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PULSE PCN

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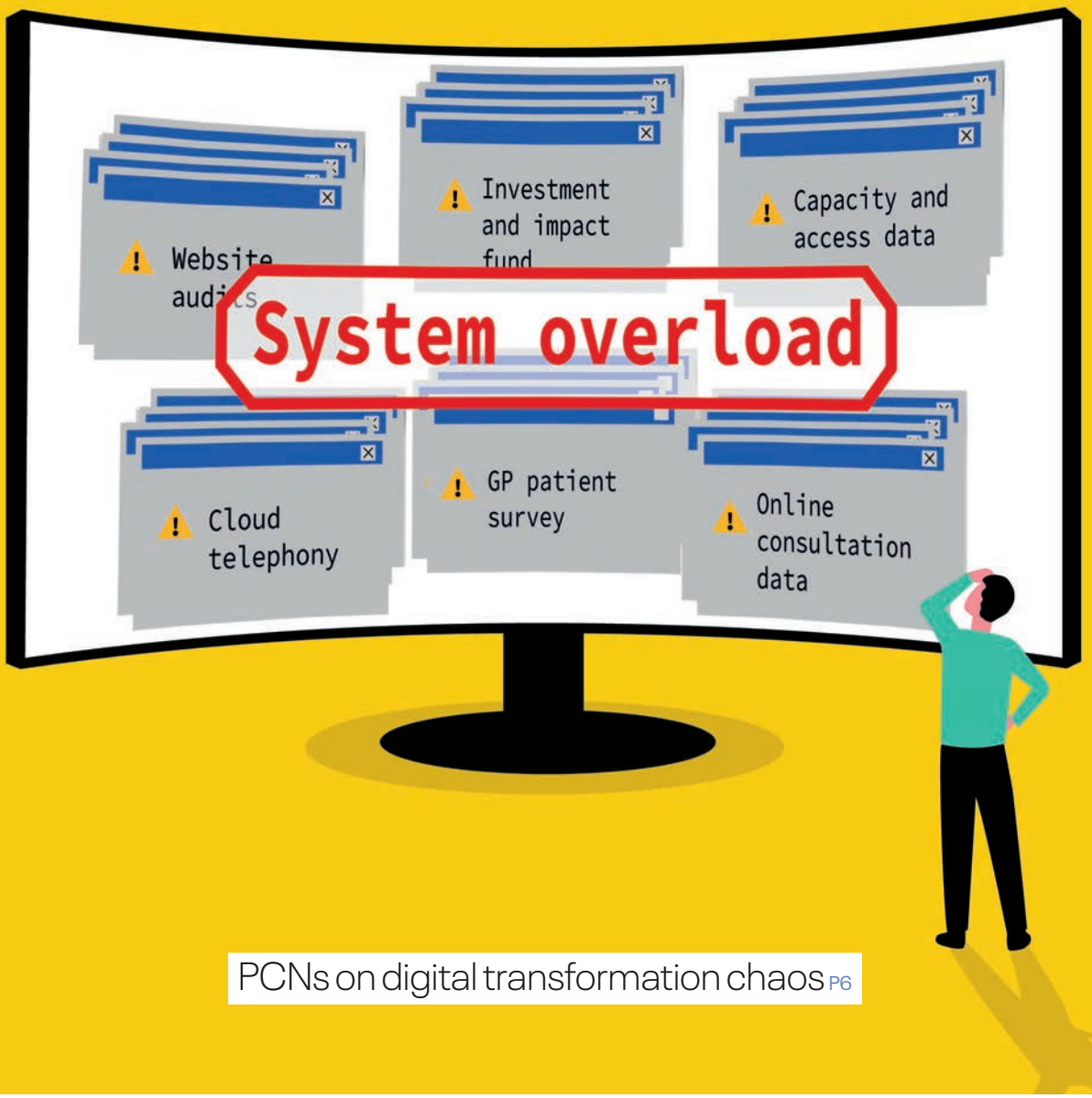
WINTER 2023



PCNs on digital transformation chaos P6

INSIDE

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CARDIOVASCULAR

NT-proBNP

INFLAMMATION

CRP

DIABETES

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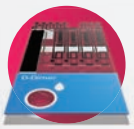

D-Dimer

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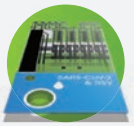

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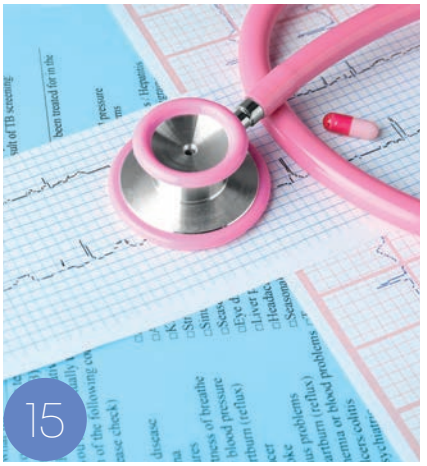

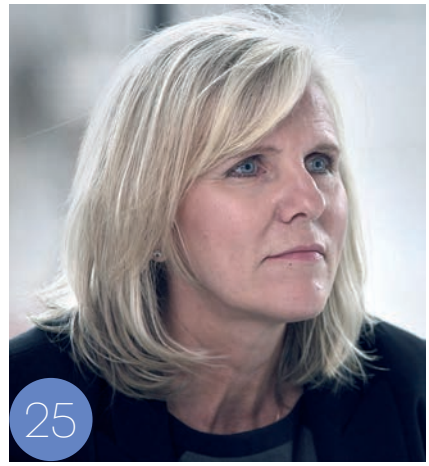

PULSEPCN

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: NICK LOWNDES

PCNS IN BARNET REFER PATIENTS TO FOOD BANKS

By Jess Hacker

All seven PCNs in the London Borough of Barnet are registered to refer their patients to receive food bank support, Pulse PCN has learnt.

The programme, led by Barnet Social Prescribing Service, has seen 40 patients referred for food bank support between April to June of this year alone: an increase of 20 times on the two referrals made in July to September 2021, before the cost-of-living crisis took full effect.

Barnet GPs who recognise a patient might need help covering food costs can refer to one of 24 social prescribers in the borough who assess their reason for needing support.

Social prescribers then offer patients vouchers for one the food banks across the borough, including those in churches or mosques or run by the Trussell Trust, which has sites across the UK, at no cost to the PCN.

The food bank referral scheme is a gateway for practices to address wider social issues facing their patients, Barnet Social Prescribing Service said.

Each patient referred to a social prescriber is offered up to six consultations, which signpost them to services that can help manage debt or benefits.

The cost of the food voucher is picked up by the food bank.

In 2019/20, a quarter (25%) of people in Barnet lived in households with an income less than 60% of the UK median. The food bank service has been running since 2019.

Common reasons for a patient requiring food support include late benefit payments or low income, but the steep rise in inflation and its impact on housing costs has also driven people who are employed to the service, social prescribers have said.

Emma Hatfield, a social prescriber at PCN 4, Barnet, said demand for the service had initially increased during the Covid-19 pandemic, but has worsened in the years since with the cost-of-living crisis.

Caitlin Bays, social prescribing manager at Barnet Social Prescribing Service, said many patients who were referred to a link worker and then to a food bank will have presented with other compounding concerns.

The annual rate of inflation reached 11.1% in October 2022, falling to 6.8% in July 2023 but remaining higher than the 2% target the Bank of England is attempting to reach.

The chair of NHS Confederation's primary care advisory group, Professor Aruna Garcea, said: 'The scheme demonstrates the positive impact of the new roles in PCNs. It also illustrates how PCNs are a catalyst for collaboration in general practice, as well as a pillar in the community, by addressing – and responding to – local population health needs and playing a key role in joining up services across the NHS and voluntary sector. However, this is also an example of how the social determinants of health impact demand for primary care services. It is vital that we continue to invest in and commit to PCNs.'

MORE THAN 31,000 ARRS STAFF RECRUITED SINCE 2019

By Joanna Robertson

More than 31,000 staff – including pharmacists, mental health practitioners and social prescribers – have been recruited to work in general practice under the additional roles reimbursement scheme (ARRS) since 2019.

The total was announced in October by NHS England, with a video to make patients aware of the health professionals they can access through a GP surgery, after a survey suggested more than a third (36%) of people in England are unaware of the roles. The survey was conducted by NHS England on 2,007 adults, and also found that more than two in three respondents were happy to receive care from a health worker other than a GP.

The video, launched on 19 October, shows three children going behind the scenes at a general practice to meet ARRS staff and learn more about what they do.

Dr Amanda Doyle, national director for primary care and community services at NHS England, said that GP practice teams were treating half a million more patients a week than before the pandemic.

'This demand is only going to increase with an ageing population, so the NHS must adapt its services to match this need,' she said.

In total, £839m was spent on ARRS roles between 2019 and 2022 – £387m of which was spent on clinical pharmacists.

FEWER PCNS SIGN UP TO DELIVER COVID VACCINES THAN LAST YEAR

By Jess Hacker

Exclusive Nearly 1,000 PCNs have signed up to deliver the Covid-19 vaccine during the 2023/24 winter season, which is only marginally fewer than last year, Pulse PCN understands.

Last year, 1,042 of the 1,250 PCNs – or 83.3% – signed on to deliver the Covid vaccine enhanced service.

The slight drop to 80% comes despite confusion about payments and what the BMA described as a 'U-turn' on the start date, in a call for an investigation into the Government and NHS England's 'mismanagement' of the programme.

In August, NHS England had said flu and Covid vaccine programmes would begin in October this year rather than September.

But the Government then announced vaccination would begin on 11 September, following the identification of a new Covid variant, and GPs were urged to vaccinate 'as many people as possible' by the end of October.

The Government had also announced in August it would cut the fee GPs are paid per Covid vaccination by a quarter, from £10.06 to £7.54.

However, to support the 'acceleration' for Covid vaccines, NHS England then confirmed that GPs would be paid an additional £5 per dose, an extra £10 for care homes and a £200 completion payment per home: but that eligibility would expire by the end of October.

NHS England said the BMA's claims of a 'U-turn' were 'totally inaccurate and irresponsible'.

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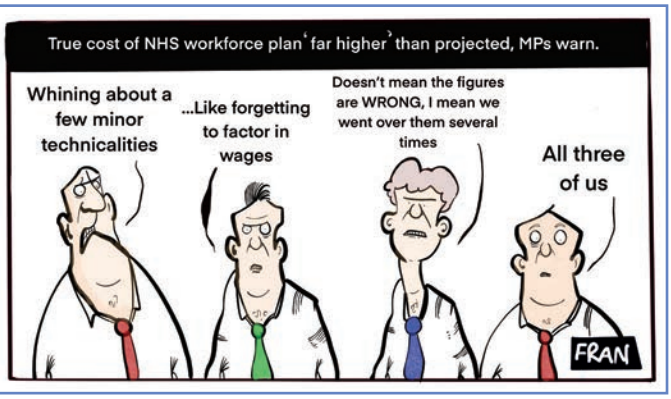

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Prescribing Information and Adverse Event reporting can be found below.

UK-TRI-2200152 August 2022

Trimbow pMDI 87/5/9 and NEXThaler 88/5/9 are indicated for maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting β_2-agonist or a combination of a long-acting β_2-agonist and a long-acting muscarinic antagonist (for effects on symptoms control and prevention of exacerbations see section 5.1 of the SPC).[3,4]

COPD: chronic obstructive pulmonary disease; **DPI:** dry powder inhaler; **ICS:** inhaled corticosteroid; **LABA:** long-acting β_2-agonist; **LAMA:** long-acting muscarinic antagonist; **pMDI:** pressurised metered dose inhaler; **SPC:** Summary of Product Characteristics.

References: 1. Usmani OS. *Ther Clin Risk Manag.* 2019; 15: 461–472. **2.** Navaie M, *et al. Medicine (Baltimore).* 2020; 99: e20718. **3.** Trimbow pMDI 87/5/9 Summary of Product Characteristics. Chiesi Limited. **4.** Trimbow NEXThaler 88/5/9 Summary of Product Characteristics. Chiesi Limited.

Trimbow 87/5/9 and 172/5/9 Pressurised Metered Dose Inhaler (pMDI) & Trimbow 88/5/9 NEXThaler Prescribing Information

