Work together to increase resilience

During the peak of the COVID-19 pandemic the resilience of the NHS was extremely tested, as the push to return services towards normal continues, with the additional asks of enhanced vaccination programmes, and the inevitable need to catch up on what wasn’t done during the height of the pandemic it is more important than ever to ensure that your team has a resilience buffer. This is particularly important as we see COVID cases rise again.

Resilience refers to the amount of flexibility in the team. At what point does the team become so overstretched that it cannot maintain a reasonable equilibrium between capacity (this includes funding as well as staff availability) and demand (workload, and importantly quality). If this reasonable equilibrium cannot be maintained then services can spiral towards a crisis. For example:

- Workload increases
- Staff work longer hours
- Pressure on staff increases, their personal resilience and morale decreases
- Staff sickness increases
- Quality decreases
- Use of locums increase
- Budget becomes overspent
- Additional pressure on staff to manage
- Quality decreases
- And so it could go on

So what can you do to develop a resilience buffer? Team resilience can also refer to the individual levels of ‘bounce-back-ability’. This needs to be considered, and, in most cases, across a number of organisations – for example, across all practices in a primary care network (PCN), between PCNs and other community services, across an integrated care system.

What is needed here is transformational change, and a shift in leadership to support more than just the transactional call for additional resources, this is about redesigning services around potential pressure points, and considering how to use all staff across areas to best effect and having open and honest conversations about personal and team resilience. Now is the time to consider this – before winter and the additional pressures that may emerge hits.
How could you tackle this – at PCC we are working with PCN clinical directors across a number of areas, so looking at services from a PCN point of view. PCNs also have a unique opportunity to recruit and use additional workforce using the additional roles recruitment scheme.

- What challenges are top of the list as concerns – the flu vaccination programme is likely to be one, but there will be many others
- Who else in the area can support – for example pharmacists, community nursing teams etc
- How can this programme be managed to enable each practice to maintain capacity for other pressures – setting up the flu clinics in other settings, using a wider range of workforce (including those outside general practice, as well as using new roles recruited in the most effective way) etc
- Ask patients for their views and ideas
- Consider even the most innovative solutions

Using another example – that is more system wide, how can services in the community support hospital capacity to enable resilience in hospitals to be maintained. Much has already been done on this – but looking at two streams with the right leaders in the room is crucial:

- Community capacity to manage discharges
- Prevention of admissions

This needs to be at place level or ICS level. Break down the issues to make a manageable discussion and make incremental changes to develop a resilience buffer.

The only way sufficient flexibility can be maintained in teams is to think out of the box, work collaboratively and consider the system and not just individual organisations.

**Time for extraordinary leadership**

When working far from certainty and far from agreement leaders need to:

- say yes to the mess
- build networks
- focus on a clear purpose or issue
- challenge assumptions
- contain and manage anxiety

As Einstein said about work:

1. out of clutter find simplicity
2. from discord make harmony
3. in the middle of difficulty find opportunity

(Albert Einstein 1879 – 1955)

Now is the time for leaders to work together, and we have found this can often be facilitated virtually, to discuss and develop innovative solutions to the pressures every area is about to face.

**Author**

Helen Northall
Chief Executive, PCC

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Crunch time for patient involvement

Eighteen months ago I wrote an article in PCC Insight about whether patients were being involved in setting up and running PCNs. I’ve seen a few tentative steps forward, but nothing that could be described as co-design or co-production. Now there are new challenges for primary care, which could really do with patient input.

The only reference to patient participation in NHS Confederation PCN Network’s One year on report is a quote from a clinical director (CD) that they “are still firefighting and have no opportunity to increase patient participation”.

It would be foolish not to recognise the size of the task CDs have and that engagement with patients hasn’t been the top of the list since the pandemic hit. I don’t say that patient engagement was impossible during lockdown, but I can understand that it got lost among many other priorities.

However, with apparently more and more instructions and directives hitting GP and practice manager desks since lockdown began, perhaps they can now sympathise more with patients who want a say in what and how their primary care services are delivered.

