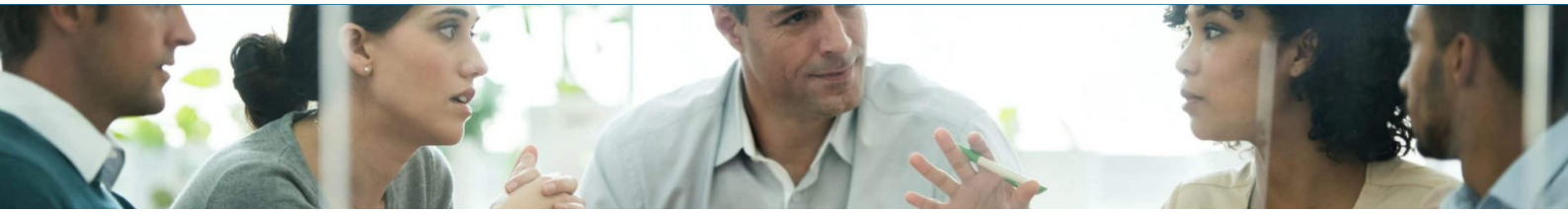
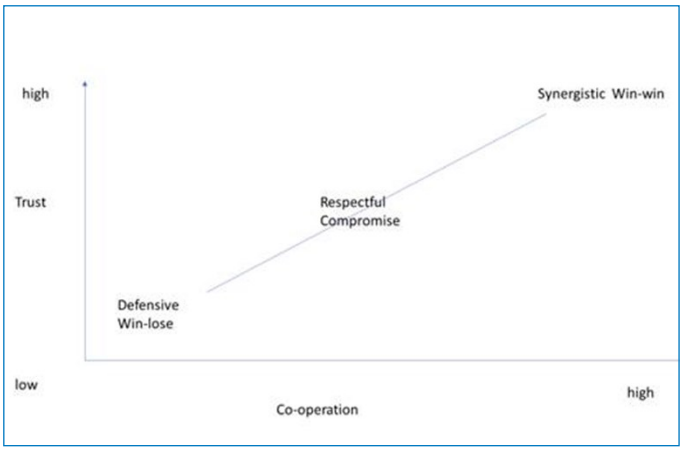
Insight

June 2021



Listen, gain trust and co-operate

Collaboration is one of the words we are hearing most often as integrated care systems are starting to take shape. But how can you help this to happen? One of the themes in the Long Term Plan and strengthened by the White Paper is that organisations should work across the system – not just considering their own targets or financial position, but those of the system. To start with – who to collaborate with? Although the White Paper outlines who should be on the boards, for practical collaboration to improve the health and care of the population there is a need to collaborate at the right level, with the right partners for the changes being considered. This won't always be the same group of people and organisations. For some areas this may be at ICS level, but more likely to be at place or PCN level. Involving health partners (Trusts, PCNs, GP practices, community services including other primary care services) local authorities, patients, voluntary, community and social enterprise partners and community groups will be important depending on the area being considered. To successfully collaborate and keep the relevant partners on board win-win solutions will be needed – but how to get there?



Stephen Covey, in the seven habits of highly effective people, recognised that valuing differences is the essence of synergy, but to get there you need to thoroughly understand others so that you can then present your ideas contextually based on others concerns. So seek first to understand others. We usually listen with our own frame of reference in mind – so we evaluate what others say – agreeing and disagreeing based on our beliefs, we may question or probe – based on our frame of reference, we advise, based on our experience and interpret, based on our understanding of the world. Suspend judgement – and really listen, check your understanding of what others are saying; build trust by understanding their world and their concerns. Probe to find how they feel about the situation and express understanding of their perspective . Use active listening with open questions.

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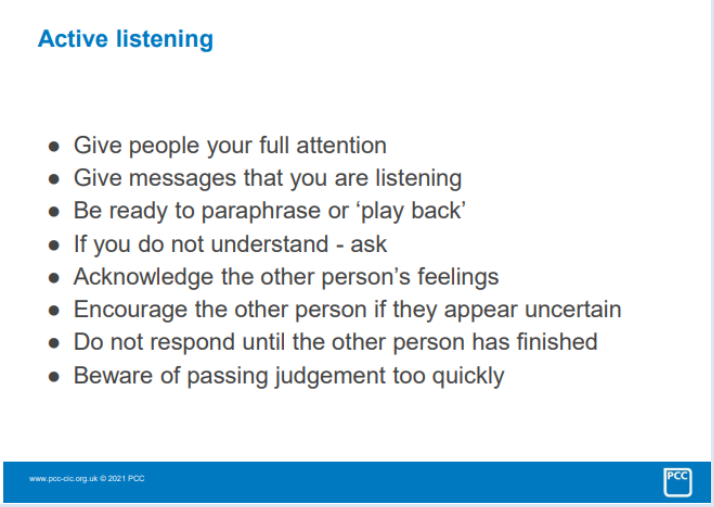

How this can be done can include reframing and checking your understanding of the situation – then seek to jointly find alternatives and solutions, with an open mind. Find a shared purpose and work through why is this important. When you work through a solution with others, explore why you are doing it this way, what is the problem being solved. Work through a story of what the future looks like that you can share and use to communicate to others who will be involved in implementation. What will be the call to action – why does this need doing and what shared problem will this solve?

Start by listening, gaining trust and genuinely working through a shared solution. Addressing others concerns will gain the trust and co-operation needed to move from defensive – win/lose solutions to shift to the win/win changes that are needed to develop care for the future across systems, at place or primary care network level.

So seek first to understand, listen without imposing your own frame of reference and beliefs, check your understanding with other parties and jointly consider all the alternatives. Only then agree the clear desired outcome, the shared story of what the future will look like making sure all parties are happy with this vision. Then work back as to who needs to do what, the call to action for each team, clearly articulating the problem this will solve – and plan steps to make real changes together to improve care for your population.

If you would like support to facilitate your discussions or plan your approach contact enquiries@pcc-cic.org.uk

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Improving the primary care estate

Introduction

The pressures facing general practice such as increased workload, an ageing population, responding to the pandemic and the need to extend access to primary medical services has put significant strain on existing infrastructure including premises. The introduction of primary care networks (PCNs) and the additional roles reimbursement scheme (ARRS) which is incentivising a rapid expansion of the primary care workforce, is putting extra pressure on the availability of fit for purpose premises from which to deliver modern primary care services.

PCC recently supported a clinical commissioning group (CCG) in the North of England to improve their governance processes to receive, validate and consider applications from GP practices for funding support for the development and improvement of their premises.

GP premises improvements

GP premises procurements, development and improvements can vary in size and complexity including:

- improvements to existing facilities

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- new premises for GP contractors and their practice staff
- premises to accommodate a wider range of services and additional roles

The NHS (General Medical Services - Premises Costs) Directions 2013 set out the arrangements for NHS England and NHS Improvement (NHSE&I) and CCGs with delegated commissioning responsibilities to fund premises improvement grants for contractors to extend or improve their premises and, in some instances, financial assistance for the development of new general practice premises.

Responding to an expected increase in applications from practices, the CCG wanted to improve the way in which bids for premises funding are managed and establish a fair and transparent governance process to evaluate applications from GP practices.

The CCG is also working with PCNs to assist them developing their clinical strategies and supporting estates strategies for each PCN. This will strengthen the CCGs ability for decision making, using the new governance processes when strategically assessing applications for investment in the primary care estate.