Please refer to the Summary of Product Characteristics (SPC) before prescribing. **Presentation:** Each Trimbow 87/5/9 pMDI delivered dose contains 87micrograms (mcg) of beclometasone dipropionate (BDP), 5mcg of formoterol fumarate dihydrate (formoterol) and 9mcg of glycopyrronium. Each Trimbow 88/5/9 NEXThaler delivered dose contains 88 micrograms of BDP, 5 micrograms of formoterol and 9 micrograms of glycopyrronium. These are both the equivalent to a metered dose of 100mcg BDP, 6mcg formoterol and 10mcg glycopyrronium. Each Trimbow 172/5/9 pMDI delivered dose contains 172mcg of BDP, 5mcg of formoterol and 9mcg of glycopyrronium. This is equivalent to a metered dose of 200mcg BDP, 6mcg formoterol and 10mcg glycopyrronium. **Indication:** ***COPD*** *(Trimbow 87/5/9 pMDI and Trimbow 88/5/9 NEXThaler only)*: Maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or a combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist (for effects on symptoms control and prevention of exacerbations see section 5.1 of the SPC). ***Asthma (Trimbow 87/5/9):*** Maintenance treatment of asthma, in adults not adequately controlled with a maintenance combination of a long-acting beta2-agonist and medium dose of inhaled corticosteroid, and who experienced one or more asthma exacerbations in the previous year. ***Asthma (Trimbow 172/5/9):*** Maintenance treatment of asthma, in adults not adequately controlled with a maintenance combination of a long-acting beta2-agonist and high dose of inhaled corticosteroid, and who experienced one or more asthma exacerbations in the previous year. **Dosage and administration:** For inhalation in adult patients (≥18 years). ***COPD & Asthma:*** 2 inhalations twice daily. Maximum dose 2 inhalations twice daily. Trimbow pMDI can be used with the AeroChamber Plus® spacer device. Patients should be advised to take Trimbow every day even when asymptomatic. If symptoms arise in the period between doses, an inhaled, short-acting beta2-agonist should be used for immediate relief. When choosing the starting dose strength of Trimbow in asthma patients, the patients' disease severity, their previous asthma therapy including the inhaled corticosteroid (ICS) dose as well as the patients' current control of asthma symptoms and risk of future exacerbation should be considered. Patients should be regularly reassessed by a doctor, so that their doses of Trimbow remain optimal and are only changed on medical advice. The doses should be titrated to the lowest doses at which effective control of asthma symptoms is maintained. The aerosol particles of Trimbow are characterised by an extrafine particle size distribution. For BDP this results in a more potent effect than formulations of BDP with a non-extrafine particle size distribution (100mcg of BDP extrafine in Trimbow are equivalent to 250mcg of BDP in a non-extrafine formulation). **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and precautions:** Not for acute use in treatment of acute episodes of bronchospasm or to treat an acute disease exacerbation. Discontinue immediately if hypersensitivity or paradoxical bronchospasm occur. Deterioration of disease: Trimbow should not be stopped abruptly. Cardiovascular effects: Due to the presence of a long-acting beta2-agonist and a long-acting muscarinic antagonist, use with caution in patients with cardiac arrhythmias, idiopathic subvalvular aortic stenosis, hypertrophic obstructive cardiomyopathy, severe heart disease, occlusive vascular diseases, arterial hypertension and aneurysm. Caution should also be used when treating patients with known or suspected prolongation of the QTc interval (QTc > 450 milliseconds for males, or > 470 milliseconds for females) either congenital or induced by medicinal products. Limited data in asthmatic patients with cardiovascular co-morbidities or risk-factors suggest that these patients are also at higher risk of adverse reactions like local fungal infections or dysphonia. Trimbow should not be administered for at least 12 hours before the start of anaesthesia as there is a risk of cardiac arrhythmias. Caution in patients with thyrotoxicosis, diabetes mellitus, pheochromocytoma and untreated hypokalaemia. Increase in pneumonia and pneumonia hospitalisation in COPD patients receiving ICS observed. Clinical features of pneumonia may overlap with symptoms of COPD exacerbations. Systemic effects of ICS may occur, particularly at high doses for long periods, but are less likely than with oral steroids. The daily dose of both Trimbow 87/5/9 & 88/5/9 correspond to a medium dose of ICS and the daily dose of Trimbow 172/5/9 corresponds to a high dose of ICS. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation, decrease in bone mineral density and, more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression. Patients on Trimbow should be reviewed regularly and the dose of ICS is reduced to the lowest dose at which effective control of asthma is maintained. Use with caution in patients with pulmonary tuberculosis or fungal/viral airway infections. Potentially serious hypokalaemia may result from beta2-agonist therapy (particular caution with severe disease). Formoterol may cause a rise in blood glucose levels. Glycopyrronium should be used with caution in patients with narrow-angle glaucoma, prostatic hyperplasia or urinary retention. Use in patients with severe hepatic impairment (classified as having Child-Pugh class C) or severe renal impairment (glomerular filtration rate [GFR] <30mL/min/1.73m^2), should only be considered if benefit outweighs the risk. Consider referral of patients reporting blurred vision or visual disturbances to an ophthalmologist as causes may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy. To reduce risk of oropharyngeal candida infection, patients should be advised to rinse mouth or gargle with water without swallowing or brush teeth after inhaling prescribed dose. Trimbow 88/5/9 NEXThaler contains lactose. Lactose includes small amounts of milk proteins, which may cause allergic reactions. **Interactions:** Since glycopyrronium is eliminated via renal route, interactions could occur with medicinal products affecting renal excretion mechanisms e.g. with cimetidine (an inhibitor of OCT2 and MATE1 transporters in the kidney) co-administration, glycopyrronium showed a slight decrease in renal clearance (20%) and a limited increase in total systemic exposure (16%). Possibility of systemic effects with concomitant use of strong CYP3A inhibitors (e.g. ritonavir, cobicistat) cannot be excluded and therefore caution and appropriate monitoring is advised. *Related to formoterol:* Non-cardioselective beta-blockers (including eye drops) should be avoided as reduces effect of formoterol. Concomitant administration of other beta-adrenergic drugs may have potentially additive effects. Concomitant treatment with quinidine, disopyramide, procainamide, antihistamines, monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants and phenothiazines can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance towards beta2-sympathomimetics. Hypertensive reactions may occur following co-administration with MAOIs including drugs with similar properties (e.g. furazolidone, procarbazine). Risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Concomitant treatment with xanthine derivatives, steroids or diuretics may potentiate a possible hypokalaemic effect of beta2-agonists. Hypokalaemia may increase the likelihood of arrhythmias in patients receiving digitalis glycosides. *Related to glycopyrronium:* Co-administration with other anticholinergic-containing medicinal products is not recommended. *Excipients:* Presence of ethanol in Trimbow 87/5/9 and 172/5/9 pMDI may cause theoretical potential interaction in sensitive patients taking metronidazole or disulfiram. **Fertility, pregnancy and lactation:** No studies have been performed in regards to safety in human fertility, but animal studies show impaired fertility. Should only be used during pregnancy if the expected benefits outweigh the potential risks. If treatment during pregnancy is necessary, the lowest effective dose should be used. Children born to mothers receiving substantial doses should be observed for adrenal suppression. Glucocorticoids and metabolites are excreted in human milk. It is unknown whether formoterol or glycopyrronium (including their metabolites) pass into human breast-milk but they have been detected in the milk of lactating animals. Anticholinergics like glycopyrronium could suppress lactation. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from therapy. **Effects on driving and operating machinery:** None or negligible. **Side effects:** *Common:* pneumonia (in COPD patients), pharyngitis, oral candidiasis, urinary tract infection, nasopharyngitis, headache, dysphonia. *Uncommon:* influenza, oral fungal infection, oropharyngeal candidiasis, oesophageal candidiasis, fungal oropharyngitis, sinusitis, rhinitis, gastroenteritis, vulvovaginal candidiasis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, dysgeusia, hypoaesthesia, otosalpingitis, atrial fibrillation, electrocardiogram QT prolonged, tachycardia, tachyarrhythmia, palpitations, hyperaemia, flushing, hypertension, asthmatic crisis, cough, productive cough, throat irritation, epistaxis, pharyngeal erythema, diarrhoea, dry mouth, dysphagia, nausea, dyspepsia, burning sensation of the lips, dental caries, aphthous stomatitis, rash, urticaria, pruritus, hyperhidrosis, muscle spasms, myalgia, pain in extremity, musculoskeletal chest pain, fatigue, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased, cortisol decreased. *Rare:* Lower respiratory tract infection (fungal), hypersensitivity reactions, including erythema, lips, face, eye and pharyngeal oedema, decreased appetite, insomnia, hypersomnia, angina pectoris (stable and unstable), extrasystoles (ventricular and supraventricular), nodal rhythm, sinus bradycardia, blood extravasation, paradoxical bronchospasm, exacerbation of asthma, oropharyngeal pain, pharyngeal inflammation, dry throat, angioedema, dysuria, urinary retention, nephritis, asthenia, blood pressure increased, blood pressure decreased. *Very rare:* thrombocytopenia, adrenal suppression, glaucoma, cataract, dyspnoea, growth retardation, peripheral oedema, bone density decreased. *Frequency not known:* psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes, blurred vision. (Refer to SPC for full list of side effects). **Legal category:** POM. **Price and Pack:** £44.50 1x120 actuations. **Marketing authorisation (MA) No(s):** PLGB 08829/0193 (GB), EU/1/17/1208/002 (UKNI), PLGB 08829/0199 (GB), EU/1/17/1208/007 (UKNI), PLGB 08829/0200 (GB), EU/1/17/1208/010 (UKNI). **GB MA holder/UKNI Distributor:** Chiesi Limited, 333 Styal Road, Manchester, M22 5LG, United Kingdom. **Date of Preparation:** Jan 2022.

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SYSTEM OVERLOAD

Digital and transformation (D&T) leads were added to additional roles reimbursement scheme (ARRS) positions last October and the deadline for patients to have access to their records is now past. So how are PCNs managing the digital transformation of practices? *Emma Wilkinson* reports

It is just over a year since the role of digital and transformation (D&T) lead was added to the list of additional roles reimbursement scheme (ARRS) positions that PCNs could get funding for. While many are still learning what it entails and building relationships with practices, the introduction of the capacity and access payment (CAP) provided a certain amount of focus and, of course, funding.

Now tasked with developing and delivering on capacity and access improvement plans to unlock the final 30% – worth £73.8 million – D&T leads are working to improve patient experience of contacting practices, making it easier for them to access primary care and also managing demand and ensuring appointments are recorded accurately.

Yet there is much variation in experience, approach, focus and relationship with integrated care boards (ICBs). Some have been left to fend for themselves while others report close collaboration with regional teams. One common theme appears to be a desire to make better use of systems already in place rather than leap to the next new shiny IT toy.

"There's nothing out there that says what a D&T lead should work on
Alex Harper

Getting started

Conor Price, chief information officer for Herefordshire General Practice and managing director of data specialist company Primary Care Analytics, says the D&T lead role was desperately needed and was always missing in primary care, compared with secondary care.

But he notes it was introduced without clear guidance and says there is confusion over the digital 'and' transformation aspects. In the absence of any real direction, a job description was produced by Tara Humphrey, CEO and founder of THC Primary Care, which provides support and training to PCNs, which lots of people have adopted because there wasn't anything else, he adds. In the early days people didn't know what their remit was and there was a lack of leadership.

'Now there's a real focus on digital. NHS England is driving it and the capacity and access plan is trying to push PCNs to think of more efficient and effective ways of managing workload, giving patients access to the practice in multiple ways. It is a really necessary role but there isn't enough support and that's the struggle,' he says.

It's still very early days, he adds, not least because many of those starting as D&T leads are coming from outside general practice and have to gain the trust of their PCN and practices, he adds. 'It is difficult starting from scratch and I've seen a lot of people come from outside general practice, which is great but it is an incredibly nuanced system and takes time to learn. [They have to] build relationships and understand key areas to focus on.'

Yet there is a lot to be positive about so far, he says. 'I have been impressed by how well these [D&T leads] have cracked on, getting an understanding of what is being used in the PCNs, looking at the gaps and exploring which tools and systems can close those gaps.'

There has been a realisation that we need to get the basics right first and understand where gaps and issues might be, he explains.

But David Thorne, transformation director at Well Up North PCN in Northumberland, believes the introduction of D&T leads has been a 'chaotic mess'. It arrived suddenly with generous funding but no real guidance, he says. 'In my view only a small minority of PCNs are doing this properly.' He adds that there is not enough long-term strategic thinking.

Alex Harper is D&T lead at Northern Parishes PCN in West Lancashire. She recently shared her experience of the role at the Best Practice conference and learned that everyone was struggling with what they had been brought in to do. 'There's nothing out there nationally that says [what] a D&T lead should be working on.'

She has worked for a decade in primary care, and says the D&T role was welcome news for PCNs who had never been able to access funds for this type of senior leadership position but there was a strong feeling of worry about 'what's coming next, what's on the horizon.'

Finding focus

The GP contract changes, the CAP and the delivery plan for recovering access to primary care all brought more clarity, Harper adds. 'For me this is about striking a balance between knowing your stuff and being able to influence the practices into changing things and recognising that they don't need me to come in as a sort of superhero and tell them how to fix things because they know their patients best.'

Harper sees her job as a support role or facilitator. For her PCN that began with a big baseline exercise to understand where they were starting from, so they could measure the impact of any changes made. She did website audits, secret shopper phone calls, looked at social media and online consultation data.

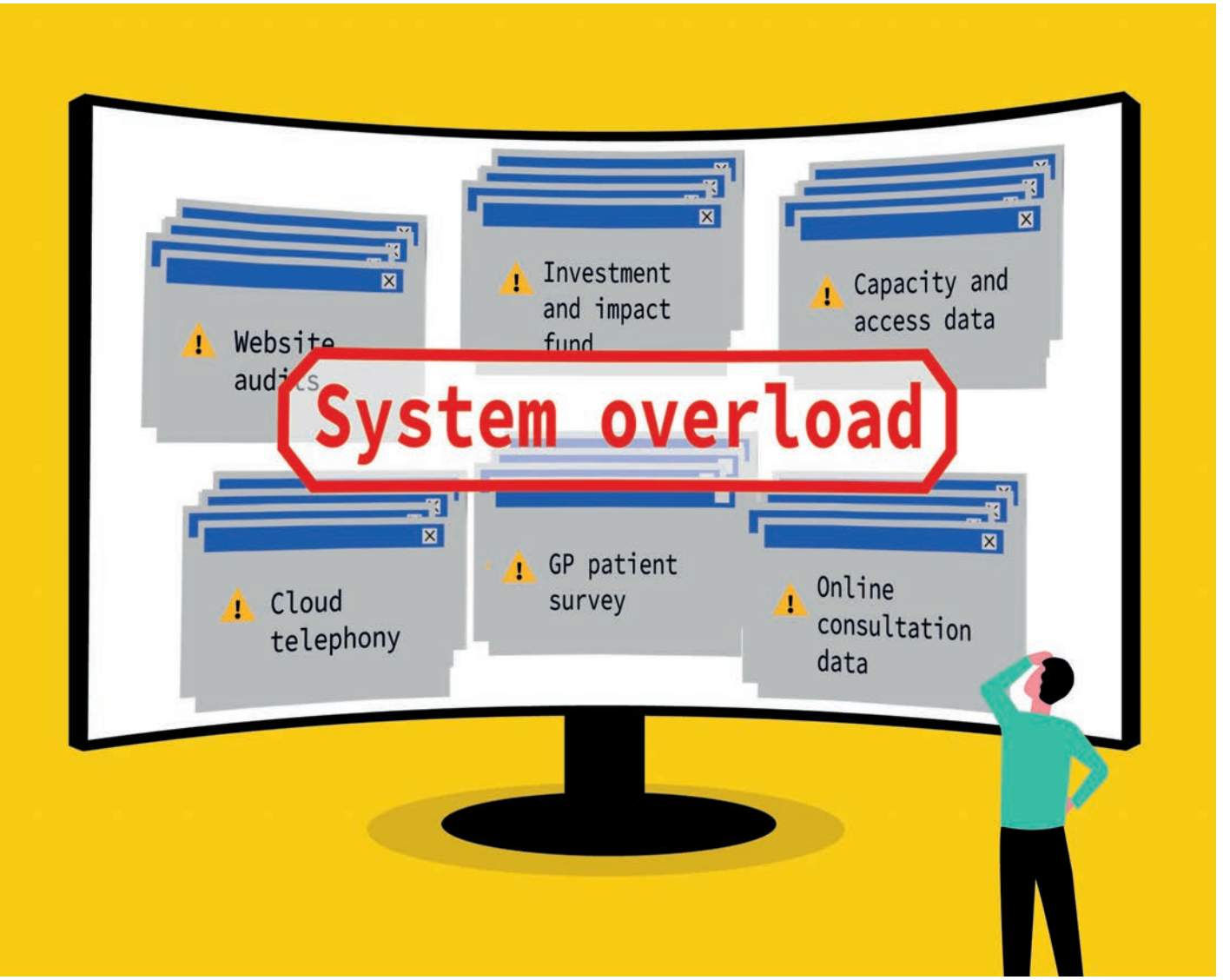
'It was very helpful because when I shared that with practices there was an element of competitiveness and it piqued their interest about why a practice was doing a bit better in some areas.' At the end, she generated a table of key opportunity areas, which fed directly into their capacity and access improvement plan submitted to the ICB.

