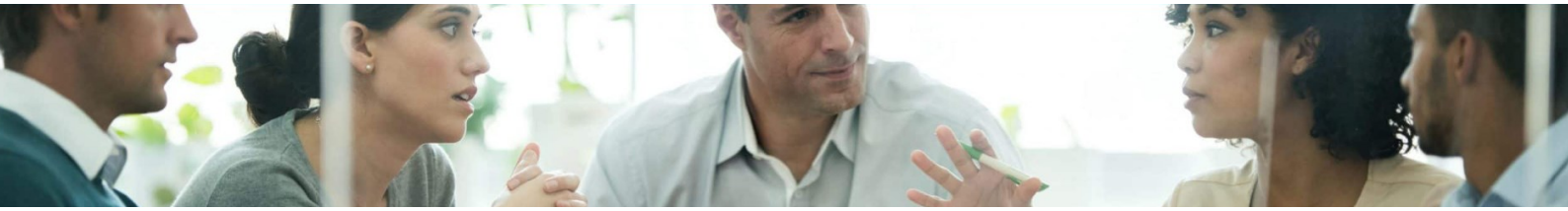
Insight

August 2023



PCN future and stabilising dental services

Welcome to the August edition of PCC Insight. This edition considers the future for primary care networks (PCNs), with a strong case being made for them to morph into integrated neighbourhood teams. With this direction in line with the Fuller stocktake and more care being managed outside of hospital, using virtual wards and with multidisciplinary teams embedded in general practices and PCNs, it seems a likely direction.

The theme of multi-disciplinary and multi-organisational team working continues as we look how West Malling successfully embedded the community pharmacy consultation service in their day to day working. Recruitment and retention of GPs and how to identify the local factors that can make a difference is considered.

There is a case study on how the South West implemented services to stabilise dentistry to support the current demand for urgent dental care, improve oral health and ensure improved access to dental services for those patients who don't meet the urgent care criteria. We also look at the equalities responsibilities for NHS organisations – and ask are you ready for the equality test? We finish with a question from our contractual helpdesk – a service that is becoming increasingly well used by integrated care boards.

If you have a case study you wish to share, we look forward to receiving it for the next edition.

Author: Helen Northall, Chief Executive, PCC

What next for primary care networks

Nationally some primary care networks (PCNs) are finding themselves increasingly hamstrung by the lack of any clear policy direction by NHS England and with the upcoming GP contract review there is uncertainty as to what is coming next. We know the five years of the PCN directed enhanced service (DES) ends in March 2024. Given the position of the Government and next elections will the contract review be a mere role forward for a year or a full five-year refresh?

The question is whether it is worth investing time and effort into the PCN given the chance that things may all change again in a little over nine months. Life for PCN clinical directors, managers and leaders is tough enough, without having this additional uncertainty to contend with. How real is this uncertainty, and how likely is it that PCNs will be replaced by something new in just a few months' time?

What is the big picture? Our NHS has entered the new world of integrated care systems (ICSs). It is fair to say that even those working in these new bodies are finding it hard to fully get their heads round what they are supposed to be doing. The latest noise from the Government following the Hewitt Report on ICSs suggests that they are going to remain the overall direction of travel for the NHS into the near future, irrespective of the potential change of Government.

ICSs are built on the notion that all the different parts of the NHS system (and to an extent local government) work together in partnership to improve the delivery of care for patients. General practice is one of these parts of the system. Historically the system has found it impossible to partner with the multitude of GP practices across the country, which was the main driver behind the introduction of what is now 1200 plus PCNs established (at least in theory) around neighbourhood areas.

Given the ongoing push for partnership working across the NHS, it therefore seems highly unlikely that there will be a backward step from the joint working between practices that PCNs have created. While this will undoubtedly be much to the disappointment of the many GPs and practices who dislike the requirement to work with other practices

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through PCNs, this unpopularity will not result in a national reversion to practices as the primary unit for the delivery of resources into general practice.