GP premises funding: application and evaluation of bids

The process and arrangements for GP premises funding support can be summarised as follows:

Outline Proposal	GP contractor identifies requirement for premises improvement
Eligibility	GP contractor reviews requirement against eligibility criteria
Bid for funds (1)	GP contractor completes expression of interest (EoI) template
Bid for funds (2)	For bids in excess of 50k, GP contractor develops supporting documentation (project initiation document or business case dependent on size and scale of scheme)
DV rent assessment	Where potential impact on future revenue costs for commissioners, CCG appoints district valuer to assess recurring revenue implications of the scheme
Investment decision	CCG formally considers the application against eligibility criteria, availability of funds and investment prioritisation.
Offer of funds and written agreement	For capital funding, the application is referred to NHSE&I. Subject to NHSE&I approval and availability of funds, an offer letter is issued to GP contractor. For revenue funding, if bid is supported by the CCG they will issue an 'offer letter' directly to the applicant GP Contractor
Project delivery and completion	GP contractor undertakes works in line with agreed specification. NHSE&I and CCG monitor progress and approve claims for payment. On satisfactory completion of works, recurrent revenue and abatements are actioned

Responding to an expected increase in bids from practices, the CCG wished to strengthen its internal governance arrangements for managing, evaluating and prioritising applications for funding support, in a systematic, fair and transparent way.

The enhanced governance arrangements introduced are characterised by the following key features:

- A structured approach to considering applications with clear decision points supported by a range of approved guidance and templates
- Establishment of a CCG Infrastructure Steering Group to act as initial screening panel for applications but also to provide general premises advice to the CCG
- Stratification of applications into one of four categories to reflect scale, complexity and risk profile, with each category having specific requirements for documentation required to support the application.

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- Distinct phases in the process, including an initial 'informal' phase whereby the GP contractor and the CCG work collaboratively to develop a credible and eligible bid for formal consideration later in the process. Early engagement is particularly important in the context of the Premises Costs Directions, as any costs incurred by a GP contractor that are not agreed in advance with commissioners (including increased recurring premises cost consequences) will not be eligible for retrospective funding support.
- Robust and effective reporting and tracking of applications at all stages of the process, establishing an effective audit trail of application status, decisions and timelines.
- A partnership approach between the CCG and relevant PCN leads, the NHSE&I primary care premises team and Strategic Estates Advisors within NHSE&I, supported by effective consultation with key stakeholders including the Local Medical Committee.

This process for GP practices bidding for premises funding support together with effective commissioning arrangements for considering applications should be relevant to all CCG's.

We would be pleased to provide further information on how PCC can provide a wide range of premises related support and expertise, including estate strategy development, the application of the NHS (General Medical Services – Premises Costs) Directions, and focused training for staff working in commissioning functions with responsibility for premises.

For further information please contact enquiries@pcc-cic.org.uk

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Do we have the leadership for the world of integrated multi organisations?

Following our chief executive Helen's article on Integrated Care Systems (ICS) in the April edition of Primary Care Insight and thinking about our excellent product the Confident Leader, my mind turned to what is needed to more than meet the aspirations of Simon Stevens' bequests to us. Simon has been for me an excellent NHS CEO and thus difficult to replace. My fear is the NHS will revert to a hospital focussed CEO who favours 'big beasts' with only the traditional lip service to primary care, localness and the community's health. I would be more than happy to be disabused.

We have been bequeathed the Primary Care Network (PCN) and now ICS both of which potentially encompasses and indeed should embrace beyond only healthcare. It must be about health of which a health service important though it is, only contributes. I would like readers to proffer their ideas of what health is and encourage them to look and seek beyond an absence of disease. My definition of being healthy is feeling good about yourself including having more control over your life events and of course the benefits endowed by health behaviours. Health is a positive and active state of being and population health is about communities and the individuals living within.

As a medical doctor I chose general practice as I wished to be a doctor to an individual rather than a specialist in 'body parts', a generalist not a partialist. During my 36 years as a GP, I was for 13 years a local councillor and

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many of my patients were my constituents. For the first time having worked in a nationalised industry the NHS, I sought something from them- their votes. It changed my perspective as a doctor. I was indeed much more of the community and how can you have population health without the community? So what has all this to do with you. Very little I hear yourself think and you could well be right but hopefully there are some useful outputs from my experience. We need to reset the relationship between the NHS and its community of citizens.

A fundamental issue is NHS patients need to be regarded as both customers and citizens. Younger generations are increasingly less likely to tolerate the 'take it or leave it' attitude so prevalent in nationalised industry. The concept that a want is less important than a need is a professionally engendered judgment. How is a patient meant to know the difference without recourse to a professional carer or at least accessible information when the need arises? And yet the judgement prevails in our NHS fuelling a too judgemental attitude by many NHS staff? Patients of course made errors but so do clinical staff. Are there better systems than a nationalised model for healthcare apart from a private model? Yes in our near European neighbours who have generally better satisfaction, certainly better healthcare outcomes and are better funded! The NHS plan of 2000 reinforced the view that a nationalised NHS is best but I think that view needs to be imperatively reviewed!

To come to my point, the policies we have inherited from our outgoing NHS chief executive of PCNs and more latterly ICSs allowed us several benefits. A potential bringing together of the health service, the care services and public health service to focus on prevention, cure, care and the health of the population. New Zealand's inspirational Prime Minister has it when she described her country as a team of 5 million. That's the mindset we need in our NHS and the PCN and ICS are excellent ways of achieving such an aspiration. And yet my years of experience suggests it will be mostly led by NHS leaders with a traditional 'top down' compartmentalised mind set which will negate the broader vision.

Can we influence that change presupposing that we desire it, or should it be the 'same old' leadership? We cannot however ignore the facts. Many more people died in the UK from Covid-19 than most other countries for two reasons, the high levels of the infection and because our nation was so unhealthy before Covid-19 struck. UK has the worst population health in Europe. Health inequalities have been widening over the past decades although reversed during the Blair government. People who live in the most deprived places now spend more years with disability and get ill years earlier than in the least deprived ones. This degrades lives and reduces the contribution people can make economically and socially. BAME communities (although that glib acronym is likely to be changed to a description that reflects humanity) have even worse health.

For a more community as well as customer focussed NHS that enabled beyond healthcare, we need a new type of leader. We will explore the topic in a subsequent article.

Author

Professor David Colin-Thomé, OBE
Chair, PCC

Upcoming PCC Events

Effective online meetings — 8 June (14.00-16.00) and 17 June 2021 (10.00-12.00) - online

Are too many of your meetings classed as 'a waste of time or boring and frustrating?' Then develop the capabilities and confidence to manage engaging meetings that gain commitment, add value, and achieve outcomes.