One area of focus was increasing friends and family survey responses and standardising questionnaires, which led to one practice getting 190 responses after getting barely any. There's also been a jump in the number of positive answers.

The aim is also to increase the number of patients using online services by improving practice websites.

'Telephone access is one of my favourite things to talk about because the [practices] were all on cloud-based telephony but were still struggling with the number of calls coming in.' The work found that for one practice, almost a third of calls were about prescriptions. Other practices that weren't getting prescription requests had shorter call waiting times, but Harper says it was important not to just switch the service off, because it would damage the patient experience. Instead they have been doing a project to guide patients towards the NHS app and helping them use it. Now prescriptions only make up a quarter of calls to that practice.

At Nottingham City PCN, D&T lead Charlotte Ivers says there is a high proportion of patients who don't own a smartphone or computer or are digitally excluded for other reasons such not having English as



NICK LOWNDES

a first language or being unable to read and write. This includes a high population of people who are experiencing homelessness as well as transient populations.

'Everything we create in terms of a digital platform, then needs an access route with non-digital means. That has been my focus since I started – improving what I can in terms of digital inclusion and making sure we're not leaving people out.'

They are making use of Accurx triage. Much of the focus has been staff training and upskilling of reception teams. 'With the best will in the world we can only have so many reception teams, so many phones and means of access but once patients are coming through, we can triage them to the right place to be dealt with in the fewest number of appointments.'

Digital services company Redmoor Health had already been helping practices implement online consulting systems and when the D&T role came out it seemed a natural progression to support people new to the job. It supports D&T leads and also offers a digital managed service to cover the D&T role.

Dillon Sykes, programme lead for the service, said when the CAP came out it gave the D&T role a focus and funding for initiatives.

'For the first two or three months we were pulling all the data and presenting the baseline,' he explains. Where improvement plans were refused by the ICB they helped to provide more detail and metrics to get them over the line, he adds.

Getting the data together means that easy wins, such as encouraging more patients to order medicines online, are suddenly obvious to everyone.

Dr Alexander Jayaratnam is a GP and digital lead at Medicus Health Partners in London and Enfield Unity PCN. He says Medicus, which is a large practice, started moving to digital working three years ago and trials new projects before rolling out to the wider PCN. This gave a solid foundation when the new D&T lead came in. 'Sometimes the pace of change is quite phenomenal,' he says. 'If you had told me three years ago I'd be using an online video consultation as a daily process, I wouldn't have believed you.'

Technology marketplace

Most recently, much of Dr Jayaratnam's work has been talking to prescribers about products that are available, which has been a real shift in his role. This week, his team has been considering an online social prescribing platform.

'But the one single key factor is the idea of business intelligence,' he says. 'It is all well and good that we can introduce these things but we need to look at where they're going, what we've done with them and how we can improve them and make sure we're targeting the right patients so we can make meaningful clinical changes.'

Thorne says his PCN is working through everything systematically and is getting agreement so that all practices are on the same systems and every decision they make is clinically led not technology led. PCNs should not be placing all their focus on looking for the next shiny →

tech that is going to magically solve their problems, he says, but it's a supplier-led market at the moment.

'Suppliers are coming out to immature organisations that have got funding and unclear roles and some kind of expectation and people are procuring systems in a disjointed way. So you have got 10 practices in a town and they have all got different systems. We're trying to be much more structured and methodical.'

He sounds a warning note. How does that work if the rumoured procurement framework comes out at the end of the year and you've bought a system that's not in the framework?

The pressure from suppliers can be overwhelming. 'In a typical day I will have six to 10 approaches from suppliers and if I was a different kind of person I could be easily led.' It would be too easy to jump at software or apps promising to transform mental health or gynae provision, he adds, because there is a lot of hype.

'Sometimes the technology you need is very simple. It doesn't have to be some amazing thing. But when I have been part of clinical conversations there is hardly any clinical conversation, it has all been tech led,' he notes.

One example is a project called Farm Fit where practices set up a stall, say, at a monthly sheep market. The nurse running it said too much technology would put people off when all you need is a blood pressure check and a chat. 'I would see that as fulfilling transformation.'

This has all prompted a sudden influx of suppliers on to the market, agrees Price. 'There is now a problem seeing the wood for the trees, all claiming they can do one thing or another. It is going to be really hard for D&T leads to know what's good and what's bad.'

Frameworks aren't necessarily helping the situation and the risk is there will be thousands of practices on different solutions that can create more silos and prevent cross-organisational working, he adds.

When I have been part of clinical conversations, they're all led by the tech

David Thorne

Challenges and barriers

One of the biggest frustrations for Price – and he is not alone in this – is that GP appointment data are not fit for purpose. 'This drives me insane, it really does and it's caused so many frustrations across the practices.' The data only record appointments, which are a small part of GP work, and there is no real clarity on true capacity and demand, he adds. This is something that everyone is aware of but it has not been addressed.

For most PCN D&T leads, it has been a steep learning curve in terms of culture and influencing change, understanding products and interoperability, Sykes adds. He says that some of the problems shouldn't necessarily be laid at their door. 'If a website isn't meeting the benchmark, some of that has to be for the supplier to solve.'

'One of the biggest challenges that D&T leads are facing is engaging with their practices and influencing their practices because there isn't any headspace or time to sit back. Some practices are saying, do [such-and-such] for us now but actually [the D&T] role is to co-ordinate,' says Lisa Drake, director of quality, service and improvement at Redmoor.

Another issue is being able to make long-term decisions. And some procurement decisions are being made by ICBs, she says. 'We're in a hiatus. Do we stick with what we've got, even though we know it's not great, and focus on making [things] better for the next 12 months? Or do we jump into a different product, a new supplier, a different relationship – and what does that change look and feel like to my practices? Just as importantly, can I influence practices to make that decision?'

A lot of practices will stay with a poor product because that's easier than managing the change to something that's just slightly better, she adds.

Harper notes she often gets called the digital lead and others have said they get known as the IT person. But the transformational part of the job is just as important – and is easily forgotten. At the same time, some practices are more advanced from an operational perspective than they are technically with what is available to them.

'One of my practices wants to be able to offer patients the ability to change an appointment between telephone and face to face on the NHS app, but there isn't the functionality so this requires a huge workaround,' she says.

'I find I'm going down rabbit warrens at the moment,' says Emma Smith, D&T lead at Central and West Warrington PCN in Cheshire. 'A lot of [the work] is based on data but [we're] trying to understand lots of practices' data and what they mean and how to help them and see solutions [to suggest]. Practices work in different ways and might have different [kinds of] team so it's quite challenging. We are taking baby steps and trying to standardise some very simple things.'

Cheshire and Merseyside also has the challenge of implementing the Patchs online consultation system, which was purchased by the ICB, which then told practices they were to use it, she explains. 'We're the people trying to find out how it all works and how you use it in practice. [We're doing these] day-to-day things without even thinking about mega projects we want to do.'

Louisa Thompson at the neighbouring East Warrington PCN in Cheshire says that when she came into her post, she had big visions. But they are having to get the basics right first. 'We're starting small with some changes then getting the team's confidence that it's working before working up to the bigger things.'

She says it feels like they don't have the chance to get something running smoothly before another change is thrown their way.

Recently they were told about a bid for a pot of digital transformation funding, and they had just three weeks to write plans for it, gather information and get team input.

But in terms of achieving the 30% additional funding based on improvement, PCNs feel secure that they will pass their assessment. 'It was so wishy washy,' says Smith. 'How could they say we haven't achieved? None of us is sitting back doing nothing.'

ICB support

In Warrington, Thompson says they have all submitted their capacity and access improvement plans but there has been no feedback. 'We're all sort of proceeding anyway,' she says, and adds that she assumes the lack of comment to be a good thing. They had the national template to fill in but no other guidance, so they collaborated locally to ensure they were presenting it in a standard way with a standard level of detail.

By contrast in Nottingham, Ivers explains they got their improvement plan back a couple of times asking for more detail about things like timelines. This was tricky but the feedback was helpful. 'We recently had an email that told us [in detail] what was required [for the 30% funding] so we have been able to [confirm] we have probably achieved this.'

At the national level, Redmoor is in a good position to see the variation in approach, adds Drake.

'We saw that some ICBs gathered all the data and supplied them to all of their practices and said that's your baseline, come back to us if it's not right. Others gave [practices] a blank spreadsheet and asked them to find their own information.'

'My personal view is that PCNs need to have a good working relationship with their ICB early to understand what their ICB is looking for as evidence. They don't want to get into the last quarter of the year and find that the ICB is requiring in-depth data to secure their final 30% of the funding.

'If the ICBs aren't already providing guidance on what they are expecting to see, the PCNs, provider collaboratives and federations should be asking the ICB what they are looking for. The last quarter in general practices is a very busy time. We don't want people spending hours trying to gather information minutiae at the last minute. They need to understand early what is needed.'

Price notes that ICBs are assessing PCN improvement plans in very different ways. 'Vague [details] are enough for one ICB and definitely not for another. The guidance document is fair and you can see why it is done that way, but I don't know why we haven't seen better guidance.'

What is needed, says Price, is more engagement from national and regional teams because there are areas where there is no support between the ICB and PCNs 'and that should be frowned upon'.

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ADVERTISEMENT FEATURE

DELIVERY OF A NET ZERO NHS

Ipsen have provided funding for this meeting and have had an influence on the meeting concept and choice of speakers

On 27 September 2023, Ipsen brought together a group of healthcare professionals to evaluate the current situation regarding the NHS net zero goal, and to discuss current and prospective interventions to aid its achievement. The panel also considered the advantages of incorporating medicines optimisation into the transformation towards sustainability.

Much of the Faculty view the net zero target as unattainable, and at times, demoralising. The NHS is a hugely complex system and to create the ideal change, major systemic changes need to occur within the system.

The NHS is currently challenged with very pressing issues such as staff shortages and long waiting lists, so net zero is not a priority for those working within the NHS. When staff try to implement change, they face a lot of upheaval and barriers. One Faculty member found it challenging to implement teleconferencing pre-COVID. However, almost overnight, teleconferencing was put into practice due to COVID. This demonstrates that the NHS is capable of change, in an emergency. The net-zero goal needs to be moved further up the prioritisation list to facilitate change.

Currently, most of the green changes implemented are the result of the goodwill of a few people in a practice. They need leadership, incentives, time, and funding to create systemic change.

> **We're working in a system that's totally broken, totally not supporting us in the work we do**
>
> Dr Jon Rees

What interventions have already taken place?

Despite the challenges staff members face when implementing change, the Faculty were able to share examples of green interventions already in place.

Since COVID-19, patient and staff travel has been reduced by remote appointments. One Faculty member explained that patient travel has been further reduced by the introduction of blood tests in some primary care practices; this reduces the distance patients must travel while increasing the funding for primary care.

Patient travel time can also be reduced by facilitating primary care clinician's contact with a secondary care specialist. If a GP's query can be answered by a specialist, this can reduce unnecessary referrals and tests, thereby reducing patient travel and wastage of NHS resources. One of the Faculty members spoke of a chat system, whereby primary

CRITICAL AREAS OF THE NHS TO TARGET TO REDUCE CARBON EMISSIONS INCLUDE:

- **Patient travel**
- **Supply chain**
- **Drug wastage**
- **Standardisation of care**
- **Manufacturing of pharmaceuticals**
- **The NHS estate**

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care clinicians can contact him and other specialists for advice; this reduces the number of unnecessary referrals he sees.

Discussing the opportunities and strategies already implemented sparked new ideas for some Faculty members. Learning of successful interventions might motivate others to try their own ideas while providing ideas to other healthcare professionals wanting to reduce their practices' carbon footprint.

Where are the opportunities to reduce carbon emissions and will they impact decision making?

Drug wastage and the manufacturing of pharmaceuticals were highlighted as critical areas to target. This led the Faculty to discuss what pharmaceutical companies can do to help reduce carbon emissions.

When a patient is prescribed a supply of medication that later becomes unsuitable for them, there are no strategies for repurposing these unused drugs. Although this medication cannot be prescribed to other patients, one Faculty member thought it would be more sustainable if pharmaceutical companies found a way to recycle these drugs for research or other uses.

Although there is a large emphasis on recycling and what an individual can contribute to the green agenda, the recycling of pharmaceutical packaging is a minimal contributor to the sustainability of the NHS. One of the largest contributors is how the drug is manufactured and the carbon emission generated in its manufacture. The Faculty explained that they would choose the greener option if the two drugs were identical in safety, cost, and efficacy. When deciding which drug to prescribe, the cost, efficacy and safety are of more importance than how sustainable a drug is. To be able to prescribe more environmentally friendly drugs they need to be just as efficacious, safe, and cost-effective as their competitors.

Will medicine optimisation contribute to the net zero goal?

