

Humber and North Yorkshire ICB did not disclose to Pulse PCN its total underspend on ARRS roles but did say that one bid for £40,000 had been reallocated.

Dr Jackson is frustrated that they have not been able to access ARRS underspend for any other purpose. 'If we can't recruit to the ARRS staff groups, the funds are lost. We have recruited to roles outside of ARRS which are really important and adding value, for example a data analyst, an urgent care manager [who is a] nurse and an advanced nurse practitioner but because they are not in the additional roles scheme we have had to fund them ourselves and at increased risk.'

He adds: 'We could have recruited advanced clinical practitioners as well, but because the candidates were from a nursing background rather than physio, pharmacy or occupational therapy, we weren't able to fund them through ARRS. Some high-level skills and experience were denied to general practice at a time when we need them the most. Relaxation of the constraints on ARRS would be really welcome,' he says.

The experience of Dr Geetha Chandrasekaran, CD of North Halifax PCN, highlights the varied approaches ICBs are taking.

'We have a good relationship with our ICB and have frequent →

updates on ARRS underspend,' she says. 'We have not needed to bid yet and have not explored wider than just our place. Last year we tried to bring forward roles and look at place-based projects to enhance patient services.' Her general view is that there has been no resistance to making use of any underspend and any projects PCNs put forward.

In Greater Manchester there has also been a collaborative approach, says Dr Faisal Bhutta, joint CD of Hyde PCN. Hyde has used its ARRS allocation and has a system to make use of underspend, he explains.

'We have agreed other PCNs can put a business case to use this money if the original PCN can't use it. There is a panel in Greater Manchester that decides,' he says.

Ms Baird says Manchester shows the kind of conversation that should be happening everywhere. She wants to see more collaborative engagement instead of PCNs having to work it out for themselves.

'Implementing these roles is really difficult. In a trust you would have teams of people thinking about deployment and organisational stuff. Where's the support for general practice to do this?'

'At the moment there's too much of a tendency to say "you're independent contractors, just crack on". I'd like to see more co-ordination across the ICB and ICS at place level but that requires people with the knowledge of general practice.'

It takes a system-wide approach to solve the problems. The resistance to funding nursing roles out of the ARRS comes from nervousness at NHS England that this would exacerbate nursing shortages elsewhere, which is understandable she says, but must be resolved.

We asked how to access the underspend but had no answer

Dr Emma Rowley-Conwy

The same was seen with mental health workers. Community mental health trusts were nervous about workforce shortages so were resistant to helping PCNs recruit under the joint scheme.

But with support from the wider system, these challenges can be overcome and that is what is missing for many PCNs, she says.

She points to the example of Bradford, where there was an ambulance paramedic shortage. To improve retention, they set up rotational posts through primary care and the ambulance trust. It is that sort of wider programme that PCNs need to overcome capacity and recruitment issues, she says.

'It was a win-win for everybody. It kept people interested and motivated and gave them time off the ambulances and helped to develop their skills in long-term condition management because they were working primary care.'

Dr Emma Rowley-Conwy, CD at Streatham PCN in south London, said they have no significant underspend at place level but believe there may be underspend in the wider ICS. 'We have been asking how we access this for some time, but still have no clear answer.

'I think the issue is with finance and contracting as we had a spreadsheet a month or so ago that purported to be our ARRS spend and projected a 75% underspend, which all PCN CDs confirmed was absolutely not the case because we are projecting to only underspend a little.'

One challenge for CDs is that it is difficult to land a human resources budget on spend because you can't predict staff leaving in the final month of the year, or vacancies you can't recruit to, or spend on temporary members of staff, she points out.

'You are not allowed to pay overtime to recruited staff. Even if we ask our third-party providers for additional capacity in the short term, they cannot recruit or find staff on this basis,' she says.

Overall, it is a muddle, she explains. 'Last year any underspend was allocated on basis of PCNs projecting an overspend, but we did not bid – the NHS England guidance was not followed. We never knew what the total spend was across the ICS and what any underspend was. In the last financial year, member practices were prepared to take a financial risk of up to £10,000 each of overspend. Then at the last minute we were given the overspend by the CCG,' Dr Rowley-Conwy adds.

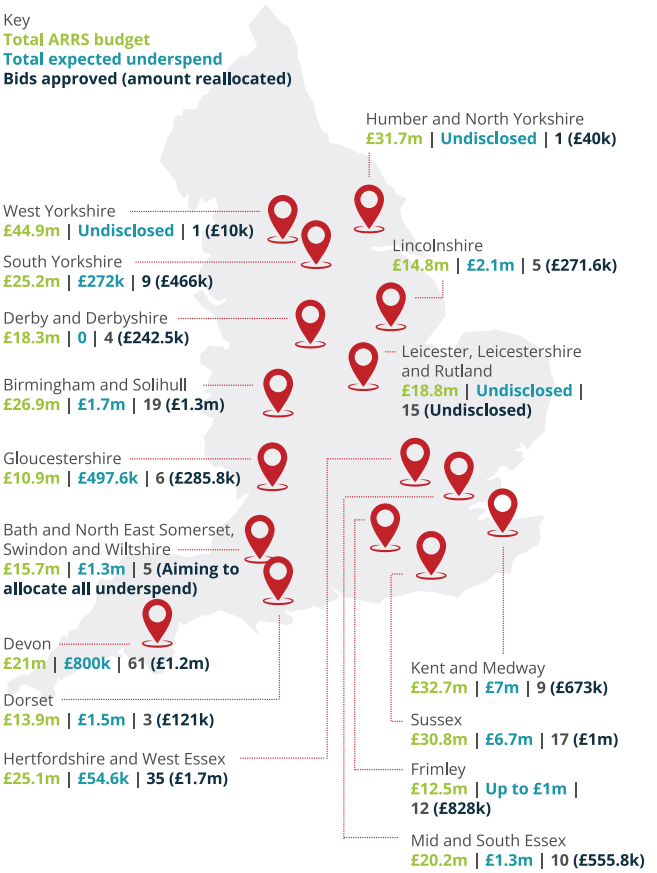
Yet those circumstances no longer exist. 'Practices can't do this now because of the financial pressures of staff pay and utility bills. They aren't prepared to take the financial risk,' she says.

Spending quickly is really difficult, agrees Ms Baird. 'Again, that's where I'd like to see systematic planning and conversation, whether that's formal or not, so rather than a really complicated bidding process where someone has to write a thesis to request a position, there's ongoing dialogue across primary care, within a place, about where we've got underspend and what's going on.

'[This would] manage the overall picture for the ARRS money rather than relying on very stressed-out CDs to try to make all those decisions individually.'