This virtual workshop focuses on developing the skills to manage meetings in a more effective way. The core principles adopted across the workshop support managers in defining a clear aim for the meeting, formulating a plan that drives engagement, and finishes with the skills that bring the best commitment and decision making from all attendees. https://www.pccevents.co.uk/2522

The Confident PCN Leader — Thursday 10 June 2021 to Tuesday 11 January 2022 (13.00-16.00) - online

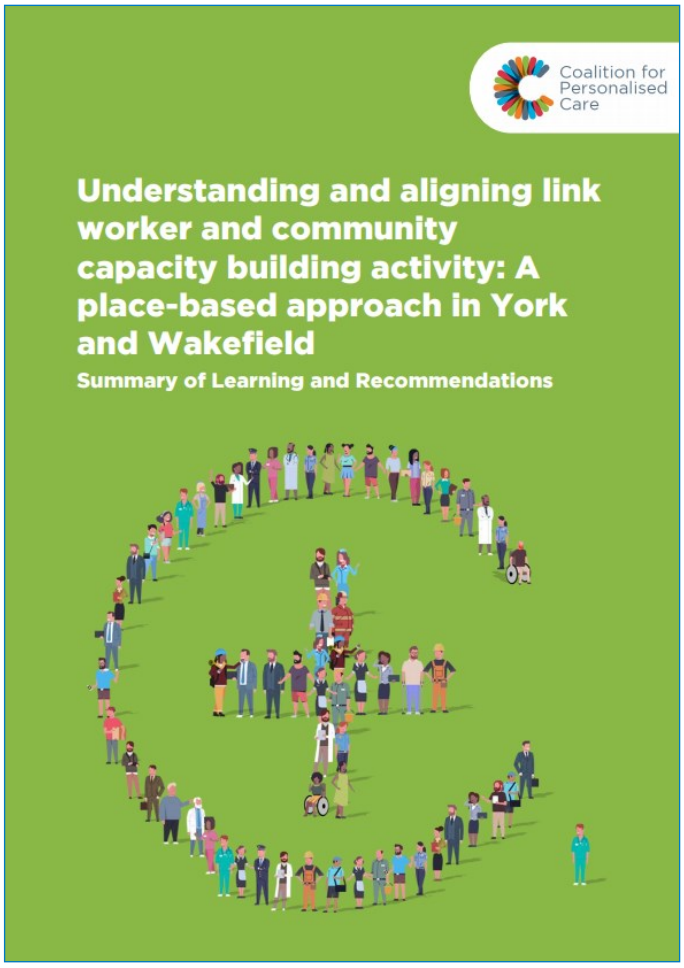
This online training programme for PCN leaders provides a supportive learning environment in which to focus on crucial strategic issues such as developing and maintaining practice engagement and the detail of, for instance, population health and collaborative working. Sessions include content on understanding people, emotional intelligence and influencing to equip the leaders with the skills needed.

https://www.pccevents.co.uk/2417

Understanding and aligning link worker and community capacity building activity: A place-based approach in York and Wakefield

Personalised care is central to a new service model for the NHS, including working through primary care networks, in which people have more options, better support, and properly joined-up care at the right time in the optimal care setting. Universal Personalised Care (UPC) is a vision and strategy for making personalised care business as usual for health services in England and includes a focus on the role of social prescribing link -workers and their interrelationship with wider community capacity.

The Coalition for Personalised Care (C4PC) is a key stakeholder body for the Personalised Care Group. The C4PC partnership has a high level of diversity and reach and includes many people with lived experience. Partners were aware of the many different organisations employing link workers or involved in community capacity-building activity in areas where they were working. They felt that a piece of work that was place-based and explored ways to understand and align link worker and community capacity-building activity would be helpful to the delivery of social prescribing in line with UPC. C4PC was engaged in January 2020 to explore how social prescribing, the role of link workers and voluntary and community assets, worked together at place level. C4PC agreed a work programme, to be delivered in two places in the north of England, York and Wakefield. The work was co-ordinated by Community Catalysts and was delivered by three of the C4PC partners, the National Association of Link Workers, the Health Creation Alliance and the Social Care Institute for Excellence.



This work began in January 2020 and prior to the Covid-19 Pandemic. There was an inevitable pause in the work as the focus of all areas turned to managing and mitigating the impact of the pandemic in their area. The vital role of communities, the value of the voluntary sector and the importance of the work of social prescribing and other link workers in supporting people at this time, became a dominant theme of this period of the pandemic and their experiences enriched the learning from the C4PC programme of work. Work began again on the work programme in September 2020 and was completed in early January 2021.

The report was published in March 2021 and summarises the findings of this work programme and the practical recommendations to help Integrated Care Systems (ICS) better align social prescribing and other link worker activity and organisations involved in community strengthening activity. This alignment will help make best use of scarce resource, add value to the work of the different organisations involved and help health and other partners understand where investment may be best deployed. The overall aim is to strengthen the role of social prescribing link workers, the VCSE, and wider community support for improved health and wellbeing of populations.

The report provides valuable insights for health, local authority and VCSE colleagues keen to work together in their own place to align link worker and community

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capacity building activity to improve community and individual wellbeing. It also demonstrates a highly effective model of collaborative working by C4PC partners, which the Coalition hopes will be the pattern for future collaborations bringing together the insights and knowledge of different groupings of partners to address different challenges.

You can read the full report here and there is a video available:
https://www.youtube.com/watch?v=5Z_MkT55Mgo

PCC supports the training of link workers through our SocialPrescriberPlus programme.

Author

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Using population health data to inform ARRS recruitment

At PCC, we have been delivering workshops on the development of the additional roles reimbursement scheme (ARRS) with clinical directors, PCN managers and practice managers and listening to their different experiences of expanding their workforces under the scheme.

Funding for the ARRS has increased nationally from £430m (2020-21) to £746m max. (2021-22) with an allocation available for each primary care network (PCN) depending on the size of the population it covers. Clinical commissioning groups (CCGs) draw down the funds but only as new roles are recruited within PCNs. PCNs are therefore being strongly encouraged to make use of their ARRS allocation to ensure people in their neighbourhoods benefit from the funding available.

The need to utilise this additional resource has come at a time when there are competing priorities in primary care, not least the Covid-19 vaccination programme. When you are very busy it can be tempting to take a pragmatic approach to the question of what new roles you might need, starting with what you know is useful. General practice has embedded clinical pharmacists over the past few years and they have demonstrated their worth in a primary care setting, so PCN leaders are telling us that using ARRS funding to increase pharmacy staff across a PCN is a comfortable decision. Similarly, recruiting more social prescribing linkworkers to reach out into communities to tackle the health inequalities highlighted by the pandemic can seem like a sensible idea.

But how to make best use of the remaining funding allocated to each PCN? Primary care leaders know they do not need to recruit one of every new role, but how can population health data help them to make informed choices about what roles would add value in their neighbourhood?

Practice-level data available on NHS ViewPoint helps PCNs to understand the current physical health needs of patients together with key demographic information about the make up of the population in age, ethnicity and deprivation. They can use this information to hone recruitment of additional roles.

For instance, analysing data on diabetes could identify:

- people who are at high risk of developing type 2 diabetes
- people who have newly diagnosed type 2 diabetes
- people with ongoing management of type 2 diabetes

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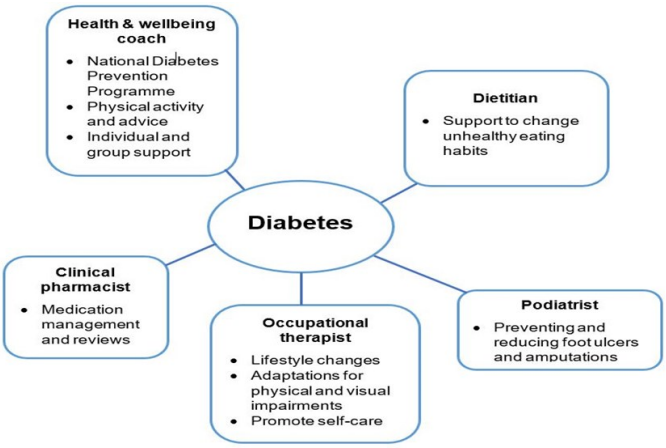
The PCN would then consider which of the clinical and non-clinical additional roles could enhance care for pre-diabetics and diabetics at different stages in their self-care and management of the condition (see fig.).