Moreover, Covid has shown how valuable community action can be in a crisis (in some cases at PCN scale) – something that might be built on in PCN’s intended role as being a local focus for bringing together all parties involved in healthcare and social care at local level.

At the time of writing, there are two particular issues where I believe patients have a necessary and valuable contribution.

2020 vaccination programme

My first issue is short-term: how to make this year’s flu vaccination programme work and maximise numbers vaccinated. GPs face not only the constraints of social distancing, but also the addition of 50 to 65 year-olds swelling the ranks of those eligible. Doubtless there are other issues I’m not aware of.

I’ve spotted that at least one PCN has been working up a plan to deliver a single vaccination programme for all its member surgeries. I guess many surgeries are holding fire on their final planning in expectation of central guidance on how to manage the process.

From a patient perspective, what options are likely to make us more likely to go for a jab? Has anyone asked? Will patients feel safer and be more likely to attend an outside venue, perhaps with a drive-through facility? Or will use of the surgery with a one-way system through their existing building attract just as many? How accessible is the proposed venue?

Will vulnerable patients be treated differently – bigger gaps between slots or whatever? How will patients reach the venue: easy access by public transport would have been a consideration, but does thinking need to be altered if some patients are now wary of using public transport? Maybe temporary vaccination venues at more than one location in a surgery’s catchment area would be helpful as a way of minimising travel?

The breadth of any patient engagement may have to be limited by time and resources. But at minimum a surgery’s PPG may be able to offer some insights, even if surgeries’ options are ultimately limited by central guidance.

Primary care from a distance

This second issue is medium and long-term. It seems pretty certain that Covid driven developments such as total triage, remote consultations, and use of telemedicine, are to a greater or lesser extent likely to be here to stay.

As far as I can tell, patients have largely embraced the changes since March. Needs must; and for many, these new arrangements may be seen as an improvement over the ‘old normal’ as well as perhaps encouraging greater self-care. But what is the range of views about these arrangements maybe becoming permanent?

We already have an insight report from National Voices and Healthwatch†. This seems a valuable early contribution to patients’ experience and it calls for a ‘blended’ approach to meet the needs of patients.

Continued...
Patient needs and wishes will vary and I believe even those who are positive about the changes are likely to have questions. These should be invited and welcomed as a help in designing future systems. And, if taken seriously and responded to, may help give all patients some reassurance that things will work for them.

Questions like:

- will GP face-to-face appointments become such a rarity that patients, particularly those with long-term conditions, will lose the relationship with a particular doctor?
- how does remote consultation or use of apps work with those with learning disabilities or dementia…?
- how do you check remotely a possible ear infection in a child or the feet of someone with diabetes or something intimate…?
- do we need to be wary of over-medication because GPs feel the need to cover themselves more when not seeing a patient face-to-face?
- what help – financial or technical – can we expect if we are now going to be invited to get our own blood pressure monitors or to use apps to manage our condition?
- will I find different approaches if I ‘see’ different health professionals in my PCN?

Most of what I’ve seen written about the ‘new normal’ in primary care focuses on the technicalities and what is achievable and what works for the healthcare system. In order to bring patients of all sorts along with the changes, we need to be informed, involved and engaged. No-one wants to be talking in the next few years about how the major shift in delivering primary care disadvantaged the less robust in society because patients were not at the heart of things.