CHARLES MILLIGAN

ARRS UNDERSPEND BIDS APPROVED BY ICB AREA



ICBs RELEASING UNDERSPENDS FOR PCN BIDS

Five ICBs are currently or will soon start inviting PCNs to bid, including:

Bedfordshire, Luton and Milton Keynes; Black Country; Greater Manchester; Staffordshire and Stoke-on-Trent; Suffolk and North East Essex.

Northamptonshire ICB reported it had not had any applications for additional ARRS funding.

At least 8 ICBs estimate they will have no underspend for 2022/23, including:

Buckinghamshire, Oxfordshire and Berkshire West; Cambridgeshire and Peterborough; Norfolk and Waveney; North East London; Nottingham and Nottinghamshire; Somerset; South West London.

Derby and Derbyshire ICB also forecasts no underspend, but has reallocated funding regardless (see map, above).

BOTTOM LINE: ARRS IS A FORCE FOR GOOD

PCNs and ARRS roles are proactively delivering care before patients reach crisis point

The phone rings in Norwich. Dorothy thinks 'Who could that be?'. No one really calls her. She makes it to the phone – it takes a while. It's someone called a care co-ordinator asking how she's doing, wanting to check on her COPD and formulate a plan to help her manage it. (See our PCN profile, page 28.)

In Dagenham, Essex, Lina sees a video in her native language explaining why she should get a cervical smear test. It's given her pause for thought. (See our roundtable, page 15.)

Jake's mum makes sure her son takes his inhaler but he's been using it in the wrong way. That's fixed now, thanks to the nurse who came into school. (See our PCN profile, page 28.)

Plagued by hot flushes and insomnia, Sarah attends a group clinic (see page 25) on menopause and receives 90 minutes of expert advice and forms bonds with other people who are experiencing the same thing.

Primary care at scale, PCNs and ARRS roles are proactively delivering care before patients reach crisis point. For the patients it's a game changer.

However, our investigation (see cover story, page 6) found that the unspent ARRS money is not all being reallocated to PCNs and that there is variation in the way PCNs are able to access that underspend.

While there is markedly less underspend than in previous years – 6% of the total budget compared with 40% in 2020/21 and 2021/22 – 6% is still £64m, which could make a significant difference to PCNs and patients.

PCNs and their parent integrated care boards (ICBs) need to be fighting with NHS England to retain that money. Preventing ill-health and helping people manage their conditions in the community are far better ways to approach healthcare than waiting for an emergency. But arguments about the DES are already brewing as we head into the final iteration of the GP contract.

We know some of the DES plans, thanks to sister title Pulse, which revealed in February that the investment and impact fund (IIF) will increase from £260m to £305m. This will include £246m for a capacity and support indicator, which covers patient experience and patients being seen within two weeks. There will also be £59m for clinical indicators such as cancer and flu.

There will be the usual call from the BMA GP Committee for practices to not sign up. However, as we've seen in previous years, nearly all practices will as they won't refuse a major income stream they've already had for four years.

It will be imperfect. The ARRS roles will remain restrictive. The estates and training issues will remain. Many of the IIF indicators will be difficult to achieve, and some won't make sense.

But the rhetoric and ire about the DES will impact the clinical directors (CDs) who remain enthused about the changes they are making. Perhaps like our new columnist Dr Sian Stanley (see page 21), CDs can feel insulated by the PCN and maintain focus on delivering patient care supported by ARRS roles.

Because for the real Dorothy, Lina, Jake and Sarah, PCNs are a force for good – a proactive health service, instead of a reactive sickness service.

Victoria Vaughan is editor of PCN

WE'RE GOING THROUGH CHANGES

Professor Aruna Garcea, chair of the NHS Confederation's PCN advisory group and our new columnist, looks at the role of primary care

Against a backdrop of prolonged industrial action and a winter of extreme pressures across the whole of the NHS with spiralling demand and significant gaps in the workforce, it is easy to lose sight of what primary care is achieving day in, day out.

In December alone, primary care delivered nearly 27 million patient appointments. By comparison, just over 2 million patients were seen in A&E in the same month. To meet this level of patient demand the whole of the multi-disciplinary team (MDT) has to be constantly fleet of foot and resilient, pushing boundaries and barriers, working beyond traditional general practice walls.

To ensure a robust future, 21st century general practice continues to expand those MDTs from physios to occupational therapists and practice nurses. It is also bringing in new staff through the additional roles reimbursement scheme (ARRS) including mental health practitioners, first-contact physiotherapists and clinical pharmacists so that patients can see the right professional.

A fundamental block of this resilient structure is the general practice partnership model, which often sees partners working in a 'task and finish' mode rather than set hours. As partners own the practice they work in, they are heavily invested in its success.

However, increasing numbers of younger doctors are choosing to work as salaried GPs and to develop portfolio careers, which jeopardises that resilience and raises issues about long-term sustainability. A recent survey from The King's Fund found that fewer than 33% of trainee GPs said they wanted to work full-time clinical hours and only 35% said they aspired to become a partner.

To deliver for patients, general practice needs to consider how to develop new functions that haven't previously existed. Personalised care planning and population health management; trying to meet increasingly complex needs in the community despite a dearth of social care; understanding the wider determinants of health while political climates change all the time; and doing all this despite a huge workforce shortage. The key is to think differently and create innovative solutions, often at pace.

It is crucial to increase primary care resilience by investing in workforce development and recruitment, IT infrastructure and estates. General practice needs to be better equipped with investment and resources. This should also ensure that the partnership model can continue – alongside newer types of general practice schemes including GP federations and trust-led primary care.

Many of our PCN members tell us they see the partnership model as central to the continued success of primary care in their localities. Others acknowledge that in some regions the model may need to be reshaped for a sustainable future.

Whatever the make-up, the best people to identify and shape it will be local primary care teams working with other partners in health, social care and the voluntary sector. One size does not fit all; every geography and patient population will be different. But for this to happen meaningfully we need greater investment in estates, infrastructure and workforce. With the right tools we can create even greater resilience and plan for a brighter future.

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

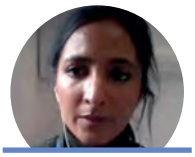
PCN ROUNDTABLE

EARLY CANCER DIAGNOSIS

Primary care leaders joined Pulse PCN editor *Victoria Vaughan* to discuss challenges and progress in early cancer diagnosis

ALAMY

DELEGATES



Dr Baldeep Syan
GPSI oncology in Hammersmith and Fulham, west London

Dr Bal Dupa
CD at Oldham East PCN, outer Manchester

Dr Kanchan Sanikop
Cancer lead for Brierley Hill PCN, Dudley, West Midlands

Sarah Forster
Strategic business and transformation manager at Medics PCN, Bedfordshire

Dr Shanika Sharma
CD and cancer lead at Barking and Dagenham PCN, east London

Dr Binodh Chathanath
CD at Bexhill PCN, East Sussex

Victoria The early cancer diagnosis specification came into the contract in 2020. What has that meant for your PCN and how has it worked in practice?