Medicine optimisation is viewed as a key part of the NHS' goal to net zero. The NHS needs to standardise their approach across the board. Many Faculty members agreed there are too many tests, medicines, and interventions in certain patient situations. Sometimes what is needed is less, and a consideration of what is best for the patient's quality of life. This was mainly discussed in the context of elderly patients and needing realistic conversations about what medicine can achieve for them. Patients are sometimes prescribed medication that will have little efficacy for them and can poorly affect their quality of life due to side effects. By reducing medications for these patients, you not only improve their quality of life, but also reduce drug wastage.

What is the probability of meeting the net-zero carbon emissions target?

Most of the panel agreed that the goal is challenging to achieve and that they are currently not on track to reach it. Some even believe that healthcare will never be net zero. However, there is still hope to reduce carbon emissions substantially if the goal is broken down into smaller more manageable tasks. The NHS needs help from their staff, patients, and politicians to edge closer to net zero.

THE END

The need for better use of primary care will not fade away – every £1 invested equates to £14 in economic growth

As 2023 draws to a close there are a number of significant endings on the horizon. For Pulse PCN, this Winter issue marks the twelfth and final print magazine as we move to a fully digital format. And the five-year PCN Network DES ends in March 2024.

Looking back on our coverage there are three major changes that PCNs have overseen. First, practices have come together across dividing lines. Second, practices are caring for patients in a more proactive way as seen in our profile of Cheltenham Central PCN (page 28). Third, there is a wave of new recruits into primary care under the additional roles reimbursement scheme (ARRS).

This final change has been the most controversial. If judged by the government target of hiring 26,000 new recruits, it's been a success. At the last count, the figure was 31,000. But people in posts doesn't equal success. They have to be the right people, with the right support and space to free up GP time and increase patient access. Opinion on that is divided.

I've heard clinical directors say it is wonderful that they can use care co-ordinators to reach people they know are underserved. That mental health practitioners have provided more appropriate care and freed up GP time.

I have heard others lament the training burden, the inflexibility of the specified roles and the pressure on estates. It seems that ARRS roles have turbo-charged primary care only if PCNs were already in a good place.

More broadly, the ARRS has put pressure on community pharmacy as pharmacists are the most hired role. There is controversy about GP associates. And Dr Katie Bramall-Stainer, chair of the BMA's GP Committee, recently suggested GPs should act as gatekeepers to the roles – because GPs can deal with more than one issue in an appointment and prevent misdiagnosis.

This year's NHS Long Term Workforce Plan further endorsed the scheme, committing to increase the number of non-GP direct patient care staff by around 15,000 and primary care nurses by more than 5,000 by 2036/37 and establishing a workforce of 10,000 physician associates by 2036/37.

Whatever fate holds for PCNs, the ARRS is not fading away. Neither is the need for better use of primary care. The NHS Confederation recently concluded that every £1 spent in primary care equates to £14 in economic growth, so investing £1bn boosts the national economy by over £14 bn.

Although this is the last print issue of Pulse PCN, we too, will not be fading away. To reflect the changing media landscape and to deliver our stories more immediately we will continue to provide news, views and analysis at pulsetoday.co.uk/pcn and via our newsletters and events. We have always been about serving GPs who see the opportunities created by PCNs. Primary care at scale has always been a place for policy makers to tinker – primary care groups, primary care trusts, clinical commissioning groups, PCNs – but the facts don't change. It is cheaper to treat people in primary care than in hospitals, patients don't want to go to hospital unless it's vital and GPs sit at the heart of each community. We continue to serve the leaders of that community.

ONLINE
To stay up to date with all PCN news, views, insight and roundtables visit pulsetoday.co.uk/pcn

Victoria Vaughan is editor of PCN

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Prescribing Information and Adverse Event reporting can be found below.

UK-TRI-2200171 November 2022

ICS: inhaled corticosteroid; **LABA:** long-acting β_2-agonist; **LAMA:** long-acting muscarinic antagonist; **pMDI:** pressurised metered dose inhaler.

References: 1. Trimbow pMDI 87/5/9 Summary of Product Characteristics. Chiesi Limited. **2.** Trimbow pMDI 172/5/9 Summary of Product Characteristics. Chiesi Limited. **3.** MIMS online. 2022. Available at: www.mims.co.uk **4.** Scichilone N, *et al. J Asthma Allergy.* 2013; 6: 1–11.

Trimbow 87/5/9 and 172/5/9 Pressurised Metered Dose Inhaler (pMDI) & Trimbow 88/5/9 NEXThaler Prescribing Information

Please refer to the Summary of Product Characteristics (SPC) before prescribing. **Presentation:** Each Trimbow 87/5/9 pMDI delivered dose contains 87micrograms (mcg) of beclometasone dipropionate (BDP), 5mcg of formoterol fumarate dihydrate (formoterol) and 9mcg of glycopyrronium. Each Trimbow 88/5/9 NEXThaler delivered dose contains 88 micrograms of BDP, 5 micrograms of formoterol and 9 micrograms of glycopyrronium. These are both the equivalent to a metered dose of 100mcg BDP, 6mcg formoterol and 10mcg glycopyrronium. Each Trimbow 172/5/9 pMDI delivered dose contains 172mcg of BDP, 5mcg of formoterol and 9mcg of glycopyrronium. This is equivalent to a metered dose of 200mcg BDP, 6mcg formoterol and 10mcg glycopyrronium. **Indication:** ***COPD*** *(Trimbow 87/5/9 pMDI and Trimbow 88/5/9 NEXThaler only)*: Maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or a combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist (for effects on symptoms control and prevention of exacerbations see section 5.1 of the SPC). ***Asthma (Trimbow 87/5/9):*** Maintenance treatment of asthma, in adults not adequately controlled with a maintenance combination of a long-acting beta2-agonist and medium dose of inhaled corticosteroid, and who experienced one or more asthma exacerbations in the previous year. ***Asthma (Trimbow 172/5/9):*** Maintenance treatment of asthma, in adults not adequately controlled with a maintenance combination of a long-acting beta2-agonist and high dose of inhaled corticosteroid, and who experienced one or more asthma exacerbations in the previous year. **Dosage and administration:** For inhalation in adult patients (≥18 years). ***COPD & Asthma:*** 2 inhalations twice daily. Maximum dose 2 inhalations twice daily. Trimbow pMDI can be used with the AeroChamber Plus® spacer device. Patients should be advised to take Trimbow every day even when asymptomatic. If symptoms arise in the period between doses, an inhaled, short-acting beta2-agonist should be used for immediate relief. When choosing the starting dose strength of Trimbow in asthma patients, the patients' disease severity, their previous asthma therapy including the inhaled corticosteroid (ICS) dose as well as the patients' current control of asthma symptoms and risk of future exacerbation should be considered. Patients should be regularly reassessed by a doctor, so that their doses of Trimbow remain optimal and are only changed on medical advice. The doses should be titrated to the lowest doses at which effective control of asthma symptoms is maintained. The aerosol particles of Trimbow are characterised by an extrafine particle size distribution. For BDP this results in a more potent effect than formulations of BDP with a non-extrafine particle size distribution (100mcg of BDP extrafine in Trimbow are equivalent to 250mcg of BDP in a non-extrafine formulation). **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings and precautions:** Not for acute use in treatment of acute episodes of bronchospasm or to treat an acute disease exacerbation. Discontinue immediately if hypersensitivity or paradoxical bronchospasm occur. Deterioration of disease: Trimbow should not be stopped abruptly. Cardiovascular effects: Due to the presence of a long-acting beta2-agonist and a long-acting muscarinic antagonist, use with caution in patients with cardiac arrhythmias, idiopathic subvalvular aortic stenosis, hypertrophic obstructive cardiomyopathy, severe heart disease, occlusive vascular diseases, arterial hypertension and aneurysm. Caution should also be used when treating patients with known or suspected prolongation of the QTc interval (QTc > 450 milliseconds for males, or > 470 milliseconds for females) either congenital or induced by medicinal products. Limited data in asthmatic patients with cardiovascular co-morbidities or risk-factors suggest that these patients are also at higher risk of adverse reactions like local fungal infections or dysphonia. Trimbow should not be administered for at least 12 hours before the start of anaesthesia as there is a risk of cardiac arrhythmias. Caution in patients with thyrotoxicosis, diabetes mellitus, pheochromocytoma and untreated hypokalaemia. Increase in pneumonia and pneumonia hospitalisation in COPD patients receiving ICS observed. Clinical features of pneumonia may overlap with symptoms of COPD exacerbations. Systemic effects of ICS may occur, particularly at high doses for long periods, but are less likely than with oral steroids. The daily dose of both Trimbow 87/5/9 & 88/5/9 correspond to a medium dose of ICS and the daily dose of Trimbow 172/5/9 corresponds to a high dose of ICS. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation, decrease in bone mineral density and, more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression. Patients on Trimbow should be reviewed regularly and the dose of ICS is reduced to the lowest dose at which effective control of asthma is maintained. Use with caution in patients with pulmonary tuberculosis or fungal/viral airway infections. Potentially serious hypokalaemia may result from beta2-agonist therapy (particular caution with severe disease). Formoterol may cause a rise in blood glucose levels. Glycopyrronium should be used with caution in patients with narrow-angle glaucoma, prostatic hyperplasia or urinary retention. Use in patients with severe hepatic impairment (classified as having Child-Pugh class C) or severe renal impairment (glomerular filtration rate [GFR] <30mL/min/1.73m^2), should only be considered if benefit outweighs the risk. Consider referral of patients reporting blurred vision or visual disturbances to an ophthalmologist as causes may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy. To reduce risk of oropharyngeal candida infection, patients should be advised to rinse mouth or gargle with water without swallowing or brush teeth after inhaling prescribed dose. Trimbow 88/5/9 NEXThaler contains lactose. Lactose includes small amounts of milk proteins, which may cause allergic reactions. **Interactions:** Since glycopyrronium is eliminated via renal route, interactions could occur with medicinal products affecting renal excretion mechanisms e.g. with cimetidine (an inhibitor of OCT2 and MATE1 transporters in the kidney) co-administration, glycopyrronium showed a slight decrease in renal clearance (20%) and a limited increase in total systemic exposure (16%). Possibility of systemic effects with concomitant use of strong CYP3A inhibitors (e.g. ritonavir, cobicistat) cannot be excluded and therefore caution and appropriate monitoring is advised. *Related to formoterol:* Non-cardioselective beta-blockers (including eye drops) should be avoided as reduces effect of formoterol. Concomitant administration of other beta-adrenergic drugs may have potentially additive effects. Concomitant treatment with quinidine, disopyramide, procainamide, antihistamines, monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants and phenothiazines can prolong the QTc interval and increase the risk of ventricular arrhythmias. L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance towards beta2-sympathomimetics. Hypertensive reactions may occur following co-administration with MAOIs including drugs with similar properties (e.g. furazolidone, procarbazine). Risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Concomitant treatment with xanthine derivatives, steroids or diuretics may potentiate a possible hypokalaemic effect of beta2-agonists. Hypokalaemia may increase the likelihood of arrhythmias in patients receiving digitalis glycosides. *Related to glycopyrronium:* Co-administration with other anticholinergic-containing medicinal products is not recommended. *Excipients:* Presence of ethanol in Trimbow 87/5/9 and 172/5/9 pMDI may cause theoretical potential interaction in sensitive patients taking metronidazole or disulfiram. **Fertility, pregnancy and lactation:** No studies have been performed in regards to safety in human fertility, but animal studies show impaired fertility. Should only be used during pregnancy if the expected benefits outweigh the potential risks. If treatment during pregnancy is necessary, the lowest effective dose should be used. Children born to mothers receiving substantial doses should be observed for adrenal suppression. Glucocorticoids and metabolites are excreted in human milk. It is unknown whether formoterol or glycopyrronium (including their metabolites) pass into human breast-milk but they have been detected in the milk of lactating animals. Anticholinergics like glycopyrronium could suppress lactation. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from therapy. **Effects on driving and operating machinery:** None or negligible. **Side effects:** *Common*: pneumonia (in COPD patients), pharyngitis, oral candidiasis, urinary tract infection, nasopharyngitis, headache, dysphonia. *Uncommon:* influenza, oral fungal infection, oropharyngeal candidiasis, oesophageal candidiasis, fungal oropharyngitis, sinusitis, rhinitis, gastroenteritis, vulvovaginal candidiasis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, dysgeusia, hypoaesthesia, otosalpingitis, atrial fibrillation, electrocardiogram QT prolonged, tachycardia, tachyarrhythmia, palpitations, hyperaemia, flushing, hypertension, asthmatic crisis, cough, productive cough, throat irritation, epistaxis, pharyngeal erythema, diarrhoea, dry mouth, dysphagia, nausea, dyspepsia, burning sensation of the lips, dental caries, aphthous stomatitis, rash, urticaria, pruritus, hyperhidrosis, muscle spasms, myalgia, pain in extremity, musculoskeletal chest pain, fatigue, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased, cortisol decreased. *Rare*: Lower respiratory tract infection (fungal), hypersensitivity reactions, including erythema, lips, face, eye and pharyngeal oedema, decreased appetite, insomnia, hypersomnia, angina pectoris (stable and unstable), extrasystoles (ventricular and supraventricular), nodal rhythm, sinus bradycardia, blood extravasation, paradoxical bronchospasm, exacerbation of asthma, oropharyngeal pain, pharyngeal inflammation, dry throat, angioedema, dysuria, urinary retention, nephritis, asthenia, blood pressure increased, blood pressure decreased. *Very rare:* thrombocytopenia, adrenal suppression, glaucoma, cataract, dyspnoea, growth retardation, peripheral oedema, bone density decreased. *Frequency not known:* psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes, blurred vision. (Refer to SPC for full list of side effects). **Legal category:** POM. **Price and Pack:** £44.50 1x120 actuations. **Marketing authorisation (MA) No(s):** PLGB 08829/0193 (GB), EU/1/17/1208/002 (UKNI), PLGB 08829/0199 (GB), EU/1/17/1208/007 (UKNI), PLGB 08829/0200 (GB), EU/1/17/1208/010 (UKNI). **GB MA holder/UKNI Distributor:** Chiesi Limited, 333 Styal Road, Manchester, M22 5LG, United Kingdom. **Date of Preparation:** Jan 2022.