Since writing this article in July, Mike’s PPG has completed a survey to get an early understanding of patient reaction to the Covid arrangements his surgery put in place. The resulting report can be found at https://www.johnhampdensurgery.co.uk/ppg.aspx

The Doctor Will Zoom You Now: getting the most out of the virtual health and care experience https://bit.ly/3kRaek4

Author
Mike Etkind
Chair of a PPG and founding member of his PCN’s patient group

Upcoming PCC Events

Creating and maintaining change (online) - Thursday 22 October and Wednesday 4 November 2020 (10.00 - 12.30)

This session will equip you with tools to manage change such as Kotter’s steps and the transition curve, as well as looking at how culture underpins our behaviour and breaking down some of the associated trends and behaviours that we come across regularly in culture rich organisations, such as those in the health and social care sector.

https://www.pccevents.co.uk/2427

Financial management considerations for GP partners - Wednesday 28 October 2020 (10.00 - 12.00)

All GP partners need to understand financial management and the implications of being a partner in a monetary sense. This training module aims to furnish all partners with the knowledge and acumen required to play an active part in the business side of their partnership.

https://www.pccevents.co.uk/2421

The Confident PCN Manager - Wednesday 11 November 2020 to Thursday 29 April 2021 (six half day sessions)

This online training programme for PCN managers provides a supportive learning environment in which to look up from the operational and focus on crucial strategic issues such as developing and maintaining practice engagement and the detail of, for instance, governance and delegated responsibility; population health and partnership working. Sessions include understanding people, emotional intelligence and influencing to equip the manager with the skills needed to succeed in a complex environment. The programme replicates elements of our flagship face-to-face Confident programmes as we use a coaching approach through the six modules and we are responsive to the group’s needs, current issues, concerns and circumstances.

https://www.pccevents.co.uk/2418
The Covid crisis leads to an opportunity to improve clinical outcomes and patient experience

A recent webinar with 180 primary care network (PCN) clinical pharmacists, GPs, nurses, rheumatologists, system leaders and patient organisations discussed the ways that the PCN model of care can:

- Simultaneously implement the structured medication review (SMR) and optimisation service specification and improve the management of inflammatory arthritis (IA) and other long-term conditions.
- Improve access to care
- Lower costs to the NHS
- Deliver better outcomes for patients
- Improve the adherence of patients on IA treatments
- Deliver care closer to home
- Shorten waiting times to see clinical specialists
- Improve the integration between clinical specialists and primary care

The webinar organised by PCC, the National Rheumatoid Arthritis Society (NRAS) and Medical Management Services with support from an educational grant from Abbvie was entitled “Simultaneously implementing SMR and optimisation and improving integration for inflammatory arthritis” and it heard from:

- Ms Debbie Ratu, PCN Operations Director, North Buckinghamshire PCN which started a unique PCN Model of Care in the community for patients on disease-modifying anti-rheumatic drugs (DMARDs) to deliver the above benefits
- The founder of the NRAS Ailsa Bosworth MBE, about how a “New 2RARight Start Programme” improves access to support for self-management.
- Dr Raj Sengupta, Rheumatologist, Royal United Hospital, Bath on how NICE guidance on the diagnosis, initiating treatment & regular treatment reviews needs to be improved for patients with inflammatory arthritis.
- Dr Selma Stafford, GP, Clinical Director, Sussex MSK Partnership which has increased capacity in primary care by offering patients with MSK direct access to advice, assessment and self-management by introducing first contact practitioners.
- Dr Stuart Kyle, Rheumatologist, North Devon Health Care Trust who has developed a very timely service to improve the convenience and quality of IA services for patients across Devon by introducing virtual clinics.

As Debbie Ratu, PCN Operations Director in North Bucks PCN said “We have been working with private sector providers (Phoenix Healthcare and Medacy Clinical Services) to design and deliver a private sector, specialist pharmacy – led clinical service on developing this new DMARD service specially trained clinical pharmacists with the hospital rheumatology team significantly improve patient access, outcomes and support via this new model of care. It is not about preventing patients from seeing consultants when they need to, it is about delivering quality care closer to home and frees up consultants to see acutely unwell patients sooner.”

Debbie went onto say “This clinical hub means the patient will remain under the overall care of the rheumatologist and allows for scalability both across Buckinghamshire PCN’s and extending the service to patients on the new biologic treatments”.

Helen Northall Chief Executive, PCC said “This webinar is the start of a staged project with Medical Management Services looking at how this clinical hub model combined with other new innovations such as virtual clinics and the NRAS 2RA right start programme can improve the true value of integrated services by improving clinical outcomes, patient experience and overall efficiency”.