Sarah At Medics PCU we couldn't have delivered what we have if I didn't have a cancer lead that was clinical in my PCN and buy-in from my GPs. It's a fantastic deliverable, but an awful lot of work. Obviously 2020 was a very difficult time. The specification was paused while many of us were doing vaccinations. But we worked well with system partners and Cancer Research UK (CRUK).

We asked our practices to complete an audit. From that we found that one of our practices had a really good approach, leading on the referral process. It was not a coincidence that the year before they had worked with CRUK. We set up a small task group of three GPs, who met every month to thrash out the best referral practice pathway. There are lots of other elements but that's the biggest piece.

You need to take that time. It's just not doable otherwise.

Shanika I completely agree with Sarah. We were lucky that one of our GPs was the previous CCG cancer lead and did a lot of work with Macmillan, so she brought in a Macmillan cancer co-ordinator who helped to drive it by getting practice engagement, sharing resources and sharing data on cancer screening and how it looked at a practice level and at a PCN level. I know we've got data on Fingertips, but when you have someone who's mapped it for your PCN and they present what the practices are looking like, it really helps.

We evaluated our safety-netting tool and found it was not as effective as we hoped. Soon after that, we had a clinical effectiveness group run by Queen Mary University London (QMUL) in east London. It developed a new safety netting tool that was rolled out across all the practices and put on all the clinical systems. It's really helped drive the early cancer diagnosis. But without this system support it's very difficult on an individual PCN level.

Binodh We are a PCN with three large practices, so we identified three GPs to represent their practices as cancer leads and employed a cancer care co-ordinator. The cancer co-ordinator made links with the East Sussex Cancer Alliance and the Macmillan team and we did presentations to educate our clinical colleagues and the admin team about running searches, identifying people and inviting them to screening programmes. A key thing we did was to encourage one admin person from each practice to become cancer champions. They liaised with patients and made the connection between the cancer care co-ordinator and the practice. We hold a monthly meeting to discuss updates. We've improved a lot. At the beginning, there was a lot of chaos about doing FIT tests and not having blood tests together for the local trust.

Baldeep In terms of our PCN and the wider borough at Hammersmith and Fulham, being the cancer lead, I had the benefit of data. It is slightly older, I could go into meetings with each PCN and show them their position in the borough and the wider situation.

Chair Victoria Vaughan
Pulse PCN editor

ALAMY

We revamped our safety-netting tool which has made a big difference to early diagnosis
Dr Shanika Sharma

In terms of the PCN DES, I found it worked well to break things down for each practice into small manageable chunks with an action plan so it wasn't overwhelming. Otherwise, you're trying to boil the ocean with this big chunky piece of work.

One of the interesting things we did was significant event analyses (SEAs). They helped develop a community of practice in the PCNs. And they've helped change practice, with things like safety-netting and reviewing cancer diagnosis. A lot of good work has come out of that.

Bal The PCN DES has started to focus our minds. Working at scale, working with other practices has been really useful. But we also have to be very critical of ourselves. The reality is the outcomes for our patients. Since the PCN DES came into place, [outcomes] have deteriorated. Health inequalities for cancer have got worse. If you speak to our secondary care colleagues, they're very critical of primary care – and there may be reasons for it. They're critical of the fact that we shut up shop. I speak to a lot of professors of oncology, who say, [some] cancers are now irretrievable. [They're seeing] the late stages of cancer a lot more. That's something my friends in oncology are really disheartened about.

Cervical screening was a big success for general practice over many years. Now something has changed – suddenly, people have lost confidence in coming to us to get smears done. We need to be critical of ourselves. Have we focused on the wrong things? Have we sat in rooms talking to each other, but not talked to people outside us? And [4.6 million people did not take up their latest test] – it hasn't been good enough because they're not coming forward.

Being critical about the PCN DES, we've become very insular in how we're looking at cancer. Yes, we're talking to Macmillan, but not to people who are commissioning cancer care. Very few of us are having good conversations at scale with oncology departments, cancer trial patients and people who are commissioning the screening procedures. Our cervical screening and breast screening programmes are commissioned at a national level. We haven't got any traction in those conversations so far.

Shanika These points are really important. Our cervical screening rates in Barking and Dagenham were historically lower than the national average anyway. But, during the Covid pandemic, we noticed they were dropping even further. We got together as a PCN, and made some videos in different languages, to target hard-to-reach populations – people from Asian or Eastern European backgrounds. We did videos in many languages and encouraged practices to send them out.

The link with health inequalities work is really important. We're currently working with our public health partners. We put a bid in for health inequalities money across Barking and Dagenham. One of the projects aims to encourage breast screening in elderly patients, and to explain to them the importance of breast screening. The proactive approach for cancer screening has been identified as a priority in our borough-wide partnership. I agree this must be done outside the PCN. It has to be across the board with public health at the local authority, with secondary care, with community services all on board. →

We need public health in England to raise general awareness about red flags and the purpose of screening

Dr Baldeep Syan

The SEAs also identified that some things are beyond the control of primary care. It identified a lot of problems with diagnostic pathways. There were patients who were referred for a CT scan by primary care, but never had the scan, or it wasn't safety-netted.

Binodh Bal, this is exactly what we are thinking about. We have extended our hands towards the commissioners, the secondary care cancer delivery manager and the CRUK team. We have a quarterly meeting with all of them, and that's when we have the SEAs and discuss difficult cases. This has helped improve relationships between each of us. Now, through the cancer champions, the secondary care managers have access to the practices. We've asked them not to reject referrals, and if they need more information, the champions provide it. Sometimes we have to go outside the specifications, but at the end of the day, these small things make a big difference later on.

Sarah I'm interested to see what people think about the impact of telephone triage over the last three years. Are things not being picked up because patients aren't being seen face to face?

Bal There is a concept in primary care that 'every contact counts'. We say 'Yes, I know you've come for your ear infection, but do you realise it's really important to have your smear?' I think there is a distance growing between primary care. Maybe we need to re-evaluate.

In our practice, which is in a very deprived area, our screening rates were very good but they dropped off. We attributed it to telephone triage. We've gone back to fully face-to-face appointments, and guess what? Our screening and vaccination rates are coming up because you remember 'the contact counts' and the doctor has a pastoral role. It's been a conscious decision to view the triage machine as another tool rather than a replacement, which is how it was viewed in Covid. Seeing your patients does reduce health inequalities. That's a reality. We know that.