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GRAND AMBITIONS

We need more local autonomy while also retaining a core national focus

The last few months have been quietly meaningful for primary care. Our NHS Confederation North Star report,[1] which sets out our vision and ambitions for at-scale general practice and primary care, has been published, and negotiations on the new GP contract and PCN DES for 2024/25 are under way.

The health needs of our population are becoming increasingly complex and demand is rising. Providers have undergone a rapid evolution, yet this does not appear to be enough.

We know we need greater investment in primary care. The first four years of PCNs have seen an increase in integration, at-scale prevention including vaccinations, and the introduction of a single point of access to a range of practitioners through the alternative roles reimbursement scheme (ARRS), which has proved a real opportunity to do things differently and enabled patients to be seen by the right professional at the right time.

But to continue this evolution, it is essential to follow the principles of the Fuller Stocktake – personalised care for those who need it most delivered through a joined-up approach to prevention and access. Our vision builds on these foundations, through the creation of integrated neighbourhood teams (INTs), which draw together the full range of primary care providers, in addition to local authority, voluntary, community and social enterprise (VSCE) organisations and community and social care.

Primary care is uniquely placed to lead the development of INTs. It embodies a culture of cradle-to-grave care, relational continuity, generalist expertise and multidisciplinary teamworking, all of which will be central to INTs. Our objective is to enhance, transform and innovate across primary care, ensuring its readiness to fulfil expectations of INTs and at place and system level.

As well as our North Star report, negotiations on the new GP contract and PCN DES are taking place between NHS England and the BMA. Our primary care network at the NHS Confederation engaged with its members over the summer, ahead of contract negotiations, and has made a series of recommendations[2] that must be central to the contract if the potential of primary care at scale is to be realised.

This can be done by giving more local autonomy to services while retaining a core national focus on areas of high impact, as well as providing continuity and assurance to providers with a clear, concise long-term vision. There also needs to be greater flexibility in the use of ARRS funding to meet the needs of local populations and make primary care a more attractive place to work. PCN leaders also told us that both the GP contract and PCN DES should rise annually with a new pay uplift clause.

Our vision of the future of primary care is one that evolves and embraces new technologies, staff roles and clinical care pathways in a sustainable way while retaining the ethos of traditional general practice. With these suggestions implemented, primary care can have a brighter, resilient future.

ONLINE
Keep up with Professor Aruna Garcea 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

1 NHS Confederation. Empowered, connected and respected: a vision for general practice at scale and primary care. 2023
2 Leicester City and Universities PCN. Supporting general practice at scale: fit for 2024/25 and beyond. 2023

PCN ROUNDTABLE

CARDIOVASCULAR DISEASE

Clinical directors (CDs) and cardiovascular disease (CVD) leads joined editor *Victoria Vaughan* to discuss the PCN CVD diagnosis and prevention service

ALAMY

DELEGATES

Dr Amisha Mehta
CVD champion, London borough of Westminster, covering four PCNs

Dr Arshad Khalid
Clinical director (CD), Fosseway PCN, Leicestershire

Dr Dan Bunstone
CD, Warrington Innovation Network, Cheshire

Dr Farzana Hussain
Former CD, Newham Central PCN, east London

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

Dr Shanika Sharma
CD, West One PCN, east London

Victoria The PCN cardiovascular disease (CVD) diagnosis and prevention service was introduced in October 2021 and began by focusing solely on improving hypertension case-finding and diagnosis. How has implementation of this service gone in your PCNs?

Farzana Newham PCN is a larger network with 67,000 residents and 74% black and minority ethnic (BME) [patients] and high deprivation levels. CVD is one of our biggest killers of young people.

Case-finding for hypertension and atrial fibrillation (AF) was already happening at practices. For example, my practice of 5,000 patients was involved in a hypertension pilot that was run by NHS England in conjunction with community pharmacy. Anybody over 40 can pop into the pharmacy to be assessed and given a 24-hour blood pressure monitor. It was so successful in our practice that we rolled it out to the whole PCN. A lot of the patients in our area are on zero-hours contracts and it's hard for them to keep appointments so being able to walk into the pharmacy has been really good.

With AF case-finding, we do pulse checks alongside flu jabs. Patients who are over 65 are coming in anyway, so we give healthcare assistants an extra minute to check the pulse while doing the flu jab.

Shanika About 18 months ago, we started work with UCL Partners on a familial hypercholesterolaemia (FH) pilot – a proactive care framework for the condition. It has really helped identify a cohort of patients who need more targeted interventions. It ran across two PCNs with a total population of 90,000 patients and was all about screening and cascade testing in primary care.

The evaluation found that if it was rolled out to all PCNs, it could potentially increase the FH diagnosis by 5% and then an additional 14% through the cascade testing.

We also did a population health management pilot focusing on hypertension because we're one of the most deprived boroughs in London. The main thing we identified was that it must be a holistic approach to wellbeing – health was identified as contributing to 20% of wellbeing, whereas 80% were the wider determinants - and that's helped to shape a lot of the health inequalities work that we've been doing.

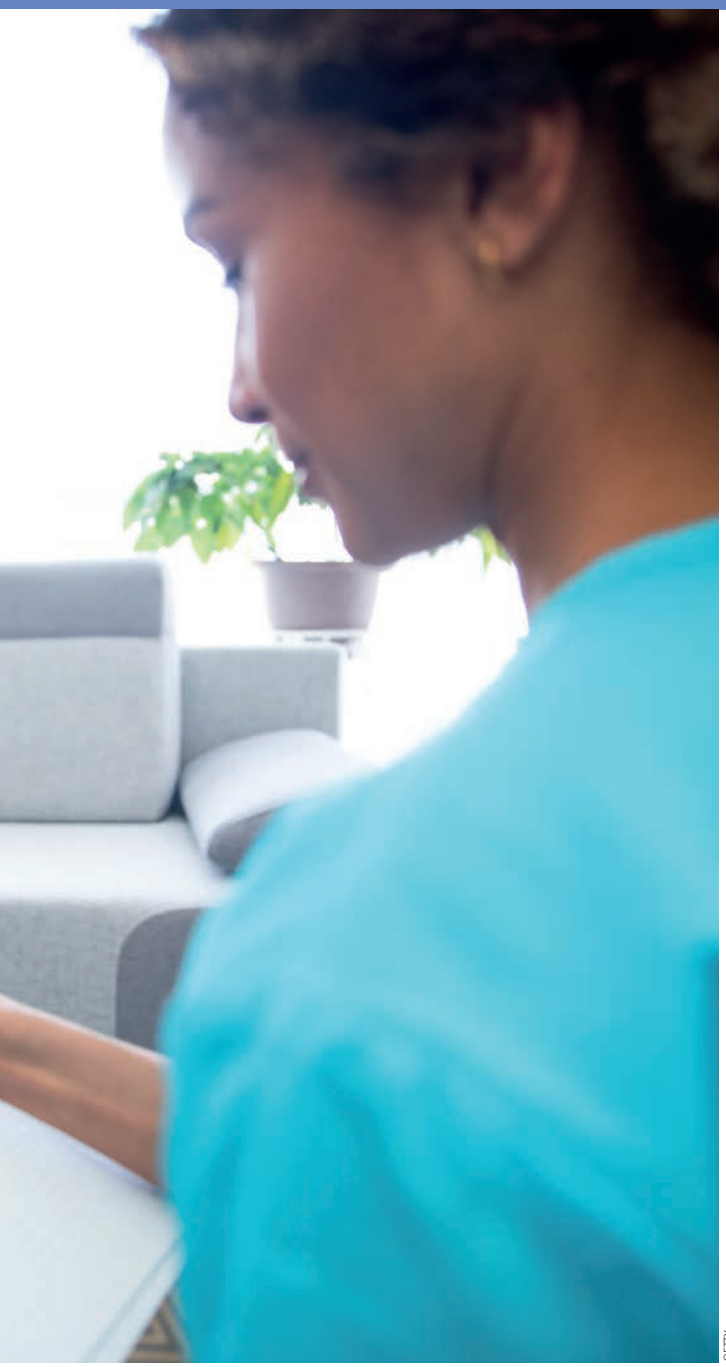
When it comes to case-finding, [we are] thinking outside the box and going to places where residents often go, such as hairdressers or bingo. There was a pilot where we managed to pick up a lot of potentially hypertensive patients during a bingo game.

Dan In Warrington we've mainly focused on hypertension. We're using an app called Healthy You, which allows us to monitor and manage our patients remotely.

The remote care element has been amazing. The surgeries don't necessarily manage the patients – they maintain the practice lists, but all the work is done with a separate, dedicated team who look at lifestyle and medication treatments, and the patient is escalated to an advanced nurse practitioner when any prescribing is needed.

The audience we've picked initially is one that is probably disengaged or has been lost to follow-up for whatever reason. So we've had to use

Chair Victoria Vaughan
Pulse PCN editor



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a variety of measures to reach out and engage our patients and it's been really effective.

We've prioritised the hypertensive patients with high blood pressure who aren't properly controlled, and will probably move on to screening later. The reason is we know these patients are there so we can get on and treat them. We've got around 1,000 patients onboarded across the PCN, and we've treated around 300 to 350 to date with around 250 in a treatment pipeline. I suspect we've probably prevented three to four heart attacks or strokes.

Arshad Along with my CD role I'm transformation lead in cardiology in Leicester, Leicestershire, and Rutland (LLR), which has a population of 1.1 million, as well as CVD network role for LLR in NHS England.

"We've been running a pilot with Omron to remotely monitor
Dr Amisha Mehta

In December of last year, I found out we had access to £110,000 of NHS England money that had to be spent by the end of March in CVD. We had to think quickly, so we identified the five practices where incidence and prevalence of hypertension are below what we would expect, and then suggested the five PCNs use the funding however they wished to find new cases. By the end of March, we had found 545 new cases, which we thought was a result.

Amisha In Westminster, there are eight of us CVD champions working across four PCNs, which covers a total of 330,000 people, and we're working on different strategies of how to improve CVD across our PCNs.

It's only started in the last few months so we're at a phase where we're gathering information and data. I'm working with clinical lead pharmacists, and they have different strategies from GPs so that's very insightful.

With regards to hypertension, we've been running a pilot with Omron for six months, which is remote monitoring via a digital platform. It's not the easiest way of formatting things because some people are not digitally savvy, though we hopefully have come up with strategies to make that work. And then over the last year we did a lipid pilot, which was successful.

Laura In West Warrington PCN we've undertaken a big transformation project – the Clinically Led Workforce and Activity Redesign (CLEAR) project, which is funded by NHS England. We've had the help of data analysts to look at where we could make meaningful impacts on the way we deliver care. It's not about trying to come up with a new model; it's looking at what we're doing now and how we can be more effective.

We're now moving to the implementation stage, which NHS England has given us more funding for. One of the workstreams is obesity and obesity case-finding. We've got three lifestyle coaches in the PCN now and a dietitian so we're keen to look at getting those people into a lifestyle MOT to impact on risk reduction. →

If I had a magic wand I'd go to the people who don't go to the doctor. Go to the markets in east London and you see people who look sick

Dr Farzana Hussain

We're also delivering the over-40s health check in a different way – in a similar model to the mass Covid clinics. It's a very cost-effective way of delivering care because you remove a chunk of work from practices to deliver en masse. We're going to expand that with new diabetes patients and pre-diabetes patients.

And we're big advocates of outreach. We've trained lots of our staff so everyone can take blood pressure and we go out to places in the community. In December, we're going to pilot our own team of blood pressure champions – people from the third sector who we'll train and then [send out with] a blood pressure machine.

The hope is that we can then roll that out and train 10 people every couple of months so there's a big team – a bit like Mental Health First Aiders in every workplace. You'd have blood pressure champions in every workplace and in every part of town and people would know that's someone they can talk to about their blood pressure and their lifestyle.

Victoria There are quite a lot of examples of existing pilots that you've built on. How much has the PCN service specification changed – or spurred you on – in what you were doing? It's not an investment and impact fund (IIF) indicator any more, of course, but did that help to get you to where you are now?

Dan I'd say it didn't help at all. If you look at the national attainment for QOF for finding and treating [high] blood pressure, it's above 90%. So, everybody's hitting the QOF targets, yet we know there's a massive gap. And there's no 'incentive' to address that. There was nothing in the contract that pointed us in the direction to do this and all the incentive to do it has gone.

Laura We found it interesting in the CLEAR project that they take a system-saving approach – that is, the system will save. But, obviously, as a GP, I'm interested in my patients and primary care effectiveness and productivity. So you've got to be careful who your audience is because you need to get them to do what you want them to do, and you've got to inspire them and motivate them in the right way. You can't just say I'm going to save the system this many hundreds of thousands of pounds.

Shanika All the work that we've shared so far has not been from the PCN specifications; it's been proactive work. The familial hypercholesterolaemia pilot, for example, was an expression of PCN interest that was in addition to the normal day-to-day PCN work.

And most of our funding to work on health inequalities has actually come through our partnership work because, although there's a push on PCNs delivering on health inequalities, there's no funding aligned to it.

Our partnership was a collaborative group comprising public health, the local authority and the voluntary sector and we went to Northeast London integrated care board (ICB) and presented what we wanted to do to reduce health inequalities. That's where the PCN health inequalities lead project started. We had dedicated leads to focus on this because the demand and the capacity in primary care make it very difficult to do the day-to-day work let alone anything else such as all this proactive case-finding.

Arshad I'm really proud that we've been working for over a year to commission investigations from primary care. Historically, we've had considerable disparity between practices and PCNs, with the provision of 12-lead ECG, 24-hour Holter monitoring and 24-hour blood pressure monitoring. After quite a battle, we now have the hardware established in all the PCNs across LLR to provide those three tests, the funding stream for the performance of those tests and the separate payment aligned to the interpretation of the tests.

The hardware is with all the practices, not just the PCN, so all three of those tests are available immediately in practices. If there's a practice that doesn't want the risk of interpreting an ECG or Holter, the PCN has accepted the work, and there are people who have the expertise to manage the results.

In 28 years, no GP practice has been paid to do a 12-lead ECG, a 24-hour Holter or 24-hour blood pressure monitoring. So, it's a major breakthrough in terms of diagnostics in our region.