Incorporating public health and local authority data, and the knowledge of local people, groups and organisations can help PCNs gather even richer information to support recruitment to meet needs in their areas. In an affluent area with an older population, it may be useful to recruit a first contact physiotherapist, health and wellbeing coach and podiatrist to work together on increasing strength and stability for people as they age, with a goal of preventing the often devasting first fall. In a deprived area with a history of long-term unemployment, a PCN might see the value in an occupational therapist to help people on long-term sick leave gain the confidence to get back into work, a physiotherapist to help with rehabilitation, and a health and wellbeing coach to help people set and achieve personal goals.

The analysis of data allows PCNs to align services to needs and predict local health needs in the future, identifying demographic trends in their neighbourhoods and bringing in roles to support prevention and provide anticipatory care; enabling them to better engage people in their own health and wellbeing, and help them stay healthy for longer.

Embedding the new roles into PCN and practice teams is crucial to their success, we have found that an induction programme for the new role into primary care and the general practice culture; work with the existing practice staff to understand the new role and developing champions in the practice to help embed the new ways of working helps the new roles to make a significant impact most quickly. We have supported PCN leaders to decide on skill mix, developed practice champions and provided induction programmes. Contact enquiries@pcc-cic.org.uk or visit www.pcc-cic.org.uk/pcn-and-ics-development-support/

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Collaboration

Introduction

Collaboration has been one of the buzz words in Primary Care for several years now. The NHS Long Term Plan mentions it over 20 times and the current white paper “Integration and innovation: working together to improve health and social care for all”, over 50 times. But what does it really mean in practice and how does it actually happen? Collaborating across a number of organisations brings with it numerous challenges including dealing with different values, organisational ‘jargon’, and system drivers along with the ever complex issue of forming positive new relationships. All organisations involved need to work together to establish new forms of governance for their relationships which focus both on the collective responsibilities and behaviours required to make their collaborative arrangements a success.

In the following case study, we get to find out how one place based system rapidly put these new collaborative relationships to good effect to improve the way in which care was delivered across several organisations at a time when all our attention was focussed on dealing with a worldwide pandemic.

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North East Essex Integrated Discharge Single Point of Access

Implementing the Coronavirus Act 2020 and Covid-19 Hospital Discharge Service Requirements

When Covid-19 hit, one of the first changes to legislation was the Coronavirus Act 2020, which essentially made community providers responsible for all discharge arrangements from hospitals. This had previously been the responsibility of local authorities.

This fundamental change was for pathways 1 to 3, which are increasingly complex care packages. Pathway zero, 'no additional need', representing discharges directly home, remained the responsibility of the acute provider, East Suffolk and North East Essex Foundation Trust (ESNEFT). Overall responsibility for the discharge hub, remained with ESNEFT.

These duties were previously undertaken by Essex County Council (ECC) social workers, who were required to be redeployed out into the community to effect on the ground support.

Simultaneously, hospital discharge requirements were published on 19 March 2020, setting out strict rules around timing of discharges and speed to empty hospital beds.

Overall, these were a complex set of changes and relationships that were brought into legal effect rapidly and began on 6 April 2020.

Anglian Community Enterprise (ACE) redeployed 27 therapy staff to support the model of discharge to access (D2A) and we worked incredibly closely with ECC and ESNEFT staff to put together a training, coaching and development package around the team.

This was a major change for our system and it's fair to say that there were initially real concerns about how this could be effected safely. To mitigate the risks, ACE initiated two key changes:

- Other partners were invited to join the team including: the hospice, (St Helena), the CHC Lead from the CCG and the voluntary sector coordinator (c360)
- The establishment of a scorecard which monitored activity and provided proxy quality measures. This was developed in partnership and with Newton, an independent advisor.

Initially, the discharge arrangements were overseen by daily meetings of the operational leads, with ACE CEO present, plus a weekly system oversight meeting, with ACE, CCG, ECC and place leads all present. As confidence built, the weekly oversight meetings dropped away.

From a CEO perspective, I wanted the various individuals, each employed by different organisations, to feel like they were part of a single team. That is probably what I worked on the most, both with the individuals in the hub, but importantly with senior partners at place (we call it an Alliance Board). The binding focus was an ethos of teamworking, brought by the new approach and an overriding desire to place individuals with the best packages of care possible for them.

As a collective team, we continually evaluated our performance and with senior 'air cover' gave operational staff the room to work, build relationships and trust. This was the single most important managerial action – for directors to step back and allow ops to perform!

Overall, key factors to success included:

- Collaboration with all system partners and having key decision makers in the room
- Discharge MDT meetings, powered by single data source
- Data visibility based on the patient tracker (single version of the truth). We are planning to move to a more sustainable dashboard using Power BI rather than manual excel graphs.
- Daily calls at the beginning of the Covid-19 response with senior leaders in the system now reduced to twice weekly
- Executive level oversight

Author

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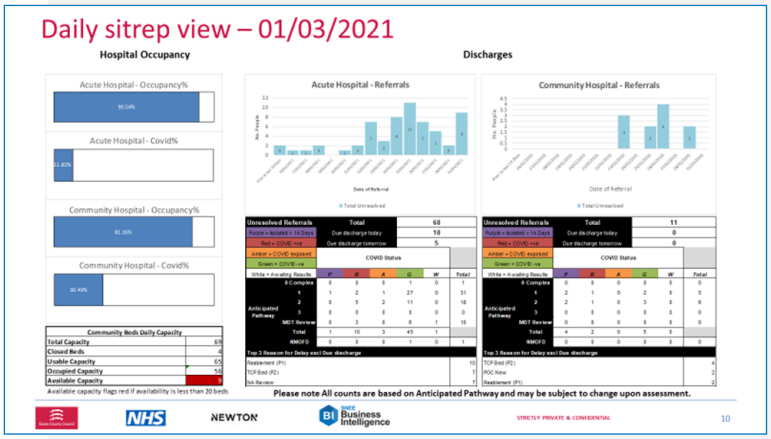


Summary

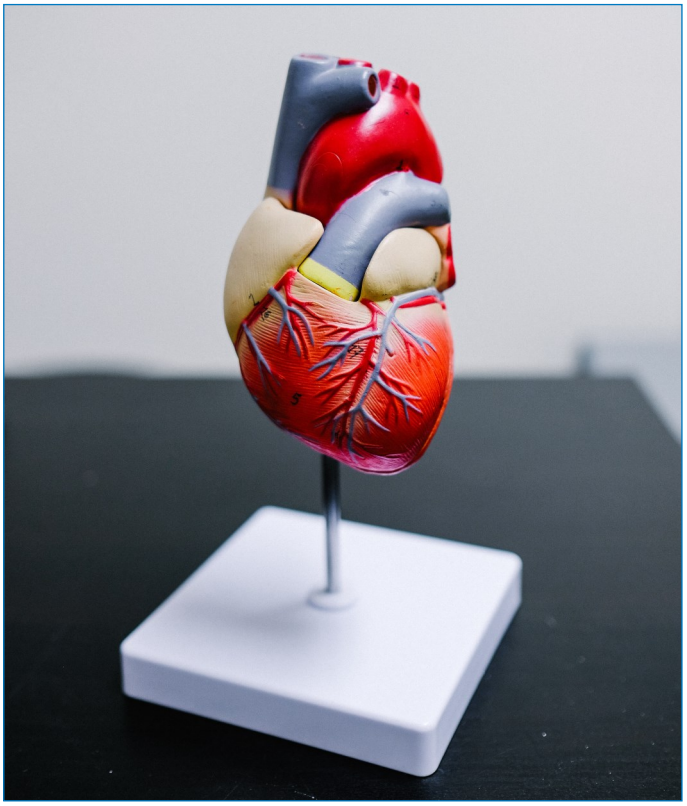
If you would like to find out more about how PCC can help you to work across organisations and gain a broader perspective of the benefits collaboration can bring, Please contact enquiries@pcc-cic.org.uk