Binodh We also are reducing our use of telephone triage. We are going face to face. And nurses have never stopped seeing patients face to face – neither did healthcare assistants. A really small number of people have telephone contacts. Our chronic disease monitoring has gone down a bit, but it's picking up. [Those face-to-face contacts are] an opportunity to emphasise the importance of all these screening programmes.

To improve access, we have set up a group of three nurses who are offering extra sexual health sessions for women at weekends. There's at least one clinic every three weeks, from 9am to 1pm, where women can drop in or make an appointment. Improving access is key.

Sarah My cancer lead's practice has completely switched back to face-to-face appointments. But our PCN has five practices that all work in their own way, as does each clinician. There are various members of PCN staff such as paramedics and physician associates who are predominantly working by telephone triage, so we can't change that.

Baldeep Public health in England needs to play a role in this as well, in raising awareness. I read a statistic the other day that a full-time GP will have eight or nine cancer cases diagnosed in one year. It's not a lot if you think cancer's going to be present in one in two people. We need campaigning for patients to be aware of what red flag symptoms are, when to present to their GP, why we do screening, and what the purpose of screening is. I don't think there's enough at the moment.

Victoria This year there was an added focus on improving referral practice, particularly in disadvantaged areas where early diagnosis rates are lower. What work have you done on this?

Binodh Our cancer care co-ordinator is working with our learning disabilities care co-ordinator and we've got another care co-ordinator who looks after people who are vulnerable and in care homes. We have produced a leaflet, which is really straightforward, so that people with learning disabilities and their carers can understand about cancer screening programmes.

We are using cancer co-ordinators to contact carers and introduce themselves, asking permission to visit and talk to them in person. We've worked with our integrated care system (ICS) lead because this is one of our programmes to improve health inequalities and increase cancer diagnosis in people with learning disabilities, serious mental illness, and people from ethnic and Asian and African backgrounds. These are the main areas we are concentrating on.

We are working with public health in our area too. It gives us loads of information about pockets of deprivation.

Shanika There are loads of research studies. Locally for lung cancer we've got SUMMIT, an early cancer detection and lung cancer screening study from University College London run by University College London Hospitals NHS Foundation Trust. As part of this, people are being offered a low-resolution CT scan and we've caught quite a lot of cancer diagnoses through that because we have an area of high lung cancer prevalence.

Also, we've been working closely with local voluntary sector organisations to tackle health inequalities. As part of our health inequalities bid, a chunk of funding was given to our voluntary sectors organisation lead and they've developed a programme of locality leads. There is a health inequalities lead in each of our six PCNs in Barking and Dagenham. Their role is to map the assets in the community and bridge those gaps between different workers – care co-ordinators, social prescribing link workers and all the other wider members of the PCN team.

Whatever we do in primary care, some people won't come to us so we need to go to them.

Bal One of the most amazing successes – which has been a sea change – is the ability for PCNs and practices to employ care co-ordinators. The amazing thing about the PCN DES is being able to locally look and get these ARRS roles on.

Shanika, Baldeep and Binodh are six or seven months ahead of us but I've got the ambition to get there. For me as an old GP that's an amazing legacy for the PCN DES – to be able to employ some of these care co-ordinators in practices. We'll get the dividends of that as time goes by. We've just done a piece of work to get people on board with that.

GETTY

Kanchan We have a designated cancer care co-ordinator who's taking the lead on this. We support her.

But from what I'm hearing today, I think our services are a little bit disjointed. I'm only involved in our PCN part and not in the wider Dudley area.

It would be helpful to co-ordinate care more with other PCNs because there's always something to learn from other areas to increase our uptake of screening.

Our cancer lead is doing a lot to increase the uptake of breast cancer. We are sending out messages to increase our first breast screenings because we found that our rates were really low – maybe about 40% when nationally they are about 70%.

I also find that secondary care and primary care in our area are not working together at all. Even if we see more patients face to face, our secondary colleagues are still doing telephone triage.

So for two-week cancer referrals, secondary care would first do a telephone consultation. The upper GI referrals do well, as do referrals for obstetrics and gynaecology.

But others like neurology are getting appointments after two or three months.

I feel we all have to work more together, not just in primary care.

Victoria So in some cases the two-week referral results in a secondary care phone call rather than a face-to-face appointment?

Kanchan Yes. So we are not in any way guaranteeing a patient will get whatever investigation they need within the two weeks of referral.

Victoria Is this something others are experiencing?

Shanika We looked at this with our SEAs escalated it to our local trust. We said look, GPs are sending people for scans. The trust did an internal enquiry and found problems. We were able to troubleshoot through this but it's really important to keep the process going. I completely agree about the two-way conversation. Unless we have that relationship [between primary care cancer leads and secondary care], it's not really happening. That integration is pivotal to move this forward.

Bal When we talk about health inequalities, some are in accessibility and pathways. Shanika, you say you've got access to scans. We don't have that in Oldham. There is variation nationally in diagnostic access, irrespective of diagnostic centres. And the elephant in the room is →

We're looking at governance structures for our diagnostic centres. For instance: who picks up the results?

Dr Binodh Chathanath

why have you got access to CT scans, Shanika, and we have not? The conversation about health inequalities [is not just] outcomes; it's also diagnostics. We're lucky in Oldham, we've got a rapid diagnostic centre. We put a bid in and we're very proud of that.

Binodh We've got two rapid diagnostic centres for East Sussex. We are still looking at governance structures. One problem is this – who is going to pick up the results?

Baldeep I'm the clinical lead for our rapid diagnostic centre at West Middlesex Hospital. We've got north-west London fully covered with GPs to access rapid diagnostic centres. We're a two-week wait. It works well and supports our local GPs. They're not worrying 'does the patient have cancer or not, how am I going to investigate it?' It can go down a vague symptom pathway if it doesn't fit along another pathway. Binodh, you mentioned the issue of who picks up the results. Once the GP has referred a patient down a two-week wait pathway it's the responsibility of clinicians at the diagnostic centre to pick up the results and carry out the necessary tests.

Shanika We have a rapid diagnostic centre. I find it helpful and valuable because, as you've mentioned, patients are getting more complex. They don't perfectly fit into one cancer diagnostic pathway so it's nice to have the rapid diagnostic centre. I'm a GP trainer and my trainees value it as well when they've got that sort of uncertainty, when they're wondering is this upper GI, is this lower GI, where do I send this person?

Also, there's an additional safety net. The other thing we've picked up on our SEAs was a couple of individuals who were referred down one cancer diagnostic pathway, and were found to be clear, but then ended up having a cancer in another organ which wasn't followed up. How do we make sure these people are looked after and their care is streamlined and communicated between the different streams?