Clive Johnstone, Managing Director of MMS said “As Helen eluded to we are looking forward to working with PCC on the follow-up stages of developing tools, techniques and measurable KPIs culminating with implementation workshops, for PCNs, clinical pharmacists, rheumatologists, other members of the MDT and the NRAS. We are also planning similar projects for other long-term conditions and would like to hear from interested PCNs and other organisations”.

Please contact Mike Fry at PCC mike.fry@pcc.nhs.uk or Clive Johnstone at MMS c.johnstone@mms.co.uk

Author

Mike Fry
Adviser, PCC
Leaders must look after themselves first …..

For an already stressed workforce the changes made to adapt to the pandemic has meant that not only have staff had to adapt to rapid change in their work routine, but leaders have been confronted with herculean challenges to keep the show on the road. Now we are trying to get back to normal and catch up on the backlog of work those in leadership roles are becoming stressed and overwhelmed by the work pressures. This pressure has to be seen within the context of an already difficult operating environment before COVID-19 and where symptoms of burnout are evident in many practices and amongst managerial and clinical staff. Therefore, when I read the helpful article by Helen Northall Next Steps for Leaders (Insight August 2020) (https://www.pcc-cic.org.uk/next-steps-for-leaders/), her advice that “the leader needs to look after themselves first” really resonated with me.

What do we mean though when we talk about leaders looking after themselves? Helen Northall gives us some very practical advice in how to take forward the challenges of developing PCNs at a time of heightened uncertainty and disruption. We are well aware of other advice about eating well, ensuring we get enough sleep, exercise, and the importance of family and friends. In our recent work with the Healthcare People Management Association – HR in the NHS, and our research into the evidence of psychological distress in healthcare professional’s after pandemics (HSJ article), we found that having trusted professional relationships, strong values, particularly altruism or sense of service, more experience and expertise were protective against developing psychological distress (characterised by symptoms of depression, anxiety, insomnia and post-traumatic stress).

We know that stress is both a psychological and physical reaction to what we are experiencing in our lives – at work, at home, in our relationships, etc. Short periods of stress can be beneficial. If we have a sense of control we can cope with work pressures, unfamiliar or uncertain situations and events. It is when we lose that sense of control that pressure or tension becomes strain which in turn leads to stress and if not resolved can produce distress.

The Stress Continuum

How can we increase our ability to manage work pressure and increase our ability to cope with stress?

There is a lot of advice to help us become more resilient. One resource I like is the NHS England’s 10 High Impact Actions. Topic sheet 6.2 on Personal Resilience. This highlights the importance of strong and trusting relationships, creating a positive work environment, and taking practical steps to look after your own health and wellbeing, such as eating well, having good sleep hygiene and exercising. It also provides good advice in how to support colleagues who have reached the point of burnout.

Neuroimaging research has shown that stress, particularly chronic stress, leads to physical changes in the brain and that can cause physical and mental ill health. Studies have shown that areas of the brain critical for learning and memory (hippocampus), motivation and mental agility (prefrontal cortex) are vulnerable to chronic or repeated stress. Stress also produces high levels of hormones like cortisol which have been associated with mood disorders and the shrinking of the hippocampus.

Developing psychological flexibility has been shown to positively help those working in the NHS to improve their psychological wellbeing. It is defined as a person’s “personal tendency to focus on their current situation, and based on the opportunities afforded by that situation, take appropriate action towards achieving their goals

Continued...
and values” (Bond, Lloyd, & Guenole, 2013, p. 332). It is the Psychological flexibility is a skill and can be developed through training and practice. The training combines elements of mindfulness and CBT to develop an increased awareness of self, ability to work with unhelpful thoughts, emotions and feelings and to focus on what is important to you.