The potential for case finding patients with cardiovascular disease in a dental setting

The NHS Long Term Plan set out the case for early detection and treatment of cardio vascular disease (CVD) and is one of the key aims. The case finding does not need to sit within general practice alone. Following the commencement of a pilot scheme in a pharmacy setting, the Office of the Chief Dental Officer (OCDO) for England understood the possibility of the impact of case finding in a dental setting. Whilst patients generally only attend a medical or pharmaceutical setting when they are feeling unwell, patients attend the dental practice on a more regular basis.

The OCDO commissioned a review, funded by the NHS England and NHS Improvement CVD Team, to test the feasibility of NHS primary care dental providers in England and their teams contributing to case finding patients within the populations they treat for CVD risk factors. This review was looking at the longer-term health economic impact of early detection of a patient cohort who may otherwise not be identified until they were in a more advanced stage of CVD.

Dr Matt Kearney (Programme Director UCLPartners and former National Clinical Director for CVD Prevention) explained why early detection of Hypertension is important. Hypertension is common, affecting more than 1 in 4 adults in England. It is a major cause of cardiovascular disease (CVD), accounting for half of all heart attacks and strokes and many cases of dementia. But it is also highly treatable – reducing blood pressure with lifestyle change and medication is very effective at preventing CVD. Despite this, around a third of people



with hypertension are undiagnosed, and because high blood pressure usually causes no symptoms, they are unaware of their increased risk and the need for treatment. Making blood pressure testing more available in community settings outside the doctor's surgery can make a major contribution to the NHS Long Term Plan ambition to prevent heart attacks, strokes and dementia at scale.

PCC was engaged to undertake a health economic review to understand the longer-term impact on the detection of and prevention and/or treatment

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of CVD patients, as well as the financial element to the NHS it was always recognised the impact that early detection could have on the person themselves.

The health economic review was undertaken by our associate Monica Duncan who systematically reviewed the literature, identified the existing national resources to support an economic review and provided a model to show the potential long term cost savings to the NHS with the early identification of patients with CVD when initially identified in a dental setting, adding to the overall number of patients who are detected for CVD.

As well as the health economic review, PCC was also asked to support the development of an initial service specification and care pathway for the identification of patients within the dental setting, we were supported in this by our adviser Wendy Crew who has experience of designing and implementing service specifications and Dr Matt Kearney.

Following the presentation of the review to the OCDO a pilot is currently being implemented in the North East, and Yorkshire and Humber. Health Education England is supporting the pilot where the pathway (focussing on hypertension and atrial fibrillation) will be tested in early pilot sites in the North, supported by Health Education England and have been endorsed by the British Heart Foundation and the Primary Care Cardiovascular Society.

The importance of collaborative working was highlighted by Shabir Shivji, Senior Dental Advisor Dental CVD Prevention Lead in the OCDO, who said:

"The NHS Long term Plan highlights the importance of collaborative working in the prevention of Cardiovascular Disease. The paper commissioned by the NHSE CVD Team, produced by the OCDO and PCC has been instrumental in developing the appropriate relationships to facilitate the pilot programme. The friendly, accessible support received by the PCC team in responding to the rapidly developing opportunity for the pilot has been pivotal in ensuring the pilot progresses".

PCC can support service evaluations and economic impact assessments for information on how we can support you contact enquiries@pcc-cic.org.uk

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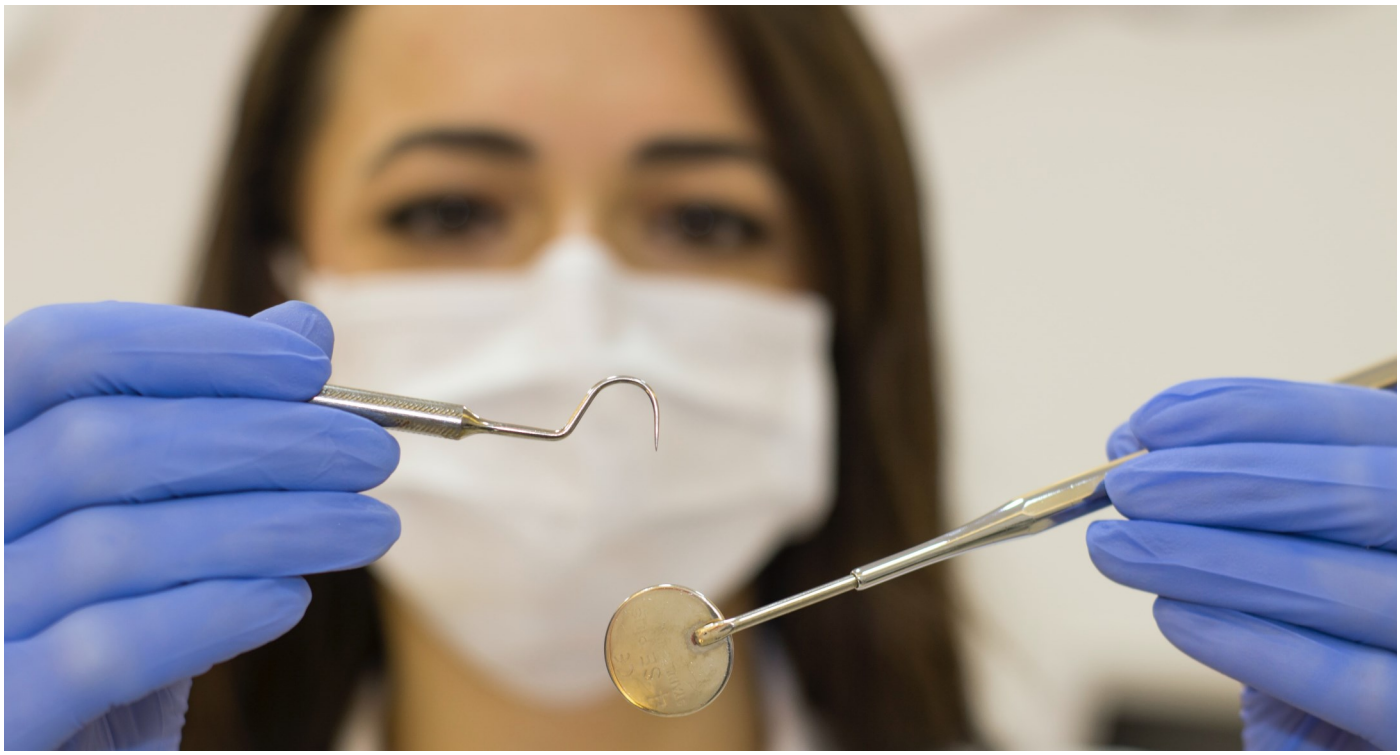

All Change for Procurement

Navigating through the maze of procurement regulations has long been a challenge for both commissioners and providers. The pressures on procurement and supply chains posed by the Covid-19 crisis, which has, in some cases, attracted unfavourable publicity, together with the end of the Brexit transition period on 31st December 2020, and proposals for NHS legislative changes with greater emphasis on integration rather than competition, have all combined to ensure that some significant changes to procurement regulations resulting in more flexibility and reduced bureaucracy were inevitable and now there is some light at the end of the tunnel reports procurement specialist Alan Turrell*.