Baldeep For our pathway, we have a filter function test. Our referral criteria are vague – to accommodate that GP gut feeling. Then we have a requirement for function tests to be done – a FIT, a CA125, other blood tests. Usually in those you can pick something up. They help decipher where the patient should go.

Bal With the case Shanika mentioned, if you're a gastroenterologist and the patient has vague lower abdominal symptoms, you examine them and if there's a mass, you refer them. But you can't do that in telephone triage. It is a reflection on secondary care – it seems to be behind us in moving back to the face-to-face consultation. Maybe we need to be more forceful to get them back on board with this.

Victoria What would you like to see in next year's DES and for the future in terms of cancer diagnosis?

Bal I'd like the whole system to be accountable for cancer outcomes, not just my part of the system for my cancer care. We need to be much more ambitious. Let's put the whole pathway in the DES, cancer care for everybody involved in the pathway, not just a referral actioned in two weeks.

GETTY

Baldeep There should be work linking primary and secondary care for cancer, and for diagnostics. I think early cancer diagnosis in the DES needs to span the breadth of patient education and diagnostics. And also treatment summaries and making sure treatment happens. We're lagging behind all that. [The DES] needs to be a lot broader.

Sarah I am a great believer in investigating the referral pathway. I assumed each practice would do each referral pathway differently but there's even more variation than that. Actually each GP does it differently, and so do locums and other members of staff. From the data we've seen in our PCN, things aren't being picked up in primary care any more. Cancers are being diagnosed with other presentations, and also not through screening. [The DES] needs to revisit what it asked in the first place because I would argue that many PCNs haven't done that.

Shanika There should be a standardised approach up and down the country in terms of access to diagnostics, access to rapid diagnostic centres. It's unfair if a PCN doesn't have access to rapid diagnostics because it is not commissioned for the PCN and it has to be done at place level. Also we need to make sure cancer diagnosis is a priority for place-based partnerships and for integrated care boards (ICBs).

Kanchan My wish list is more integration pathways between secondary care and primary care. The other significant problem we have faced is coding. We depend on coding – being able to pick up how well we are doing. Coding is not being done properly and is a huge issue in our area. There's no consistency in practices or even in different PCNs and how we pick up the referral rate and all those things.

Binodh The most important issue is stability. [We must] remove uncertainty about the DES and the contract. That's a big risk for me as a CD – what's going to happen in 2024? We've got so many people employed through the additional roles reimbursement scheme (ARRS), and I'm cautious every minute because I'm answerable to all these people.

GAME CHANGER

Dr Sian Stanley, CD for Stort Valley and Villages PCN in Hertfordshire and our new columnist, assesses the effectiveness of PCNs

When I signed up as my PCN's clinical director (CD), I naively thought it would be a matter of gathering a team, recruiting a few staff through the additional roles reimbursement scheme (ARRS), then a pat on the back and a cup of tea.

Instead it was more of a shot of espresso and a Crystal Maze of highly pressurised challenges. I feel like I've been standing in a wind tunnel for the last four years with information bombarding me at speed. Like being in the Crystal Dome trying to catch the gold tokens while avoiding the silver ones and wearing a very unflattering jumpsuit. The rules of the game changed, contracts were amended, the Investment and Impact fund (IIF) suddenly had different criteria. And then Covid hit.

Suddenly it wasn't like a game. People would die. I was in a leadership position I wasn't trained for. The DES became a distant memory and we had to make everyone safe. As individual practices we had daily huddles to discuss our fears for our patients, our families and ourselves. We learned about Microsoft Teams, bought webcams, PPE, all manner of other kit, some of which we never used and some that saved lives. We turned each site into a different level of risk, one for the immunosuppressed and another for Covid patients.

Then we vaccinated. The start of that is still one of the best days of my life.

I challenge anyone who saw the work we put into converting a football club into a vaccination centre to call it 'money for old rope'. Our team worked night and day to get the vaccine rolled out and we did it efficiently and with great spirit. I know our experience was replicated by hundreds of PCNs and federations. I think primary care was never given the credit we deserved.

But I have never been clear whether I think PCNs are a good idea or not. Our PCN has made it work but these relationships did not form overnight. We are like a family – we wouldn't necessarily choose each other and we don't always agree but we do respect each other and can compromise and work as a team.

My fellow CDs in East and North Herts (ENH) and West Essex have also provided support that only those in the Crystal Dome can understand. ENH CD Association has created a safe space where we can share learning and represent each other's views at the myriad of meetings we attend. This grouping of CDs is where some of the value of the PCN model lies. There has always been a disparate landscape of practices, all with different needs and ambitions. Through the CD Association we have created a backdrop where the differences are acknowledged but the similarities protect us.

Anyone in general practice is cognisant of the issues we have faced. Our PCN and federation have helped insulate us so we can deliver clinical care to our populations. We have used IIF money to bring in additional staff, create energy grants and build extra capacity over the winter.

I know not everyone approves of PCNs and I recognise the frustrations of practices who would rather see the ARRS money go into core funding. I understand how some groupings don't work. I also acknowledge there has never been a formal pathway for becoming a CD which has called into question our legitimacy. But after this crazy journey I know PCNs can work. With the right people, primary care at scale can be a force for good.

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

***Dr Richard Vautrey,* clinical director for Central North Leeds PCN, primary care lead for West Yorkshire integrated care board and former chair of the BMA GP Committee discusses the future of PCNs**

What should happen to PCNs after 2024?
It's essential that the funding is retained in general practice, and that the workforce is recruited, and is confident it will continue to be able to work with practices. I would like to see the workforce closely embedded in general practice and practices, so they feel part of the team. And it's essential that we give confidence to all of them, so we can continue to use the skills and expertise of all of those who are working in that environment.

What are the challenges managing a PCN in your area?
[The challenges are] no greater than any other organisation. We have been fortunate to recruit and retain good healthcare professionals who want to work in our practices. One of the real challenges we've had is the space in our practices: many practices are bursting at the seams already. Finding space for our staff to consult with patients and be active members of the practice team is a challenge for some practices where they simply don't have the physical infrastructure to do that in a way they want to.

But we're really pleased that we've been able to get a pharmacist in every practice. We've got paramedics doing home visiting, we've got social prescribers supporting us with vulnerable patients, and physios offering direct access to patients within a matter of days rather than months.

We've seen significant benefits from our PCN workforce. And it's enabled really good collaboration between our member practices.

Our PCN workforce has enabled really good collaboration between member practices
Dr Richard Vautrey

Finding space for additional staff is a big problem for practices. What's the scale of the estates issue for your PCN?
It's one of the biggest issues. We've been fortunate to recruit hundreds of new people into our general practice workforce but, at the same time, we haven't seen similar investment going to estates or IT or basic infrastructure to support their work in the practice team.