The evidence is there to show that this type of training works. In a Northumbrian trust the ACT skills resilience programme resulted in HCP’s symptoms of psychological distress were significantly reduced and their psychological functioning was better than average. This improvement was not just temporary but persisted for months after the training. Neuroimaging support these findings. Regular mindfulness practice has been shown to increase volume and function of the hippocampus and it also produces positive functional changes in other parts of the brain associated with emotions, mental agility and motivation.

Psychological flexibility is becoming recognised as a key competency for leaders and a skill that helps them to look after themselves.

Valerie Amies is a PCC associate. Valerie runs Stress and the resilient GP/leader MBTI workshops for PCC. For more information please contact enquiries@pcc-cic.org.uk

Virtually medical: a new normal for training

With Covid-19 compelling many of us to work differently, our team has moved to virtual platforms and the rollout of the revised and reworked suite of medical contracting sessions are no exception.

The pre-lockdown staple events and workshops based on the NHS England Policy and Guidance Manual (PGM) have been revamped into blocks of three virtual sessions. This is our new programme:

An introduction to the medical contract is aimed at newer staff members to medical commissioning teams, although many experienced colleague joined the sessions in August and found the refresher useful. These introductory sessions concentrate on:

Session 1 is an overview of commissioning medical services including the history and context of medical commissioning and regulatory framework

Session 2 covers the contractual framework including contract types, services and patients

Session 3 includes finance and funding streams.

In August delivery of the first sessions was well received by over 30 attendees. We had to cap attendee numbers as interest was notably higher, so a re-run has been scheduled for 3, 4 and 5 November 2020.

An introduction to contract management is aimed at all members of medical teams. These three sessions introduce the key elements and foundation of contract management. Delivery of the sessions is scheduled for 11, 16 and 17 November 2020 and consists of:

Session 1 covering contract assurance and patient list management

Session 2 covering contract variations, including contractor changes, subcontracting and retirements, incorporation and novations

Session 3 includes managing planned closures and short notice closures, including death of a contractor, breach, remedial and terminations

We will also be offering all medical team members an opportunity to work on ‘deep dive’ consideration of specific subject areas, predominantly covering contract management. These will be interactive sessions, for the virtual attendees, providing an opportunity for discussion, learning and sharing how local examples were or maybe dealt with.

Continued...
A deep dive into contractual changes consists of three interactive virtual sessions for primary care medical commissioners, looking at the issues of contract changes, building on the medical commissioning events considering finance, contracts and contract management, looking in more detail at these issues including scenarios and identifying best practice. These sessions are useful for all involved in managing GMS, PMS or APMS contracts and are scheduled for 1, 3 and 8 December 2020:

A deep dive into when things go wrong is an interactive course comprising of three virtual sessions looking at the issues of handling breach notices, contract disputes and terminations including managing planned closures and the closedown of a primary care medical contract (GMS, PMS or APMS). Even in the best of worlds sometimes things go wrong. The three interactive virtual sessions will look at how you manage these situations and will contain essential knowledge for all involved in commissioning or contracting primary care medical services. They are scheduled 26, 27 and 28 January 2020.

On a monthly basis we are running medical surgery sessions for our annual contract holders. These one hour sessions provide networking opportunities with medical colleagues working across the country. There is no set agenda and sessions are run as an open discussion with our team facilitating and answering questions.

To register for any of our sessions go to the events pages on our website - https://www.pcc-cic.org.uk/

While virtual training is the current new normal, we look forward to seeing you with video and audio turned on through Zoom or MS Teams until we next meet face-to-face.

Risk stratifying elective care patients

The NHS has been instructed to make plans for the resumption of elective care by its Chief Executive Simon Stevens.

The letter he sent was all about risk stratification.

Organisations need to be working now on identifying clinical risk for its elective patients and prioritising accordingly. This is the ‘new normal’ for elective services and is likely to be in place for more than a than a year.

When looking at clinical risk, it needs to take account of all patients regardless of the waiting list they are on. The NHS has been accustomed to prioritising referral to treatment (RTT) patients in order to meet national targets.

What needs to change?