During the Covid-19 crisis, it was evident at an early stage that urgent actions needed to be taken so that that normal tendering procedures could be by-passed and, accordingly, various central Government communications (including PPNs (Procurement Policy Notes) 01/20, 02/20, 04/20 and 01/21) reminded commissioners that existing rules did allow, under urgent circumstances, contracts to be awarded without competition together with the need to support suppliers during the crisis. However, these included a word of caution that decisions and the justifications for relaxing competition should be fully documented including evidence that risks, such as poor value for money, unequal treatment of suppliers and conflicts of interest, had been considered and addressed.

The first significant procedural change was a result of the end of the transition period with it no longer being applicable for commissioners to advertise contracts and publish contract awards in OJEU/TED (Official Journal of the European Union/Tenders Electronic Daily). Instead a new portal, Find a Tender Service (https://www.gov.uk/find-tender) is now being used and this is the place that potential providers of healthcare services, including primary care, should look for potential supply opportunities relating to high value contracts together with the existing Contracts Finder (https://www.gov.uk/contracts-finder) for lower value opportunities.

For the time being, the remainder of other public procurement procedures and regulations which were based on the EU public procurement directives continue to apply as these have been embedded into UK law such as the Public Contracts Regulations 2015 incorporating the Light Touch Regime which governs much of the procurement activity for the commissioning of healthcare services. However, Brexit provides an opportunity for a wholesale review of public procurement regulations and these were set out in December's Green paper, "Transforming Public Procurement". Although it is intended that the new single procurement regime proposed in this paper does not apply to the procurement of healthcare services it very much sets the tone with: fewer and more simplified procedures; a broader definition of "value" (MAT = Most Advantageous Tender) in the evaluation of tenders including consideration of the social value to be delivered, the degree of innovation being proposed and a provider's previous performance; and a standardised approach to the collection and publication of procurement data.

Clearly any changes to the procurement regulations specific to the commissioning of healthcare needed to be consistent and supportive of the wider legislative changes being proposed for the NHS as detailed in the February 2021 White Paper, "Integration and Innovation: working together to improve health and social care for all". These proposals are driven by the three aims of improving integration, removing bureaucracy and increased accountability with the key structural change being the designation of ICSs (Integrated Care Systems) as statutory bodies.

However to meet these broad aims changes to the existing procurement and competition regime were essential and therefore the paper proposes the abolition

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of the controversial 'Procurement, Patient Choice and Competition Regulations' (Section 75 of the 2012 Health and Social Care Act), the removal of healthcare services from the general public procurement regulations, and the abolition of the Competition and Markets Authority (CMA) jurisdiction over NHS Trust mergers. Accordingly, the vision for the future commissioning and procurement of healthcare services was set out in an accompanying paper, "NHS Provider Selection Regime: consultation on proposals". The proposed regime seeks to use competitive procurement sparingly so it is not a barrier to integration: "In future, we want competitive tendering to be a tool that the NHS can choose to use where it is appropriate, rather than being an imposed, protracted process that hangs over all decisions about arranging services, drives competitive behaviour where collaboration is key and creates barriers where integrating care is the aim."

At the core of this are three sourcing routes available to commissioners or "decision-making bodies" as they are referred to in the document (which include local authorities commissioning health care services including public health, as well as ICSs and NHS England) to determine the optimum provider(s):

1. Continuation of existing arrangements – This will apply where a change of provider is not feasible, for example where there is no alternative provision such as for type 1 and 2 urgent and emergency services and "core primary care contracts commissioned on the basis of continuous contracts, where patients have the right to exercise choice at the point of registration with the GP surgery", and in situations where there is no value in seeking another provider.
2. Identifying the most suitable provider for new/ substantially changed arrangements – By using a set of key criteria commissioners will determine if one provider or group of providers is the most suitable and may award the contract without conducting a competitive procurement. The nominated provider could of course be the existing provider.
3. Competitive procurement – This will only be used where the most suitable provider cannot be determined by using the process set out in 2) above or the commissioner wants to use a competitive process.

For commissioners this seems a much simpler and flexible menu of options for determining the optimum provider as compared with the current task of interpreting two seemingly conflicting sets of regulations represented by the Procurement, Patient Choice and Competition Regulations and the Public Contract Regulations 2015. However, the proposed Regime clearly puts the onus on commissioners to act transparently by, for example, publishing their intended approach, keeping a record of decision-making, identifying and managing any conflicts of interests and conducting annual audits and publishing annual reports.

For providers, it offers an opportunity to retain existing contracts without having to tender if they can demonstrate good previous performance and, under route 2) are assessed as being the most suitable provider against the specified key criteria which are:

- Quality (safety, effectiveness and experience) and innovation – This includes consideration of innovation and service improvement.
- Value – This embraces health and well-being outcomes to both individuals and the community rather than merely the 'cheapest' option.
- Integration and collaboration – The most suitable provider would need to be assessed as having an appetite for collaboration and being committed to integrating care and delivering joined-up services consistent with local plans.

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- Service sustainability and social value – As well as ensuring long-term stability of services, decision-making bodies will give consideration to the extent that providers are able to deliver social value. Although it is not specifically referred to in the paper, the recent PPN 06/20 advocating the use of the Social Value Model in all procurements provides a good indication of the elements to be considered including supporting communities to: recover from the impact of Covid-19; create new jobs & skills, deliver environmental benefits; provide employment opportunities for the disabled & disadvantaged; and improve health and well-being & community integration.

A particular challenge for providers is that where they are seeking new business and a competitive procurement process is not being advocated, they will need to ensure that decision-makers are aware of the services that they can offer and their ability to meet these criteria so that they have some chance of being considered as the "most suitable provider". This is likely to require proactive communication with commissioners but also represents a challenge to commissioners to ensure that they keep abreast of the potential providers and relevant market developments. Some may conclude that, in fact, the best way of doing this is to use the competitive procurement process!

Further good news for providers is that in order to be included in an AQP (Any Qualified Provider) arrangement they will no longer be expected to participate in a procurement exercise to do so but will need to meet minimum requirements such as evidencing their ability to deliver the required service, be registered with CQC and licensed by Monitor (where appropriate) as well as accepting the terms of the NHS Standard Contract and the proposed pricing structure.

Another area of interest to providers and, indeed potential controversy, is the proposal to remove the legal right to challenge contract award decisions through Monitor and to claim for damages although there will be a right of representation to the decision-making body and an option for judicial review.

Although these proposals are initially for consultation before any changes are made to the prevailing regulations, it is clear that changes are on the way which will enable commissioners and providers to work together to ensure that they result in a more efficient and effective system in determining the best providers so as to deliver the "triple aims" set out in "Integration and Innovation" of better health and well-being for everyone, better quality of health services for individuals, and the sustainable use of NHS resources.

Alan Turrell is a former Associate to PCC and on its behalf has hosted workshops on procurement and primary care contracts and has provided bid writing support to many PCC clients. He is a Fellow of the Chartered Institute of Procurement and Supply and is a Chartered Procurement and Supply Professional.