It's crucial that the Government and NHS England prioritise the investment in premises in the community, and that we get the necessary space not just to support the PCN workforce, but to be able to do more in the community setting: this is one of the stated aims of the Government and many political parties. They want to see more activity taking place in a community healthcare setting, but we can't do that without proper investment for the long term in our infrastructure.

How well does your integrated care board (ICB) work with primary care?
They're doing well with the resources they have. One of the challenges we've got, as with many other areas, is that when we want to provide more support to our practices, through income protection for QOF or suspending Investment and Impact Fund (IIF) targets, NHS England nationally doesn't give the ICB the power to do that. That is frustrating. Our ICB has a strong philosophy of devolving decision-making and resources to back to the places within our area. So most of the decision-making in general practice continues to take place at a local level, which is a good thing: we have strong relationships that are built up over many years with our ICB colleagues who were formerly CCG colleagues.

Have you noticed a change in that relationship in the switch from the CCG?
No, we haven't. I think we've been fortunate because our ICB has a strong philosophy of enabling decision-making and resources to flow to the local community, we haven't seen a difference in the way we've engaged with the various places in our region.

We're about to receive the first report from the Hewitt Review. What would you like to see from that?
There is a fine balance. We want to maintain the protection that we have from a national GMS contract. It's vital that we do that and retain the ring-fenced resource that goes into general practice through that national contract.

But having said that, if NHS England is not going to listen to the real evidence of the pressure that chasing targets is causing practices, we want to have the flexibility to continue to provide long-term care to patients who need it without the worry of having to achieve targets to maintain our income or to keep the practice running.

We need the ICB to have that ability to make those kinds of changes and to do so with our local knowledge.

Last year's Fuller Stocktake proposed the idea of morphing PCNs into 'integrated neighbourhood teams'. How do you see that shift happening?
We already work closely with our community nursing colleagues and the wider community team. But they're already stretched to capacity – as are our practices. Unless there is a significant resource shift into community teams as well as indirectly into practices, it's hard for an integrated team to do more than it's already doing.

Having a relationship when you've got people working in the same building, in the same locality, can help smoothe out the ways that working takes place. But nevertheless, I think we need to recognise that our community colleagues are as stretched, if not more stretched in places than many in general practice.

They are also struggling to recruit: we haven't seen the expansion of community teams in a way that's necessary for the growing needs of more elderly and complex population. Just bringing them together in a more integrated way doesn't solve those problems.

PAUL STUART

RUN GROUP CONSULTATIONS

Group clinics could provide personalised patient care and address social isolation while reducing clinician burnout and workload. But they are not a quick fix. *Dr Ellen Fallows* shares her experience

Group clinics could alleviate some of the biggest challenges for primary care – workload, patient demand and even staff morale.

The format allows groups of up to 15 patients to consult with a clinician in a structured manner with the support of a trained facilitator. Clinics can be delivered either in person or through a video platform and have been used for 10 years in the UK and for more than 20 in the US and Australia.

Group clinics can achieve much of what is done in a one-to-one consultation, such as arranging prescriptions, tests and referrals. A group consultation is generally 90 minutes long, so there is more time for patient support, education and problem-solving. Evidence suggests they can improve health outcomes, particularly for long-term conditions, and can allow more time for discussions of lifestyle approaches to health.

So group consultations may be a good option for dealing with complex long-term conditions, which require a time-intensive and holistic approach that can be challenging in the current workforce crisis.

How it started in my area

As part of a Thames Valley Health Education England GP fellowship, I set up group clinics at my practice to help people with cardiovascular disease and type 2 diabetes. We saw 180 people in group clinics and results included reductions in weight, average blood sugar and blood pressure – even though we often deprescribed (on the patients' requests). Our PCN clinical director supported scaling up, but Covid-19 meant we had to change our approach. We offered video group clinics to patients across the PCN, to support them to 'live well' with long-term conditions such as depression, anxiety, obesity, type 2 diabetes, hypertension, COPD, chronic pain and menopause. The offer was also open to the general public.

In a deprived area of Oxfordshire, we searched for patients on a waiting list for musculoskeletal outpatient services and offered them both in-person and video group clinics to support chronic pain.

How the group clinics worked

A health coach was trained to facilitate group clinics using the e-learning for health video group clinic package, motivational interviewing and one-to-one sessions with a GP with lifestyle medicine expertise (me). I have experience setting up and delivering face-to-face group clinics and in nutrition, obesity management, menopause, chronic pain management and lifestyle medicine.

We offered groups on fatigue and chronic pain, COPD and asthma, cancer, type 2 diabetes, weight management, low mood, anxiety and menopause. There were 100 participants from nine GP practices, and the majority of clinics were delivered virtually on MS Teams.

The feedback

When we conducted a survey, 95% of respondents (39 patients) said they would recommend a group clinic to others with similar health concerns. Also, 95% of respondents found it useful to hear about other people's experiences, and 98% felt comfortable sharing their health concerns. And 90% thought they had more time to get their questions answered. Patients reported feeling validated when they talked about their symptoms. One said it was helpful 'knowing that others have similar issues and questions', and another talked of 'light-bulb moments' after hearing others' stories.

The groups were also helpful in reducing feelings of isolation. One patient said it helped 'feeling I'm not on my own', and another described the group as 'a much-needed lifeline'.

The challenges

There is a temptation in the NHS to hope that new consulting methods might 'fix' the problems – especially demand. But no single solution will solve the issues – particularly not in the set-up phases. New systems have to bed in and work must be done to inform and engage both staff and patients.

Nevertheless, I see huge potential in this way of working. It is well suited to any long-term condition and other clinical areas too. It also facilitates the joining-up of services in a personalised way for patients and supports them with self-care. And it can address critical issues such as workforce morale by enabling teams to work more closely together.

Most importantly, it addresses social isolation, which is a greater risk factor for ill health than obesity and smoking combined – and can, in itself, be a driver for service demand.

POTENTIAL BENEFITS OF GROUP CLINICS

- **Reduce social isolation**
- **Support patients with self-care, lifestyle approaches, problem-solving**
- **Enable deprescribing and signposting**
- **Ease demand – we can see 10 patients an hour with better quality conversations**
- **Clinicians can work in teams and support each other, preventing burnout**
- **Tap into community support and put emphasis on the patient's agenda (they feel emboldened as more of them are in the room)**

GETTY

Dr Ellen Fallows is a GP in Brackley, Northamptonshire and vice-president of the British Society of Lifestyle Medicine

HIRE AND WORK WITH GP ASSISTANTS

The role of the GP assistant is to support GPs – and the evidence suggests it is working. *Dr Pipin Singh* explains why GP assistants are worthy of PCNs' attention

The GP assistant (GPA) role was designed to help GPs perform more efficiently by taking over routine administrative and clinical tasks.