Prioritising scheduled care using clinical risk criteria means that NHS trusts will have to look beyond RTT patients that are often at the forefront of actions, because they are nationally reported and subject to more scrutiny from regulators.

Systems will need to understand the entire architecture of scheduled care demand and make informed resourcing decisions based upon that knowledge and understanding. This is something that Simon Stevens’s letter made clear.

Firstly, it will require an updated Governance Framework that aims to collaborate Hospital Clinicians, Managers, Informatics, Estates and Primary Care.

We have set out the architecture for elective care that includes the specific groups of patients that should be prioritised across all waiting lists they are sitting on:
What does this mean in practice?

Two of these lists (Cancer and RTT) are well known and easy to identify. The other three less so – urgent work should be underway now to get these in place.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Cancer PTL</th>
<th>Non-RTT Follow-Ups (Long-Term Conditions)</th>
<th>Planned PTL</th>
<th>Diagnostic PTL</th>
<th>RTT PTL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Confirmed diagnosis</td>
<td>Past Due Date</td>
<td>Past Due Date</td>
<td>Suspected Cancer</td>
<td>Urgent</td>
</tr>
<tr>
<td>2</td>
<td>Awaiting MDT</td>
<td>High Risk Specialties</td>
<td>High Risk Specialties</td>
<td>Urgent</td>
<td>High Risk Specialties</td>
</tr>
<tr>
<td>3</td>
<td>Awaiting diagnostics</td>
<td>Urgent</td>
<td>Urgent</td>
<td>Long Waits (6+ weeks)</td>
<td>Long Waits (40+ weeks)</td>
</tr>
<tr>
<td>4</td>
<td>2WW</td>
<td>Due Date in next 3 months</td>
<td>Due Date in next 3 months</td>
<td>Routine</td>
<td>Routine</td>
</tr>
</tbody>
</table>

These 3 waiting lists are often the blind spots for elective care within organisations but represent more clinical risk than RTT patients.

This gives the system 4 priority groups of patients that require plans for treatment, regardless of where they are in the elective process.

This then leaves the healthcare system with 4 risk-stratified groups of patients across all elective waiting lists

<table>
<thead>
<tr>
<th>Priority 1</th>
<th>Priority 2</th>
<th>Priority 3</th>
<th>Priority 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed diagnosis</td>
<td>Awaiting MDT</td>
<td>Awaiting diagnostic</td>
<td>2WW</td>
</tr>
<tr>
<td>Non-RTT Past Due Date</td>
<td>Non-RTT High Risk Specialties</td>
<td>Non-RTT Urgent</td>
<td>Non-RTT Due Date Upcoming</td>
</tr>
<tr>
<td>Planned Past Due Date</td>
<td>Planned High Risk Specialties</td>
<td>Planned Urgent</td>
<td>Planned Due Date Upcoming</td>
</tr>
<tr>
<td>Diagnostic Suspected Cancer</td>
<td>Diagnostic Urgent</td>
<td>Diagnostic Long-Waits</td>
<td>Diagnostic Routine</td>
</tr>
<tr>
<td>RTT Long-Waits</td>
<td>RTT High Risk Specialties</td>
<td>RTT Urgent</td>
<td>RTT Routine</td>
</tr>
</tbody>
</table>

Once these groups have been identified and reviewed, the governance framework will need to assess infrastructure, estates and workforce issues that may impact on the ability of organisations to treat each group.

The output of this risk stratification will be a plan that clearly sets out how the system plans to deal with each priority group of patients.