Laura We are paid a fee to perform an ECG and then the hospital is paid to interpret it. We may as well just print it off and look at it ourselves. We have not got functional reasonable access to 24-hour blood pressure monitoring, and we've stopped using it on the whole because it takes many months to get the report.

Our PCN just bought loads of blood pressure machines – hundreds of the lowest-price accredited blood pressure machines – and patients use them and return them. I go around at the end of the financial year, and I say: 'If you've got any little pots of money left, let us know'. From that, we got some of our blood pressure machines and some sats probes. We've also encouraged patients to buy [machines] when they can.

Farzana We have very good providers so we can access 24-hour blood pressure monitoring, and also our pharmacists can do that. For ECG, it's been a local enhanced service, but we don't do the interpretation. We have a private company to do that, which is working all right, as far as we can see.

In terms of funding, I'm not a fortune teller, but it's looking shabby. It's been reported that all 42 integrated care systems (ICSs) have overspent – that says something about government funding if everybody across the country has failed.

But I don't think we're going to see any more funding. Now that access is king or queen, along with the learning disabilities and flu vaccination, we might be in a position where a lot of this good work will go because it's not sustainable. I don't think there's anything at the moment in the PCN contract that incentivises anybody to do this work and, unless we fund it and prioritise it, I don't think it's going to happen. We are chasing every single penny, but actually, now, everything is about access.

Victoria Access is now all important. How are you balancing those hypertension patients you're finding with those already sick patients coming through the door?

Dan Practices are having difficulty meeting the demand, even before you look at anything else. So, I don't think there is a balance, actually. We are managing it by setting up an entirely new service; the hypertensive service that we run is its own thing.

Our thought is we're making interventions now so that, please God,

in five years' time, patients are healthier and there is less demand on the service. It's a hypothesis but we've got to do something.

Farzana Many years ago, our clinical commissioning group (CCG) gave us self-service machines, which were very useful. Patients in my practice can just put their arm in and give our reception the results for the doctors to see. So, after the case-finding has been done, that's really good at monitoring hypertension.

But I did a bit of health promotion work recently and discovered that a lot of the public didn't know the difference between cardiac arrest and a heart attack. When half your population don't know the symptoms of a heart attack, and when to call for an ambulance, I doubt very much they'll know anything about the importance of blood pressure. And if our populations don't know why blood pressure control is important – that is, because you might die of a heart attack – then there's a problem.

As healthcare professionals, we often assume a lot of knowledge. I think education is needed, which will require funding.

"We know how to keep people well but have to sell it differently
Dr Laura Mount

Shanika We had some medical students from Imperial College London last year and they did fantastic work about why blood pressure is important. It was a series of videos that we sent out [to patients] with the blood pressure texts and we found that they really helped to push the numbers of people returning the results.

Monitoring through apps and 24-hour [devices] offers a little bit of flexibility to patients. They often can't come into appointments for a blood pressure check because work won't let them or the cost-of-living crisis or other factors. So, a blood pressure machine at home is great.

The cost of prescriptions for patients is a huge issue too. I think a lot of people don't come forward because we turn around and say you've got hypertension, you need to be on medication and that's going to cost you £10 a month, potentially for the rest of your life. When people are having to make decisions as to whether they buy food, or whether they buy a blood pressure tablet, that's very difficult. So that's another thing we need to take into consideration for our populations.

Arshad We've got at least 10 machines that people can take home. We charge a nominal £10 or £15 deposit to make sure patients return them.

And we are taking delivery of some devices to make it easy for patients to diagnose AF separately from the 12- lead ECG. We will have to wait and see how people respond to that sort of technology. That will be funded by NHS England money we made a bid for.

Victoria What do you think the future is for the PCN CVD service?

Farzana It's great to see the champions in this roundtable – excellent people who care passionately and who are going above and beyond – but they're in small supply. There are 1,250 PCNs and most I talk to are struggling just to meet the contractual demands.

We know our registers don't match with the prevalence that there should be, so we know that there are a lot of undiagnosed cases – not just hypertension, lots of diseases. So, what I would like to happen, if I had a magic wand, is to go out to those people who don't go to the doctor. People look fine if you go to the Westfield shopping centre in Shepherd's Bush, but, if you down to the Stratford market in east London, people look sick so that's where you need to go. But all of it needs funding.

Amisha Ultimately, if we do not have the funding, we won't be able to reach all the patients who require it.

We are thinking of using our community care workers to see if we can access these patients. However, feeding that information back to the general practice is another issue. Patients can go and get their blood pressure done but that information needs to reach the practice in an accurate way, a clinician needs to sign it off and prescribing [might be] needed. That's a lot more work than it seems. →

ALAMY

General practice is doing a lot of work to support the system, but that's not coming from the other side

Dr Shanika Sharma

Shanika In the last few years, there's been such a shift of workload from secondary care to primary care without resources following that work. So as a GP referring to cardiology, my referral is rejected if I've not done a 12-lead ECG, and 24-hour tape and echocardiogram and a 24-hour blood pressure monitor. And I'm told as a GP to do all these tests.

It seems like general practice is doing more work to support the system, but it doesn't seem like it's coming from the other side. So I think if we're looking to make real change and impact, it must be a system-wide response. The ICB needs to recognise that [reducing] CVD prevalence, morbidity and mortality is a responsibility across the board. It's not just for PCNs and primary care.

Arshad Shanika is absolutely spot on. In my strategic cardiology role with the long-term conditions board, we've done quite a lot of modelling to see where we'll be if we don't manage these problems.

If we look at the need for renal replacement – and this is where an awful lot of patients with CVD and diabetes are going to end up – what's coming is terrifying. And of course, the ICB is going to be picking up that the cost.

We've done the modelling to use as leverage to say if we don't go out there and make health checks more user friendly and more affordable for practices to deliver, we're going to have this need for renal replacement dialysis.

Dan Laura and I have got a bid in to the ICB and we're making a financial case. We're arguing that, when you invest, you save; we reckon we can do around a four or five-to-one return on investment purely for CVD. The NHS Confederation's recent research showed a return of investment of 14 to one for every £1 invested in community and primary care services.

So it might cost a few hundred quid to do a project, but it costs tens of thousands when a person has a heart attack – and that's just the cost to the healthcare system, not the cost to the economy or loss of work, or any of the other things that go with that.

Laura I echo what's been said. We're in a world where we've gone from clinical commissioning to financial commissioning – and it's quite sad for those who have worked in CCGs. We've lost sight of clinical quality and patient experience. We know what needs to be done – what our patients need and what the system needs to keep people well – but we're having to sell it in a different way and with a greater return than we ever did before.

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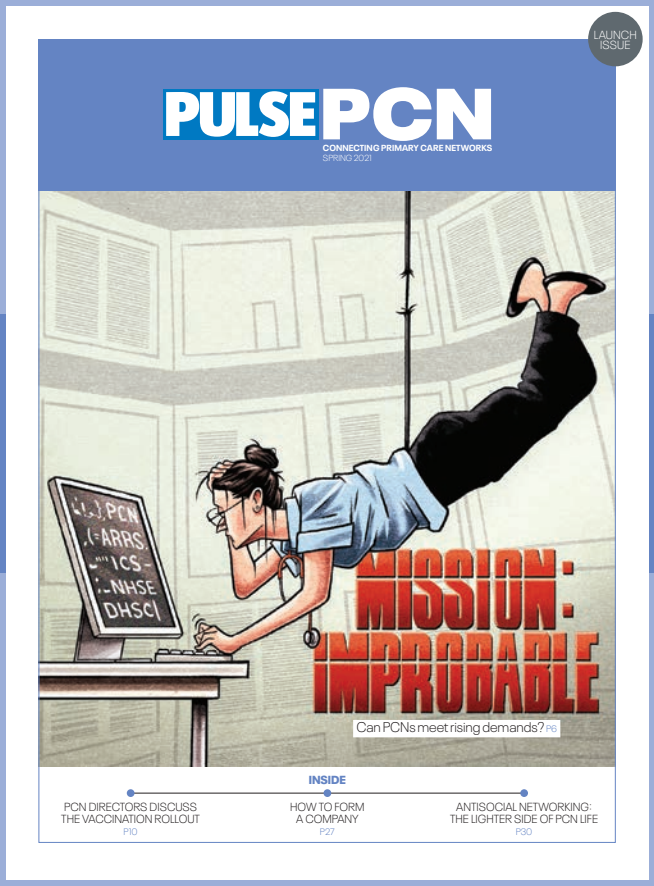

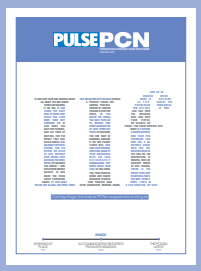

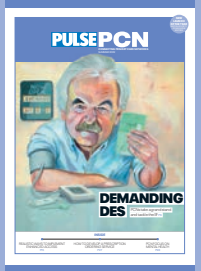

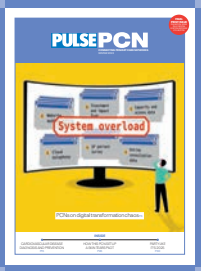

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CKD, chronic kidney disease; CVRM, cardiovascular, renal and metabolism; eGFR, estimated glomerular filtration rate; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; T2D, type 2 diabetes.

Reference: 1. FORXIGA (dapagliflozin) SmPC. Available at: https://www.medicines.org.uk/emc/product/7607/smpc#gref

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hronic heart failure

T2D + CKD + HF

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cardiorenal protection

heart failure with reduced ejection fraction

think dapagliflozin.

blood glucose level. Before initiating dapagliflozin, factors in patient history that may predispose to ketoacidosis should be considered. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or acute serious medical illnesses. Monitoring of ketones is recommended in these patient's. Measurement of blood ketone level is preferred to urine. Treatment with dapagliflozin may be restarted when the ketone values are normal and the patient's condition has stabilised. Rare cases of DKA, including life-threatening and fatal cases, have been reported in patients treated with SGLT2 inhibitors, including dapagliflozin. In a number of cases, the presentation of the condition was atypical with only moderately increased blood glucose values, below 14mmol/L (250mg/dL). In patients where DKA is suspected or diagnosed, dapagliflozin treatment should be stopped immediately. Restarting SGLT2 inhibitor treatment in patients with previous DKA while on SGLT2 inhibitor treatment is not recommended, unless another clear precipitating factor is identified and resolved. Dapagliflozin should not be used for treatment of patients with type 1 diabetes. **Necrotising fasciitis of the perineum (Fournier's gangrene):** Post-marketing cases have been reported in female and male patients taking SGLT2 inhibitors. Urgent surgical intervention and antibiotic treatment required. Advise patients to seek medical attention if they experience a combination of pain, tenderness, erythema, or swelling in the genital or perineal area, with fever or malaise. Either uro-genital infection or perineal abscess may precede necrotising fasciitis. If suspected discontinue Forxiga and institute prompt treatment (including antibiotics and surgical debridement). **Urinary tract infections:** Temporary interruption of dapagliflozin should be considered when treating pyelonephritis or urosepsis. **Elderly (≥65 years):** Elderly patients are more likely to have impaired renal function, be treated with medicines such as anti-hypertensives or diuretics, and be at a greater risk of volume depletion. **Cardiac failure:** Experience with dapagliflozin in NYHA class IV is limited. **Chronic kidney disease:** There is no experience with dapagliflozin for the treatment of chronic kidney disease in patients without diabetes who do not have albuminuria. Dapagliflozin has not been studied for the treatment of chronic kidney disease in patients with polycystic kidney disease, glomerulonephritis with flares (lupus nephritis or ANCA-associated vasculitis), ongoing or recent requirements of cytotoxic, immunosuppressive or other immunomodulating renal therapy, or in patients who received an organ transplant. **Lower limb amputations:** Counsel patients with diabetes on routine preventative foot care. An increase in cases of lower limb amputation (primarily of the toe) has been observed in long-term, clinical studies with SGLT2 inhibitors. **Urine laboratory assessments:** Patients will test positive for glucose in the urine due to mechanism of action. **Lactose:** Patients with rare hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption should not take Forxiga. **Drug Interactions: Diuretics**: Dapagliflozin may add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension. **Insulin and insulin secretagogues**: Consider a lower dose of insulin or insulin secretagogue in combination with dapagliflozin to reduce the risk of hypoglycaemia. **Effect of dapagliflozin on other medicinal products:** Dapagliflozin may increase renal lithium excretion and the blood lithium levels may be decreased. **Interference with 1,5-AG assay:** Monitoring glycaemic control with 1,5-AG assay is not recommended as measurements of 1,5-AG are unreliable in assessing glycaemic control in patients taking SGLT2 inhibitors. Alternative methods should be used. **Pregnancy and Lactation:** Not recommended during the second and third trimesters of pregnancy. Treatment should be discontinued when pregnancy is detected. Do not use whilst breast-feeding. **Ability to Drive and Use Machines:** Alert patients on the risk of hypoglycaemia when dapagliflozin is used in combination with a sulphonylurea or insulin. **Undesirable Events:** Consult SmPC for full list of side effects. **Very common** (≥1/10):Hypoglycaemia (when used with SU or insulin). **Common** (≥1/100 to <1/10): Vulvovaginitis, balanitis and related genital infections, urinary tract infection, dizziness, rash, back pain, dysuria, polyuria, haematocrit increased, creatinine renal clearance decreased during initial treatment, dyslipidaemia. **Uncommon** (≥1/1,000 to < 1/100): Volume depletion. **Rare** (≥ 1/10,000 to < 1/1,000): Diabetic ketoacidosis. **Very Rare** (< 1/10,000): Angioedema, necrotising fasciitis of the perineum (Fournier's gangrene), tubulointerstitial nephritis.

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A SENSE OF URGENCY

Setting up an urgent treatment centre in just eight months has been exhausting and inspiring, says Dr Sian Stanley

Our acute trust has an urgent treatment centre (UTC) and its contract with the current provider was put out to tender in March, for an integrated UTC to take over from November. It wanted a lead provider model, with a collaboration agreement between community providers and the acute trust. Some could call this a supercharged integrated neighbourhood team (INT).

The contractual arrangements are complex, but in essence our PCN joined with the PCN next door and won the bid. You may have noticed that from first meeting until launch was only eight months.