The evidence suggests the role has been successful.

There is improved patient access and a better flow of patients through the system. GPs are less likely to get tied up in administrative tasks that can slow clinical work.

The evidence also suggests financial savings by having GPAs undertake tasks such as insurance reports. And there is improved job satisfaction, and thus retention, of both GPs and GPAs.

What a GPA role looks like

The GPA could be an existing member of the practice team or someone who is recruited externally.

The ideal GPA will have excellent communication skills and will recognise how good communication is crucial in improving patient safety and outcomes.

They must be willing to learn and develop, and able to recognise when they need support.

A full-time GPA post is usually 37 hours with a Band 3-4 salary on the Agenda for Change scale.

GPAs are expected to adhere to practice policy and ensure their own ongoing professional development by attending training and annual updates, and undertaking an annual appraisal with a GP mentor. They may also be required to maintain a portfolio.

They are expected to be aware of professional boundaries and to report any concerns about their role, either to their PCN-appointed mentor or within the practice to a GP partner or practice manager.

Training

There are two routes to becoming a GPA. Both follow a national competency framework of five key domains with 58 competencies:

- Care.
- Administration.
- Clinical.
- Communication.
- Managing health records.

For those who want a formal certification of training, Health Education England (HEE) has an accredited training programme, which takes six to nine months to complete.

PRACTICAL TIPS

- **Ensure your team knows what is expected from a GPA role**
- **Make sure the GPA is comfortable with their environment**
- **Provide a clear induction programme and annual appraisals**
- **Invite the GPA to all team meetings**
- **Have a clear mechanism for addressing concerns – clinical or otherwise – about the post**
- **Ensure the GPA has the opportunity to debrief regularly and has appropriate mentorship**
- **If you are not a training practice, seek advice from one – they will be able to explain how to provide support and mentorship**

GETTY

Or GPAs can receive on-the-job training in the practice with a GP mentor who follows the national competency framework. There are pros and cons to both routes, but the ideal is a combination of the two. The HEE training pathway will require the GP mentor to provide structured training similar to that of a GP registrar and be aware of portfolio requirements plus any mandatory university sessions.

How can a GPA support the practice?

The practice can decide on the specifics of a GPA role, but the general aim is that a GPA will undertake tasks that will ease the clinicians' workload.

They might support healthcare assistants performing venepuncture and BMI checks. They could carry out basic observations and check BPs and blood glucose readings. Another task might be to dip urines and present the findings.

Additional patient contact might be preparation work before the GP appointment. This would include taking a basic history – noting the presenting complaint and any relevant history, such as drugs, family and social history – then presenting the case.

Any queries after the consultation from the patient could be addressed to the GPA.

The GPA role includes administrative tasks such as extracting information from clinical letters and coding the data, attending to referral paperwork and completing insurance reports.

The GPA can also liaise with care navigation teams, social prescribers and pharmacists. They can attend multidisciplinary team (MDT) meetings and share patient concerns. The partnership is responsible for the decisions that GPAs make.

The GPA role can be adapted for each practice and therefore can be very valuable. Whatever the GPA is asked to do, they must be supported and given ample opportunity to debrief with their GP mentor.

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

ONLINE

To read more ARRS articles, visit

pulsetoday.co.uk/category/pulse-pcn/

linkedin.com/groups/9022165/

SECRETS OF SUCCESS

Norwich PCN triumphed as PCN of the year at the General Practice Awards 2022. Clinical director *Janka Rodziewicz*, CEO of the Norwich PCN delivery arm, outlines the work of this innovative network

OneNorwich Practices (ONP) is the delivery arm of the Norwich PCN and has gradually and consistently invested in its workforce. It now employs almost 200 staff. Each one is focused on supporting general practice and ensuring better outcomes for patients.

The secret of our success has been developing a culture of finding our own way within the parameters of the DES to bring stakeholders together and make things work not only for the benefit of the patients but also for the 22 GP practices and the local health system.

This approach has involved taking measured risks, doing things that have not been done before, talking to people and organisations we have not talked to before and rallying the support, commitment and belief of those around us to make things happen.

In the last two years, areas of focus include proactive recruitment to the additional roles reimbursement scheme (ARRS) and next year we will be working to a £5.2m budget. We have consistently used nearly the maximum available budget each year.

We have developed a range of services and roles to meet the ever-changing landscape of primary care.

Through regular meetings with practice managers, commissioners and GPs it became clear that there were several problems common to almost all our practices:

- Difficulty recruiting new GPs.
- GPs retiring.
- An ageing population with more comorbidities.
- Growing health inequalities across the city.
- A high demand from our patients for face-to-face appointments.
- Difficulty retaining staff.
- A shortage of space in our practices to deliver services.
- A pent-up demand for services following Covid-19.
- Increased waiting times at the hospital.
- A lack of co-ordination between the different health services.
- Increased pressure on primary care.
- Increased pressure on acute care.
- Negative attention from the media.

ONP on behalf of the PCN took each of these issues and devised funding and effective solutions. Although we don't claim to have cracked each issue we are confident we have significantly improved the services our patients receive and reduced the burden on primary and acute care.

Broadly this work falls into three areas:

1 Primary care transformation We support the PCN to develop sustainable and resilient practices by helping provide staff and expertise. We also bring together partners from GP practices, social care and the voluntary sector.

2 Extended primary care We create collaborative at-scale services, to provide more care in the community and use research and data to design new opportunities for services in the community delivered collaboratively by practices and partners.

3 Integrated population model of care We are designing a way to capture population health data to inform strategic commissioning and operational delivery. We are also developing integrated, extended multidisciplinary teams at practice and locality level to respond to planned and urgent care need, and promoting a shift in ethos from a reactive to proactive model of care.

Living Well team

Norwich has a diverse population. Many of these people present in general practice as they feel they have nowhere else to turn. The PCN, working in partnership with a voluntary care and social enterprise consortium, has created an effective social prescribing offer, which has supported large numbers of people.

The partnership was formed between the PCN and five providers - Equal Lives, Mancroft Advice Project (MAP), Shelter (Eastern region) Age UK (Norwich) and led by Norfolk Citizens Advice. This partnership not only uses local health intelligence to identify local needs but provides a full spectrum of support.

The social prescribing team is not only contributing to the PCN's PC01 IIF indicator (number of referrals to social prescribing) it is also assisting with anticipatory and personalised care and helping practices achieve QOF targets.