We will see a move to strengthen the joint working between practices across neighbourhood areas that has been developed over the last five years by PCNs. The question is whether this will remain as PCNs per se, or whether these will be changed into something else. The biggest clue we have as to that question is in the Fuller Report, which states that PCNs are to "evolve into" integrated neighbourhood teams. It describes these in this way,

"This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities." Fuller report p6.

The key question appears to be whether an integrated neighbourhood team replaces the PCN, i.e., once there is an integrated neighbourhood team there is no longer a PCN, or whether the PCN represents the group of GP practices that are participating as a group in the local integrated neighbourhood team, which has a much wider group of participants than the PCN. This latter option appears to be the one being adopted by those places that do claim already to have integrated neighbourhood teams.

So, the outcome is that PCNs remain. Even Labour's health policy is to create a **"Neighbourhood Health Service",** which very much looks like it has PCNs at the centre. In fact, given the current policy void, it is hard right now to envision a future in which there is not something PCN-shaped that continues to be the conduit for most additional resources coming into general practice.

While none of us know for sure what the future holds, it does seem a safe bet that NHS England and the Government will want to build on the progress they have made through PCNs beyond March 2024. There is a chance that the name will change, but it seems extremely unlikely that the scale of working will alter as there have been no pointers in any other direction. The pressure for the PCN unit to build more effective partnerships with system partners will undoubtedly grow, but the core unit of the group of practices as a PCN seems destined to remain.

Author
William Greenwood,
Chief executive, Cheshire LMC, and governing body member of PCC.

GP Retention and Recruitment: What are we going to do about the GP crisis?

As you will know, most health systems are struggling to recruit and retain GPs.

A recent BMJ Open, publication revealed that in one region, 42.1% of GPs intend to leave or retire from NHS general practice within the next five years compared to 31.8% of those surveyed in the same region in 2014, an increase of almost a third.

With over one in 10 (16%) of respondents to a recent (2023) BMA survey advising that they plan to leave the NHS altogether after the COVID-19 pandemic, losses are set to continue further if the Government does not take appropriate action.

NHS Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) understood that it is therefore very important to attempt to better understand the prospects and the reasons for them, locally. STW commissioned Primary Care Commissioning (PCC), to help gain this crucial insight.

What we did:

Spoke to key stakeholders to ensure a good understanding of local issues; we did not assume that they were exactly the same as national issues.

Working with the ICB, devised four separate, but related surveys to ask respondents about their experiences in relation to GP retention:

- Fully qualified GPs
- Graduate Doctors in Training
- Foundation Year Doctors
- Medical Students

With a further survey targeted at recruiters of GPs, i.e. mainly the GP practices.

The ICB circulated the surveys via key stakeholders and other internal communication methods, appropriate for each target group. All GPs working in the ICB area were invited to respond, whether working permanently, or on ad hoc basis in the area.

The response rate was respectable, with an estimated 33% of responses from GPs

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(difficult to exactly assess due to being unable to be sure of locum numbers), and over 50% of responses from graduate doctors (50 out of approximately 90).

The findings were shared for the purpose of gaining a “sense check” on what the results said and proposed ways forward.

Findings:

As expected, many of the findings follow a national trend, and are outside of the gift of STW ICB.

However, a number of findings pointed to local challenges that could be further investigated or local solutions devised, with the ICB working in partnership with GP practices.

Findings outside of ICB control will be considered for future lobbying, using the evidence base that the research has identified.

The work was funded utilising the GP Retention Funds allocation. PCC would be happy to work with other ICBs in order to build this evidence base and identify/develop local solutions that could have a positive impact via local interventions.

Phil Morgan, the Primary Care Workforce Lead for STW ICB said “We’ve been really pleased with the work carried out by PCC to help us better understand the key issues and challenges facing our GPs. The consultant who designed and delivered the surveys, and then analysed and reported on the results, had an excellent understanding of the current issues facing General Practice and engaged professionally and effectively with a wide range of stakeholders across our ICB. We’re confident that PCC’s involvement will help us in our overall objectives in recruiting and retaining more GPs in our practices. We would have no hesitation in strongly recommending PCC to carry out similar work in other ICBs”.