We worked collaboratively with two community trusts, the acute trust, the out-of-hours provider and the integrated care board (ICB), and are all committed to bringing a new perspective to the UTC. The community trusts have recruited to substantive posts, the acute trust has given estate, the ICB contractual expertise and the PCNs have pulled it all together and developed the operational model. My role is medical director.

For those of you who have tried this sort of thing before, you will know that such an endeavour requires three perspectives. Primarily there is the clinical perspective, which I have been leading. There is the contractual perspective, done by our wonderful CEO who deserves a medal for wading through all the detail, rewrites and tracked changes. Then there is the operational perspective, which has been the biggest of all the curve balls with different orgnanisations, which employ people in different ways with different ways of working and different policies.

Clinically things don't change that much. There are different ways of doing things, but essentially a good interaction between patient and clinician is at the heart of what we do. To my mind, patients want kindness and competence.

A contract is a contract. It is vitally important and protects all of us but in the end, it is a black and white document on which we all do, or do not, agree.

Operational models are fascinating, though. People always talk about relationships and these have carried us through. The time frame was so tight we have had to abandon some of the traditional management language and opt for the direct approach. This has not always made for easy listening. We have had to accept that each of us is as important as the other and that together we are better. The IT has been a hurdle that looked insurmountable but we found that each organisation has an expert who can do things with a computer system that you did not know were possible.

As clinical lead I was dispatched to the ED to discuss exclusion criteria. What started as a group of clinicians who were wary of escalating workload became a group of people with similar experiences and a shared purpose.

So we are all exhausted but exhilarated, the madness that comes when you can see the destination. We have no idea where this will ultimately take us but we do know this has given us as a group of GPs a voice within the system and meaningful influence. We are working towards a common goal of making things better for patients, for ourselves and for the profession. We have made unlikely allies and created a microcosm of interorganisational harmony. It still might all go horribly wrong but so far we are doing okay.

ONLINE
Keep up with Dr Sian Stanley 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 Tracey Vell, medical executive lead for primary care at NHS Greater Manchester and medical director for Health Innovation Manchester, tells senior reporter *Jess Hacker* about the area's financial deficit

How is Greater Manchester's financial outlook?
It's not a secret that Greater Manchester has a huge financial deficit. We're not on our own. The whole of the NHS is struggling, and meanwhile we're seeing increasing frailty in the wider population. Changing the systems doesn't seem to have made that better.

At a system level, are you hearing any solutions to the national deficit?
Not solutions. We have interventions. Whether they are solutions [or not], we are wanting to control our own destiny. Obviously there are solutions coming out of central Government because the move to integrated care systems (ICSs) was a central movement. There are solutions to access and [implementing] digital [working], but there needs to be flex in a local system to look at all populations and recognise what the need is there, and deliver differently from some of the national objectives. I don't think primary care plays a great part in the Greater Manchester deficit. It's more of a solution than a problem.

What impact does the deficit have on the care that's being delivered in Greater Manchester?
There are only a few options for care when you're in debt. Either you remain in debt and deepen it or you resolve it.

The options for resolving it include decommissioning services in more expensive pots, such as hospitals. But in my view, we would need to move services. That's our core theme in Greater Manchester: population health.

Our approach is to move things closer to people's homes because that is usually cheaper as there are lower overheads. Pounds spent in primary care are worth much more, and we will get much more done with that than we would do in a secondary care setting. We need to look at moving services rather than decommissioning them.

"I don't think primary care is causing the financial deficit; I think it's the solution
Dr Tracey Vell

Where does the responsibility for changing that sit?
In addition to moving services that could potentially be decommissioned, we need to think about different funding models. We have a very hierarchical NHS that talks to providers in secondary care and commissioners but offers only limited conversations with primary care providers. Because of that hierarchy, all the transitional funding goes into the place where the deficit is set – hospitals. That deepens the deficit.

Giving [secondary care] transitional funding [will] temporarily cover over their deficit. This happens in Greater Manchester – we keep entering that cycle.

We need to be putting the transitional investments into primary care. That way we can deliver more proactive care and screening and make our population healthy. Then in five or 10 years we won't incur the cost [of illness] and we can invest in shiny buildings. That's never an in-year situation so we get into temporary funding, trying to get on top of in-year resolution. We can never change the whole way the health service works as a disease-type service in one year. Give us 10 years. But the reason we don't [get 10 years] is because there are lots of people looking into spreadsheets and ledgers for in-year savings.

If that is a 10-year plan, what is step one?
We'd need to look at how we will build that model up and battle [for] it. The system would need to decide what services should be moved: what does not absolutely need to be done in hospital, [what] should not be done in hospital. That's not to say we swing the pendulum to primary care and let primary care deliver it, but if we are already starting to make savings from the shift, we can decide what primary care can do.

To that point, primary care excels at collaboration. But what is the main task for PCNs? It's been quite confused centrally, giving different targets and different approaches. But the key approach has got to be a population health methodology, which is not in the centre. For that to work we need to consider how we train staff in risk stratification and use of data and intelligence, while looking at our whole population and asking what outcomes we want to change. This will drive integration, but not integration for integration's sake – it might become clear we need to integrate with housing [to change some outcomes], not with community nurses, for example.

Is that a step toward integrated neighbourhood teams (INTs)? Will changing primary care at scale affect the deficit?
INTs might be a step but I'm more interested in training everybody to have these conversations – you can integrate all you like. A good example is in using digital. We always think first about patient-facing digital [approaches] but we need to consider the digital back office. So we 'integrate' with the team so that the patient doesn't have to be hounded. Actually, we are just connecting behind-the-scenes with [the] digital back office. We need to change the way we talk to people using our services: we forget we are making services for them, not for us. So we need to get a grip of what we need to be providing. Overhauling that comes way before integration.

What can't stay the same if anything is to change?
What can't stay the same is how we keep putting money into services that are showing the highest workforce numbers and the lowest productivity. We have to stop investing in those and start talking to community providers, the voluntary sector, social care. We need to get behind them.

SET UP A SKIN TEAR PILOT

As part of the enhanced health in care homes service, Bexhill PCN in East Sussex set up a wound dressing service for care homes to upskill staff. Clinical director *Dr Binodh Chathanath* explains

Bexhill PCN in East Sussex has a high proportion of care homes; 29 homes are looking after about 780 older people. We decided to set up a skin tears pilot as part of the PCN training offer for care home staff, to upskill them to manage minor wounds so that patients do not have to be left untreated while they wait for the community nurses.

Prevention of skin tears is important in the care of the elderly population because of the fragility of skin. Consequently, residential homes have high number of these wounds so it's important to recognise and manage these factors and treat skin tears efficiently to prevent further harm and promote quality of life. The current process in care homes in East Sussex Healthcare Trust (ESHT) is that the district nursing team is asked by the home to assess and dress residents' wounds. The ambulance service might attend for the first dressing, depending on the time of day and how the wound is first reported to healthcare professionals. Because of pressures on services and the likelihood that injuries occur out of hours, the initial dressing will often be applied by care home staff. Although care homes keep a stock of basic first-aid dressings, these are not always suitable for skin tears.

The first dressing programme for skin tears was proposed by the district nursing team, supported by clinical leads at EHST and our PCN. The aims are:

- Prompt management of skin tears.
- Correct and appropriate use of dressings.
- Use of trained care home staff.
- Staff development and acknowledgment.
- Reducing calls to the district nursing team.
- Improved healing outcomes for patients.

This programme is for skin tears only and only for the initial dressing application. Further dressing changes are managed by the district nursing team where necessary.

Staff training and education

A training session and a skin tear protocol is provided to care homes who wish to take part in the program. Training can also be accessed via healthcare company Richardson Healthcare Online, which offers free skin tear training to care homes. It is the responsibility of the care home to ensure staff are assessed as competent before they apply dressings.

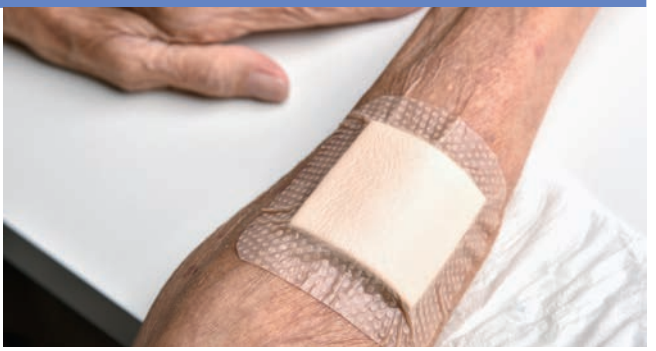
Care home responsibilities

The care home manager should ensure that:

- Staff included in the scheme are trained and competent in the task.
- An up-to-date record is kept of all care home staff who are authorised as competent to apply first dressings.
- Care home staff understand when to refer to a healthcare professional for advice.
- Paperwork is completed fully and accurately.
- Staff competency assessments are undertaken regularly. The recommended period is annually.

Care home staff should ensure that they:

- Do not exceed their competencies.
- Are comfortable and confident to carry out the task only under the scheme before agreeing to take part.
- Understand when to refer to a healthcare professional for advice.



- Notify the appointed person if dressing supplies are getting low.
- Complete all relevant paperwork promptly and accurately.
- Arrange a follow-up visit with the district nursing team if required.

Dressing stock

The dressing stock will be provided by the district nursing team and will be replenished on request. The programme uses the dressings that are recommended as best practice by the International Skin Tear Advisory Panel (ISTAP) guidelines, which set the standard for assessing and dressing skin tears. It is recommended that these are the only dressings used as first application for skin tears.

Storage and auditing

Dressings will be provided in a clear, marked, sealable container to be kept in the care home's medicine room with the district nursing team's written guidance for assessment, application and auditing. An audit trail, including stock balance, should be kept of dressings to ensure sufficient supply. A document has been provided for this purpose and will help us prove the pilot scheme is successful too.

Recording

A record of each dressing application must be kept in the resident's care plan and medicines administration record folder. A sheet for this can be provided if the care home does not already record wounds. The wound and resident's wellbeing should be monitored and a record also kept in the care plan. Nursing or medical advice must be sought if there is deterioration that cannot be managed in the care home. The pilot is managed by the care home manager and matrons and has been well received. The training was delivered face to face and online with CPD certificates. Care home leads and nurses have reported that the pathways are working and staff feel empowered and have better morale.

Dr Binodh Chathanath is clinical director of Bexhill PCN and primary care clinical lead for diabetes at Sussex integrated care system

ONLINE

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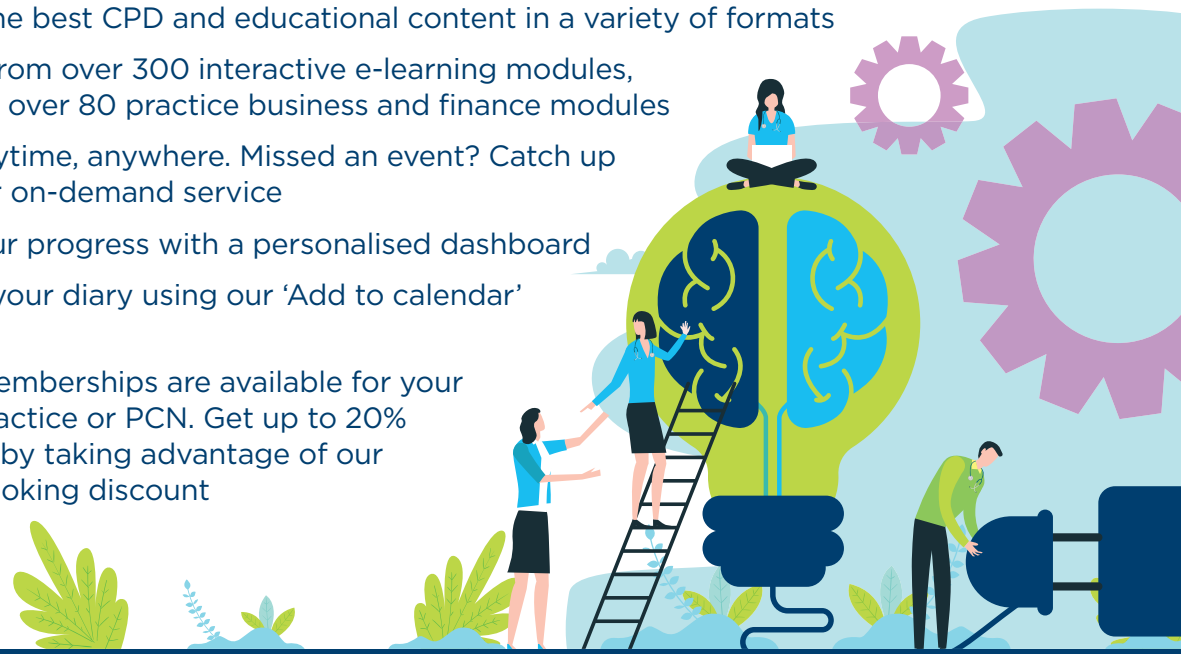

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LEARN CONNECT REFLECT

DELIVERS PROACTIVE CARE

Central Cheltenham won the PCN of the year category at the General Practice Awards 2023. *Dr Olesya Atkinson* shares how this network is proactively caring for patients

During the last four years, our PCN has transitioned from six individual practices working in complete silos to a mature PCN with collaborative working and innovative practice evidenced on a weekly basis.

Our 57,000 patients benefit from new additional services provided by 33 patient-facing and background staff with a wide range of skill-mix.

The workforce recruitment was evidence based, informed by the results of a PCN-wide audit to identify which roles would have the biggest impact on the GPs' workload and also matched to the population demographic.

Our additional roles reimbursement scheme (ARRS) teams have a clear management structure, regular supervision and peer support which is delivered by a dedicated educational lead and an advanced clinical practitioner lead to support career progression.

We developed a PCN lead nurse role to: support the nurses across all the PCN practices; enable more peer networking; standardise clinical protocols and nurse training; bring specialist care into the community such as diagnostic respiratory service and MDT diabetes care.

Using these ARRS staff, the PCN has been proactive in its delivery of care to patients, particularly those who are substance misusers, children and young people, and those who are nearing the end of life. We have also set up a musculoskeletal (MSK) service and a befriending scheme.

Substance misuse

Business intelligence data identified that a practice in our PCN had the highest prevalence of substance misuse in our locality, prompting a call for action. A cohort of patients was identified. Case notes analysis showed that nine patients were already deceased (all under the age of 50), and 43% were without full Covid-19 vaccination, highlighting health inequalities.