Early estimates suggest the Living Well programme is delivering in excess of £5m in savings locally each year. This has provided a solid foundation on which the primary care community officer roles have been commissioned and developed.

As a result, the PCN has become confident in partnership working and has commissioned further services including a type 2 diabetes

FIGURES FROM THE LIVING WELL TEAM PROJECT

- **22 practices actively referring (all practices in the PCN)**
- **14.5 WTE staff**
- **Five provider organisations**
- **More than 1,000 people referred per year**
- **Improvements across all self-reported outcomes**
- **More than 1,000 shielding people supported during Covid**
- **£1.15m social return on investment per year**
- **£5m benefits in terms of better health based on quality-adjusted life years per year**

FIGURES FROM THE IMPACT PROJECT

- **The number of patients reporting problems with anxiety/depression at 3 months decreased by 9.17%**
- **The incidence of problems reported with pain/discomfort decreased by 8.9%**
- **The percentage of patients reporting problems with self-care activities decreased by 8.88%**
- **The number of patients reporting problems with mobility decreased by 5.71%**
- **The incidence of problems reported with usual activities decreased by 3.96%**
- **Average HbA1c in the type 2 diabetes cohorts decreased by 14% to 83.3mmol/mol**
- **93.57% of patients did not require additional GP care**
- **Hospital admissions decreased by 44.11%: £493,200 saved**
- **A&E attendances decreased by 23.43%: £52,055 saved**

From left: Ian Wakefield communications and engagement manager; occupational therapist Lewis Roope (IMPACT); Gina Eyles (asthma in schools project)

programme with Age UK Norwich, and a GP high intensity user programme with one of the local trusts. The Living Well programme has helped us create collaborative care for the patients who need it most.

Integrated motivational proactive anticipatory care team (IMPACT)

IMPACT is run by occupational therapist Lewis Roope, who, on behalf on the PCN, leads a team of five care co-ordinators hired via ARRS who support the anticipatory care agenda. The team contacts patients with COPD, asthma and type 2 diabetes to offer a personalised care review and a personalised care support plan. These plans look at all aspects of health and wellbeing including physical and mental health and also emotional and interpersonal relationships along with social issues of housing and employment. Then the team creates a shared action plan, which involves referrals across the PCN and to partner organisations.

We want to build on the good work that has already been done with the 22 GP practices in our PCN. We also hope to incorporate more local population data to anticipate patients' needs more effectively.

Asthma in schools project

The issue was highlighted when a young patient failed to attend reviews and ended up in A&E. We recognised that the impact of an asthma programme could be significant and discussed this with potential partners. We also found that children from deprived areas were more than twice as likely to require emergency admission following an asthma incident, so we focused our resources in these areas.

Instead of the parent attending the GP practice for a review, the nurse attends the school. The parent is invited to the review in that familiar and convenient setting. The school also receives training on asthma. The project is run by paediatric children's asthma nurse specialist Gina Eyles.

> **A child was hospitalised with asthma because reviews were missed, so we took asthma follow-up into schools**

The programme targets children under 16 and invitations are sent to any patients on the asthma register. The school also notifies us of any known asthma patients. We also search the clinical systems to identify these children. The 10 schools involved have been enthusiastic and accommodating. Where school nurses exist, they have also been supportive. We aim to work with 1,000 children.

While most children (52%) had their asthma under control we found 12% were very poorly controlled and 28% were only partially controlled. We also looked at inhaler technique and found 69% of children required correction.

The National Review of Asthma Deaths (NRAD) recommended that all children should have a personal asthma action plan. Research suggests annual reviews and a personal asthma action plan halve the incidence of hospitalisation. Before our asthma in schools clinics, 81% did not have an asthma plan. Now, 100% of those reviewed have an asthma plan. Following positive feedback, the integrated care board (ICB) has provided financial investment to facilitate the expansion of the asthma in schools plan to the whole of Norfolk and Waveney.

The local East of England Health of the Nation 2022 heat maps inform us of the highest areas of deprivation and prevalence of childhood asthma and pinpoint the hotspots we need to prioritise, namely Lowestoft and Great Yarmouth, with the continued aim of reducing inequalities.

The General Practice Awards 2022 were run by Pulse PCN's publisher Cogora. For more information and a list of the winners visit generalpracticeawards.com

JULIAN CLAXTON

OF POTHOLES AND PCNS

Our new columnist, health journalist Andy Cowper, considers the rush to fill ARRS roles before the funding disappears

Potholes and PCNs might not appear to have much in common. Potholes arise in an underfunded environment as the result of heavy stress, uneven design and repetitive demand pressure - and are made bigger by the prevailing climate. PCNs, on the other hand...

I'm kidding. Well, up to a point.

But the financial year-end affects road maintenance, and it's also currently affecting PCNs. The cut-off of 31 March drives local authorities into a frenzy of roadworks at the end of each financial year: an underspent maintenance budget is a budget that won't get refilled the next financial year.

Almost a decade ago, the National Audit Office observed that 'the current pattern of funding, combined with the need to spend money within the financial year, means that most road maintenance is carried out between September and March ... it is less efficient than carrying out the work at other times of year because materials can be difficult to handle in cold and wet conditions, and daylight hours are shorter. As a result, almost all highways authorities need extra capacity from the market at the same time, making it less likely that they will obtain value for money'.

Knowing your ARRS from your elbow

Yes, that does sound familiar. PCNs are facing a comparable situation in their urgent need to recruit to the additional roles reimbursement scheme (ARRS) before the end of the GP contract period.

Expanding the primary care team is obviously a good move: pressures on the sector have been ridiculous for years. The multidisciplinary roles in ARRS could make a significant difference, both to the feasibility of primary care jobs and to patient access and care.

NHS England director of primary and community care Dr Amanda Doyle told an NHS Confederation webinar last November that the national funding for those in ARRS roles at the end of March 2024 (the end of the current GP contract period) will become ongoing funding in the new GP contract. She emphasised, however, that unspent ARRS money would be a different story.

Tick-tock, tick-tock

It's currently March 2023: that gives PCNs just a year to locate, hire and train ARRS staff. That's not loads of time. We are in a tight labour market and any recruitment campaign sees a certain amount of natural erosion.

This time last year, NHS England was trumpeting the hiring of 10,000 people under ARRS. That is not nothing, but the target is 26,000 by 2024.

Last April, speaking at Pulse PCN's London Live event, BMA GP Committee deputy chair Dr Kieran Sharrock suggested that to help address recruitment challenges, PCN workforce leads need to 'think flexibly' and put existing staff forward for further training when trying to fill ARRS roles.

I wish everybody a smooth recruitment drive, but do keep an eye on the road surface.

ONLINE
Read more PCN articles online at pulsetoday.co.uk/category/pulse-pcn/

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