Author
John Bennett
Partner, MBI Healthcare Technologies
A team approach to change

The NHS has just suffered probably the biggest shock in its history caused by the Coronavirus global pandemic and is still struggling to recover from its devastating impact. What is most needed by the NHS now is a period of recovery and essential development followed by consolidation and stability. This can be achieved by strong leadership, along with a well-planned and executed staff recruitment, retention, training and development drive, primarily in these key areas:

- Implementing quality-assured processes to deal with the backlog of acute elective activity and primary care routine appointments
- Addressing growing mental health needs
- Reviewing and building on the lessons learned from the Coronavirus pandemic - including the benefits, such as the increased use of digital technology in clinical and non-clinical settings
- Ensuring any new NHS investment is used effectively where needed most

What does all this mean – that change is inevitable, with staff who have managed so much pressure for a sustained period it’s really important to take an appreciative inquiry approach – work with people to reflect on and start from past successes and positive experiences – what is working, what do they feel pride in, and then take a continuous learning approach – what needs tweaking, how do we test further changes, evaluate and adapt again for continuous improvement.

“The only thing that is constant is change.”

Heraclitus – Greek philosopher

Leaders need to support this approach by providing a safe and trusting environment, with a no-blame culture, where people are as happy to talk about what hasn’t worked as well as what has worked. It’s important to be open to new ideas and allow succeeding or failing together to foster continuous improvement. A group coaching approach that is solution focused – allowing solutions to emerge and co-creating the solution to get a bigger impact, and more importantly ownership, is needed. Asking the challenging questions to test the approach in a safe environment where glitches are worked through. When disagreements happen, discuss what happened, feelings and how to move forward. Understanding what makes a team and the different team roles may help, for example using Belbin team roles, enhancing understanding of what each person brings to the team, and any missing elements to make the team successful may be valuable. There are many change approaches, Kotter provides an excellent framework, but understanding how to manage resistance and why people may resist is crucial.

Using a trust/agreement matrix and identifying your allies, opponents, adversaries and bedfellows as well as the fence sitters may bring clarity on how to get individuals, and other organisations on board. The challenge of becoming a team across organisations and driving cross organisational change forward to redesign clinical pathways, shift where treatment happens and develop high quality sustainable services for the future is just beginning.

PCC has a team that can support, contact us for more information, whether it’s to train your leaders in the approaches above, or to provide hands on support for service redesign. Contact enquiries@pcc-cic.org.uk

Author
Helen Northall
Chief Executive, PCC
Expert support when it's needed

PCC can provide expert flexible support to your area.

If your area needs project support let us know enquiries@pcc-cic.org.uk

One of our experts has managed the development and delivery of primary care strategies and led on the implementation to provide enhanced personalised and preventative care. He developed and operationalised social prescribing services, developing the service specification, leading on the procurement and implementation. Most recently he supported a CCG and its PCNs to enhance their existing social prescribing model to address the rising demand for community support and capitalise on the additional roles reimbursement scheme.

Our colleague has 25 years work experience in the field of Health and Social Care covering Care Homes for older people and NHS Primary Care. She brings her skill and knowledge of working in general practice as Practice Business Manager covering three sites.

She has led significant work on a regional primary care transformation programme which fed directly into the national primary care transformation programme.

Her skills cover primary care contracting competence with significant experience of working with primary medical contracts. She also has NHS programme, project and practice management experience, and NHS Standard Contract experience.

We have an expert who is a senior NHS and third sector manager with over 30 years’ experience. Having worked in many different roles for a range of commissioners and primary, acute, community and third sector providers, as well as national agencies, such as NHS England and NHS Improvement. Her skills and experience include programme, operational and staff management, service procurement and mobilisation, pathway review and redesign, stakeholder communication and engagement and business planning/strategy.

We have a procurement expert with 36 years experience in the NHS holding senior management posts in contracting, procurement and commissioning. He is able to provide procurement advice and support including navigating through ever-changing procurement processes within the NHS which is challenging.

He also provides support on writing comprehensive and complete tender responses. Navigating a tender response and its process can be tough but with expert advice and guidance the process can be made a lot easier. Our clients have said “Thank you again for all your help with the bid, I really couldn’t have done it without you. I can’t express how much I appreciated and valued your support throughout the whole process.”

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PCC welcomes your news for future editions of PCC Insight—if you have something to share or would like to contribute an article please let us know enquiries@pcc-cic.org.uk