Author
Alan Turrell

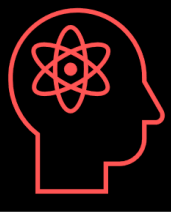
3 ways to be resilient through change

1. Value what you do

Recognise your skills, knowledge and experience – write them down

Acknowledge your strengths

Notice when you do good work



2. Keep up-to-date

Be interested and engaged – that way you can prepared

Ask questions and give your views

3. Look for the opportunity

Think how you can adapt to the change

Be curious and open to try something new

Look after the practice manager

For over a year, NHS staff have been challenged by the response to Covid-19 on a scale and at a pace not previously seen. These pressures have, overall, brought out the best of NHS leaders and practice managers with compassionate and inclusive leadership behaviours coming to the fore.

Not least because has been a particularly hard winter, with the usual winter pressures, the increased targets for flu vaccine uptake, the roll out of the Covid-19 vaccine, the continuation of the Covid-19 assessment hubs, and expectations of service delivery driving back to business as usual (adapting to new norms) and stiving for business as usual, in very unusual circumstance.

While employee wellbeing has been moving up the NHS agenda, with the developments of the NHS People Plan and the NHS Health and wellbeing framework, the last 12 months have really demonstrated the importance of this being thrust to centre stage and remind us all how critical it is to look after the employees within the NHS, because at some stage we will have dialogue with them about our own care.

The GP partners that continue to value their staff and treat them fairly, even under enormous pressure, are much more likely to retain the skills and people they need to bounce back once the crisis is over. As a new virus, it is still unclear how long the threat will last, and practice managers have been working diligently through a plethora of cascaded documentation, ever changing operating procedures in a bid to ensure that they have business continuity to see practices through the many months and a continued period of disruption, at the same time as managing patients expectations in relation to a service provider which has adopted new service delivery models to facilitate patient care continuing in an alternative mode. It will be a crucial test of GP partners agility and people support capability.

There have been many high priority considerations for practice managers in the last 12 months, which have added to their pre-existing workload, including but not limited to.

- Covid-19 guidelines, localised SOPs
- Workplace health and safety
- Employee health and risks
- Hybrid working models.
- Management of bereavement
- Long terms sick leave
- Managing Covid-19 related leave (sickness, isolation, quarantine, shielding)
- Capacity management, in covering sickness absence, along with supporting the staffing other joint ventures such as Covid-19 assessment hubs and Covid-19 vaccine clinics.
- PCN developments, and ARRS role
- Service provisions
- Patient relations and communications.

According to the CIPD Health and Wellbeing at Work Survey 2021, conducted in partnership with Simply Health there has been an increase in the proportion of managers that buy into the importance of wellbeing (67% of those surveyed) although many (46% of those surveyed) lack formal strategy or approach and tend to

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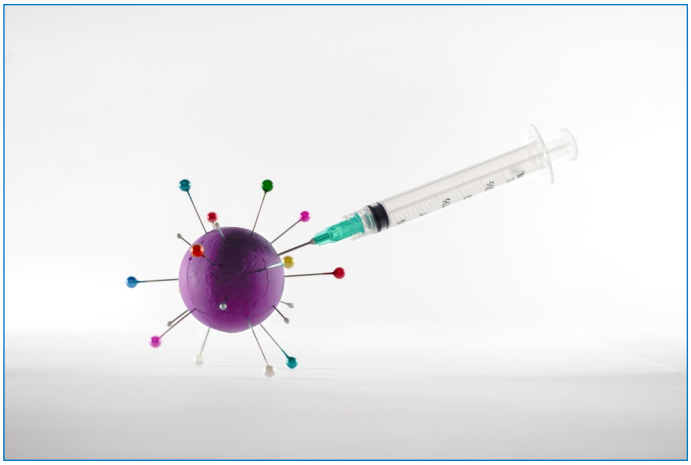
manage workforce well-bring on an ad hoc basis. Covid-19 had prompted an increased focus on mental health, and 57% of employers that were surveyed are making strides in their commitment to their employees in this area.

Most NHS employer's provider basic health promotions such as free eye tests, flu vaccines, links to advice for health eating/lifestyle though private health insurance, discounted vouchers for entrance to health and fitness facilities, and the provisions of counselling services. There are lots of options out there, though many examples of such services rarely reach the right people such as practice managers, whose role it is to continually monitor NHS staff well-being.



The most common triggers for staff reporting mental health in the workplace is stress at work, this is overwhelmingly related to workloads, followed by management styles and the new demands placed upon staff due to Covid-19. More staff are noting the effects of Covid-19 related anxiety (for example fear of contagion in the workplace or on the commute), other effects of Covid-19 related anxiety include personal factors such as personal illness and health concerns, or that of family members, and poor work life balance due to the volume and intensity of the work being carried out over the period of Covid-19.

In November 2020, mental health charity Mind revealed that more people had experienced a mental health crisis during the Covid-19 pandemic than ever previously recorded. Many people are experiencing a range of mental health issues, including stress, anxiety, depression, post-traumatic stress symptoms and burnout, and the effects are anticipated to be long-lasting for some.

This has a real impact on practice managers because they bring a sustained and motivated leadership quality and are the ones who are genuinely and extremely concerned for their practice staff well-being. This responsibly is likely to be apportioned to them on behalf of GP partners, to conduct staff engagement, to provider support and training, to implement systems and analyse the data, all in a bid to understand the problems effecting the practice staff and what solutions are to be implemented in a time/cost-effective manner.

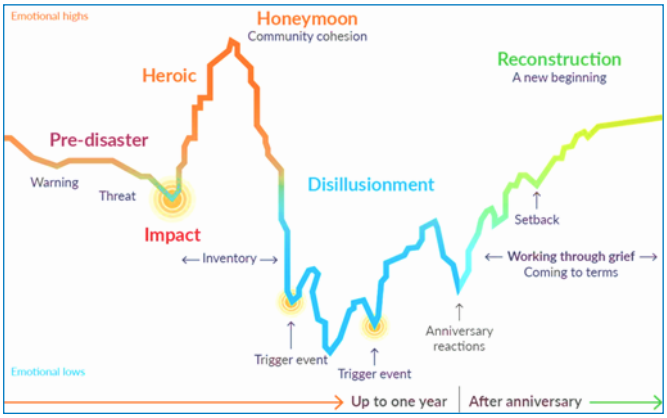
There is a current workplace concern relating to the impact of Covid-19, 70% of managers reported signs of 'Leaveism' meaning they are allocating their time off such as annual leave and sick leave, to try to remain in control of their workloads. Only 28% of managers surveyed said they were confident in their knowledge and ability to manage staff with disabilities or long-term conditions and mental health, of which only 24% of managers confirmed they have received training on mental health at work, which is a likely reflection on the 39% of organisations who have a policy or process in place to support employees with mental health at work.

Many practice managers have conducted the workforce health risk assessments in the last 12 months, and many confess to having to revisit this with their staff owing to the impact of Covid-19, not least if their staff have been symptomatic or been off on long term sick leave due to long Covid, but also recognising the workplace stress, chronic stress and the pandemic fatigue which has set in.

In recent surveys conducted with practice managers during Covid-19 training sessions 75% of them noting that they wish to focus on stress management while 64% also cited they had to start to focus on self-protection. With a common theme arising when they describe the last 12 months in primary care as: demanding, challenging, overwhelming, exhausting, frustrating, pressured, fast paced, being everything to everyone, and undervalued.