An initial attempt to engage with the remaining cohort from the surgery was unsuccessful. All patients were contacted by the practice with an offer of personalised health support, but nobody took it up. We realised we needed to think differently and deliver support outside the traditional setting of a GP surgery.

The project aim was reframed with PCN staff going to the patients to find out how to provide a joined-up service to people who do not access health services in the traditional way, and to give us the opportunity for interventions to prevent future decline in health and wellbeing.

The PCN project was run by our lead nurse, who identified where and how best to engage with this cohort in partnership with statutory and voluntary organisations. Working collaboratively, we offered support services anchored around the local charity for vulnerable, disadvantaged and lonely people, Open Door, which provides safe spaces and meals for 70 guests per day.

The following interventions have been delivered:

- A total of 44 people were screened for hepatitis C – three were positive and are now receiving treatment at Open Door.
- Three people were screened for abdominal aortic aneurysm.
- A total of 36 Covid-19 vaccinations were given and 24 flu vaccinations.
- We did 12 blood pressure checks and referred two results to the GP.
- Art-based mental health interventions were provided through Artlift.
- Social prescribing link workers were connected to the community services.
- We introduced the C card scheme, which allows young people to access free condoms and lube.
- Psychological therapies were offered – both on an individual and group basis and through funded iPads. There were weekly on-site clinics with a mental health nurse.
- Open Door staff were trained by the mental health team.
- Links were created with 'Cheltenham Know your patch', the local online platform to connect local people, places and activities.
- We offered green space on prescription – social prescribing to connect disadvantaged and vulnerable people to nature-based activities.

As the next step, we are gathering further data across Cheltenham to identify hot spots for substance misuse and antisocial behaviour in the local communities. We have already identified a community hub that is ideally placed to provide outreach support using the successful principles of Open Door.

Young people

We are also working beyond our PCN boundary with schools and have established an innovative population health management (PHM) project to identify children and young people (CYP) at risk of future health and wellbeing problems and offering bespoke, proactive intervention.

Our CYP PHM project has been captured as best practice by the NHS England PHM team and featured in the Gloucestershire integrated care board (ICB) news. More than 50 children are now receiving tailored care to help prevent long-term mental health problems. They are being proactively contacted by our CYP social prescribing link worker and offered a six-week face-to-face course on mental health resilience, including personalised support with issues such as anxiety or educational difficulties. Their progress is captured through improvement in strengths and difficulties scores (SDQ).

The course also includes topics such as the importance of going outside, appropriate relationships, having fun, healthy eating, managing

PROJECT STATISTICS FROM JAN 22 TO JUNE 23

Total young people currently identified for intervention: 78
Young people identified by schools: 12
Young people identified by system: 66
Young people we have worked with: 24

SDQ scores

- **All internalising scores (emotional and peer problems) decreased by at least 15%**
- **All external scores (conduct and hyperactivity problems) decreased by at least 10%**
- **At the start of the intervention all young people had higher problems than average and were close to average (80% of population) at the end of the work**
- **Data show an increase in ability to cope with situations, improvement in relationships and a reduction in emotional dysregulation**

From left: lead social prescribing link worker Foena Lowe, PCN operations manager Kayleigh Moore, care co-ordinator Amelia Thomas, lead clinical pharmacist Beverley Bazant, CYP prescriber Annie Anderton, PCN CD Dr Olesya Atkinson, PCN lead nurse Sarah Gallagher, care co-ordinator Alison Jarvis

TIM MOSSFORD/ UNP

emotions, friends and family. For parents this can help with parenting skills, routines and boundaries.

Annie Anderton is a CYP prescriber at the PCN who works for Caring for Communities and People, a voluntary sector organisation working with the PCN to deliver the scheme. She says: 'The children being offered this programme are not known to other services so we're supporting a group who otherwise might not have received any help. This is advanced proactive care and we're excited to be able to identify and help so many young people and positively influence their lives.'

Parents of children who might benefit were written to by Annie's team via the six GP surgeries involved and asked if they would like to meet with the social prescribing team, under no obligation.

Annie says: 'So far, no one has turned us away. In fact, parents are delighted to receive extra help. This is about building resilience and helping parents and their children to get support if they feel they want it.'

As the next step, we are lobbying our ICB to refocus the priority on prevention and early intervention. We are also piloting an exciting role, the Bluebell worker, whose aim is to provide holistic, non-medicalised support to young people who are on a waiting list for child and adolescent mental health services (CAMHS). We have built on our relationships with local schools and have placed the Bluebell worker in a secondary school in the most deprived part of Cheltenham. We are hoping that with this early intervention, some young people will be able to come off the CAMHS waiting lists, or at least avoid a crisis.

Proactive end-of-life care

Our PCN has implemented the virtual whiteboard, an innovative digital tool that proactively identifies any patient nearing the end of their life. Patients are contacted by a care co-ordinator to uncover any outstanding health and care needs, in consultation with the family and carers. Advanced care planning conversations are captured in a personalised care folder. The pilot surgery contacted about 350 patients, and evaluation has shown an increase in the number of people dying in their preferred place of death, completed ReSPECT forms, reduced A&E attendances and unplanned admissions.

MSK service

The PCN has set up a first contact practitioner (FCP) MSK service, which has been showcased by the Chartered Society of Physiotherapy. Patient surveys show a high level of satisfaction: 90% rating the service as excellent or outstanding and 100% being happy to use it again. The service has redirected a significant amount of work from GPs.

Befriending scheme

We have strong links with our local voluntary services partners, Caring for People and Communities, and have developed a befriending scheme using community volunteers who receive robust training to provide one-to-one support for vulnerable and socially isolated adults. Referrals to the befriending service are facilitated by the PCN social prescribers who also recruit volunteers. So far the scheme has supported 16 people.

MSK FIGURES FROM 1 SEP 22 TO 28 SEP 23

- **Total new patients seen: 1119**
- **Joint injections administered: 97**
- **Patients advised on exercise: 842**
- **Patients educated on self-care: 983**

The General Practice Awards are run by Cogora, the publisher of Pulse PCN. They highlight innovation in primary care across the UK. To learn more about the PCNs shortlisted visit pulsetoday.co.uk/pcn

PARTY LIKE IT'S 2025

Health journalist Andy Cowper is dismayed about the likely date for the next General Election, but sees good news for primary care in the latest party conferences

You'll always find me in the kitchen at party conferences, as Jona Lewie nearly sang back in 1978.

Actually, that's a lie. You'll always find me avoiding the costly, soul-destroying events that are political party conferences. You'll find me getting what I need through blogs, social media, livestreams and TV broadcasts.

But before we start on the 2023 party conference season, I must convey depressing news. The Institute For Government think-tank estimates the most likely date for the next UK General Election is late January 2025.

We potentially have to watch this Government stumble on for another 15 months, bereft of clues, so far out of ideas that they're practically back in. Another year-and-a-quarter of Prime Minister Rishi Sunak's tetchiness when asked a question of any minor level of difficulty. And (reshuffles permitting) that permanently baffled look on the face of health secretary Steve Barclay.

So, was there any good news for primary care in the autumn party season?

Perhaps there was. The Liberal Democrats promised to fund free nursing care and support with mobility, hygiene and medication. The party estimates the proposal would cost £5bn a year, but will save an estimated £3bn, so the net cost would be £2bn.

The Conservatives didn't offer much new on health. In the opposite of a coincidence, the NHS industrial action over pay also took place that week. Mr Barclay asserted that striking medics were 'even threatening to take the Government to court over our plans to let patients see their own test results on their own phones, rather than taking up a GP appointment'. I was bemused by this statement, as I suspect many others were: Pulse noted that this refers to a BMA legal challenge that was never made. It may be comforting for Mr Barclay to have fictional opposition of this kind. He also emphasised that banning things is bad and un-Conservative. This suggested he didn't know about PM Rishi Sunak's pledge to stop new generations being able to buy tobacco. Borrowed from New Zealand, it's likely to be tough to implement. But it is a move that will unquestionably benefit public health, and all of us should back it.

Labour was in confident mood. Labour leader Sir Keir Starmer's speech endorsed shadow health secretary Wes Streeting's reformist agenda, with warnings that 'we must be the government that transforms our NHS. We can't go on like this, with a sickness service. We need an NHS that prevents illness, keeps people healthy and out of hospital.'

This prevention emphasis is good. However, Starmer's pledge to end 'the 8am scramble for a GP appointment' is mightily ambitious.

If Wes Streeting knows how he'll end the 8am scramble, he wasn't telling us. However, he did serve up some optimism: 'there is nothing wrong with the NHS that cannot be cured by what's right with the NHS ... primary care will be at the heart of Labour 's plan for the NHS ... we'll cut red tape ... Labour will bring back the family doctor and will put mental health support in every school and hubs in every community, paid for by cutting tax breaks for private schools.'

As with the pledge to end non-dom tax, we must keep a careful eye on how many times this money will be spent.

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*

WHAT'S NEW

"Doc, can I have a PSA test?"

Are you hearing this more frequently recently? Would you like to confidently counsel patients about the pros and cons of PSA blood testing? Prostate Cancer UK have developed a resource to help you do just that.

"Why?"

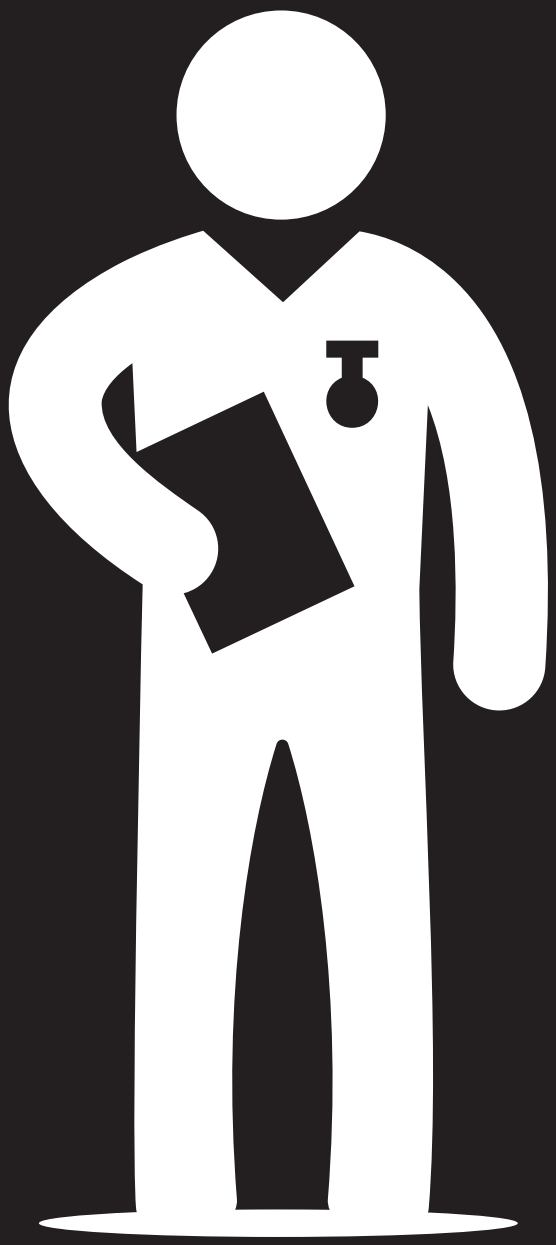
Counselling Patients on the PSA Blood Test – Pros and Cons is a resource contained in our Consultation Toolkit (scan the QR code below) designed to provide clarity on the associated benefits and drawbacks of the PSA blood test and help you support your patients make an informed decision. The intention is to help patients know their risk, understand what the PSA blood test is, and where it can be helpful.

"What's New?"

A lot. With mpMRI now in the prostate cancer diagnostic pathway, the diagnostic process is safer and more accurate. The pros and cons document includes all the most up-to-date evidence since the 2019 NICE Guidelines update. We also know more about health inequalities and how they can affect early diagnosis.

"What Now?"

Once you have discussed the pros and cons document with your patient, we can help you at every step of the diagnostic journey. The Consultation Toolkit also contains referral guidance and information for your patients.



Access your Consultation Toolkit here:
prostatecanceruk.org/consultationtoolkit

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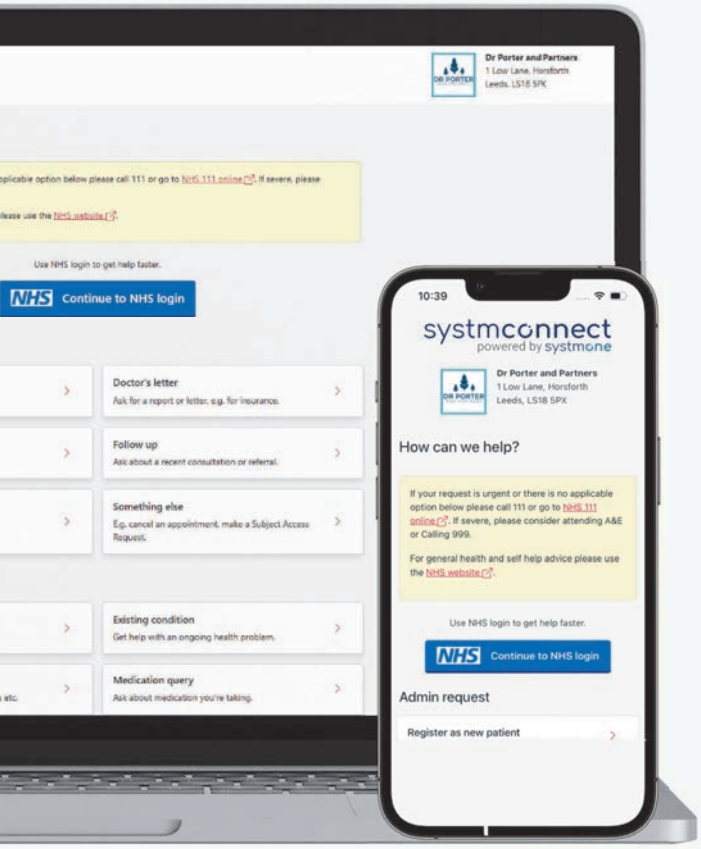

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