When we consider the Trauma curve as utilised by professionals who work with patients who display symptoms of PTSD, is a tool that can help practice managers to visualise the journey taken both individually and collectively with colleagues. This trauma curve will have triggered stress at work for many NHS employees;

Stress being state of mental or emotional strain resulting from adverse or demanding circumstances. adverse or demanding circumstances.



This trauma curve when compared to Maslow's Hierarchy of Needs, gives insight to practice managers that their NHS staff have been looking to their leaders and their employers in ensuring that their psychological and safety needs are met as a priority, little focus in the last 12 months has been on sense of belonging, or self-actualisation/esteem.

Practice managers are in a position whereby the demands they can cope with are superseded with the demand's others place upon them, this can be consuming on both time and energy, with many being described as able or resilient because they can live tumultuously and learn from it or overcome it. Practice managers present as the voice of reason or a process of positive adaption in a time of ambiguity or uncertainty.

It is important for practice managers to assess themselves against Yerkes-Dodson Law performance curve model, because if they are experiencing pandemic fatigue, chronic stress, or burnout they are likely to feel that the workload pressure has become too much and are likely to fall ill or leave.

Some closing tips to help practice managers with managing their own mental health as they continue to lead their teams through the restorative phase to business-as-usual primary care.

Key signs to look out for are:

- Lower productivity
- Change in personality.
- Lacking in energy
- Poor decision making
- Poor time keeping
- Increased sickness absence

Considerations for a Practice Manager:

- Who do you turn to when you are feeling unwell?
- Who supports you when you are feeling stressed, pressured, or overwhelmed?

Self Help tips

- Manage unrealistic expectations; it is ok to say no at times.
- Manage your own expectations of yourself.
- Practice self-care and compassion and attend to your own needs.
- Get downtime form work, you are not paid to be on-call so switch off the phone and emails.
- Connect and network with your colleagues because they may prove invaluable in their support.

Author
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Associate, PCC

A day in the life of a PCC expert adviser – Helen Simmonds

Hello, my name is Helen Simmonds and I am one of the advisers working at PCC. I have been with the organisation in my current role for nearly four years, having previously worked as an associate providing specialist support since 2008.

Someone asked me the other day what was my dream job when I was growing up; I replied in an instant a paramedic, although discovered in my teenage years on a trip to the vet with my beloved dog that perhaps I didn't have the right disposition to realise my planned career path! I guess that is why I have ended up doing this job, supporting the NHS.

I have worked in the NHS for over 20 years and started as a financial management trainee in South Wales. After working for several years specialising in financial management in the acute sector I started working in primary care.

Within PCC I am the regional lead for Wales and support the Midlands region in England, which is quite a wide and diverse area of the country. As well as regional responsibilities each adviser has a lead workstream area; mine is premises.

We have been commissioned by NHS England and NHS Improvement (NHSE&I) national premises team to provide a package of support including introductory training for commissioners on premises matters; exploring the rent reimbursement process for GP premises, improvement grants and an overview of the NHS (General Medical Services - Premises Costs) Directions 2013. We have delivered eight of these programmes virtually over the last six months, to over 250 delegates. We have received lot of interest in this programme, so we will be running it again in the next few months. Keep an eye out on our events calendar for the date.

It is an exciting time for premises. The introduction of the additional roles reimbursement scheme (ARRS) means the numbers of staff based in primary care are set to increase. However, we know that in many cases the estate is not equipped to meet the policy ambitions set out in the Long-Term Plan. Findings from the 2019 GP premises and GP partnership reviews indicated that half

of all GP-owned estate is not 'fit for purpose', whilst a staggering 80% is not 'fit for the future'. The reviews also highlighted the link between declining GP numbers and high levels of personal property liability associated with the current GP partnership model. So, there is lots of work to be done.

We are supporting the NHSE&I national premises team with a number of workstreams including a series of blogs from individuals across the country who work on premises projects, including the pioneer Cavell Centres. These will be launched on our website in the coming weeks. We'll let you know in our newsletters when they're published.

We are working with several PCNs, helping them to develop premises plans to support the delivery of their clinical strategies. With the increasing demand on space we need to think of ways of how we best utilise what is available, taking the learning from Covid-19 and ensuring that we move forward with modern, flexible and adaptable premises to deliver care from.

Another significant part of the support and my daily activities is the dedicated premises helpdesk which has been commissioned by NHSE&I for all regional teams and CCGs to access for advice (until 31 July 2021) Any commissioner can contact for advice on a specific

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premises query. I also support our dental team in the delivery of dental training, helpdesk and surgery advice sessions for all matters dental. We currently provide a dedicated helpdesk for all dental contractors and commissioners in England to answer queries about the year-end reconciliation arrangements for 2020/21, and more recently the contracting arrangements for the first half of the 2021/22 financial year. To date, we have answered over 1100 queries and counting! This support has also included recorded webinars setting out the year -end process and calculations, and commissioner workshops.

Finally, last but certainly not least is my role as the regional lead for Wales. Over the last few years, we have increased our support to the Health Boards and the clusters, as well as support to Public Health Wales for a series of leadership programmes. In the coming weeks, I will be preparing to deliver a series of personal resilience sessions with practice teams in several clusters. These will be delivered via MS Teams and will explore and identify what causes workplace stress and identify tools and strategies to develop personal resilience

So, what does my day look like? I think it can be summed up as busy and varied!

Associate support

Estate strategies

With the increasing need for PCNs to work through their clinical strategies and ensure the estate is aligned to support delivery of the clinical service model; PCC has associates that can help. This includes experienced individuals with skills in estates project and programme management across a range of healthcare settings including reconfiguration programmes, primary and community services estate development combined with business strategy, leadership and motivation of multifunctional project teams covering clinical, technical, legal, financial and infrastructure aspects of healthcare projects and programmes.

Supporting change

Service change and redesign is continually happening, as we start the journey towards the new normal the challenges include how best to manage those who have been waiting for care, or not presenting when they needed care. The tsunami of demand that will result will drive the need to change services. PCC can support the changes that you may need to make – whether its redesign in general practice, to keep the best of the changes that happened during the pandemic, or to work at system level to redesign patient pathways. We have experts in project management and change skills.

Support when it's needed

The pressure on practices and primary care networks is unrelenting with the important to do list overtaken by the urgent. Areas such as staff training and development or future planning may not be top of the list but are still essential. PCC has experienced practice managers and trainers who can support. Whether it is a one-off task, a training workshop or management of a longer project, such as relocating services.

Service reviews, strategy development and programme management

PCC can support organisations to undertake comprehensive service reviews of patient pathways, identify improvement opportunities and support their implementation. Our associate team have experience in supporting partner organisations with integrated care system development, including a series of roundtable events, aligning the commissioning system and supporting staff through the period of organisational change. We have team members who have supported a range of organisations developing strategies relating to building inclusion and equalities and diversity. Our associates have excellent experience in programme management in particular supporting primary care networks, access, resilience and workforce programmes.

Contact enquiries@pcc-cic.org.uk to discuss how we can support you.

3 ways to motivate your team through uncertainty

1. Empathise

Listen to concerns and worries – don't dismiss them

Acknowledge how people are feeling

2. Communicate

Keep people up-to-date with frequent, clear information that is easy-to-understand

Even when there is no news check-in and reassure

3. Praise

Notice the good work people are doing

Tell them so - be specific and sincere

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