Author
Adrienne Taylor
Associate, PCC

Are you ready for the Equality test?

Equalities have been at the centre of the NHS since it was founded, with the core principle of care for **all** based on clinical need alone. While some politicians and commentators might suggest there is too much of a focus on equalities in the NHS, this government's 2022 Health and Care Act places a comprehensive new range of obligations on commissioners and provider organisations to monitor, assess and formally report on equalities and health inequalities issues.

The equalities responsibilities for NHS organisations fall under two broad pillars. First of these are the duties under the Equality Act 2010 and its Public Sector Equality Duty (PSED), looking through the lens of the nine protected characteristics set out in the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race/ethnicity, religion or belief, sex, and sexual orientation).

These responsibilities should be familiar to those working in commissioning organisations as these duties fell on CCGs before the creation of integrated care boards (ICBs). This includes the need to have regard to the three general aims of the PSED in the "exercise of their functions" (These are eliminating unlawful discrimination, harassment and victimisation; advancing equality of opportunity; and fostering good relations).

Importantly, public bodies are required to report and publish equality information annually, including information on its employees (for organisations with more than 150 staff); gender pay gap reporting and information on "other persons affected by its policies and practices" (ie service users). Public bodies are also required to publish at least one Equality Objective. These need to be specific, measurable and reflect "the impact of its policies, practices and functions on people with different protected characteristics".

What has changed following the Health and Care Act 2022 is that the Equality and Human Rights Commission (EHRC), which is responsible for monitoring and enforcement under the Equality Act 2010, has clearly signalled to ICBs the need to comply with their responsibilities in this area. The Chief Regulator of the EHRC wrote to ICB chief executives in February 2023 reminding them of their obligations under PSED, including reporting and development of equality objectives, and that it will be closely scrutinising their delivery in this area over the coming months. The EHRC also identified a number of priority areas for action.

The second pillar concerns the distinct, but related, action taken to address health inequalities. These duties have a separate base in NHS Legislation. The 2022 Act

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drew on the stark inequalities seen in the Covid-19 pandemic, bringing forward requirements for the NHS to assess, act and report on health inequalities.

In particular, this requires ICBs to have a specific focus on reducing health inequalities around peoples' access to services and in the outcomes achieved. In addition, ICBs are required to address health inequalities when they are promoting integration of services and making decisions about "the exercise of their functions".

To assist ICBs in this area, the 2022 Act says that NHS England should publish a statement on the powers available to NHS bodies on collecting, analysing and publishing information about inequalities in access and outcomes and on how bodies should exercise these powers. While NHS England has gone a long way in setting the strategic direction for health inequalities with its CORE20plus5 strategy, it has yet to publish this formal health inequalities statement, though its development is likely to be well underway.

To underline the importance of health inequalities as a strategic priority for ICBs the 2022 Act required that each ICB's annual report should explain, in particular, how it has discharged all these health inequalities duties and review "the extent it has exercised its functions" in line with the NHS England health inequalities statement. Further to this, the 2022 Act requires NHS England to performance assess each ICB on their delivery of these health inequalities duties, with NHS England publishing its own report summarising the summary results of the ICB performance assessments.

Put together, these new changes provide a substantial equality test for ICBs to meet on an annual basis, with NHS organisations required to account and formally report annually for the separate scrutiny of the EHRC and NHS England.

Fortunately help is at hand, with the recently published reporting[1] by NHS England providing a template for Equality Act reporting, (but for a much bigger and broader organisation). The EHRC have indicated they intend to take a collaborative approach to support and share good practice with ICBs as they meet their obligations in this area.

Likewise, the CORE20PLUS5 approach sets out NHS England's current thinking on health inequalities in advance of it publishing its formal statement under the 2022 Act.

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That said, management teams will have to start action now to define and refine their approach in these areas if they are to be confident of meeting the reporting deadlines in 2024.

John Paul is able to support ICBs in this area of work, contact enquiries@pcc-cic.org.uk for more information.

John Paul studied as a biochemist and trained as journalist. Over the last three decades he has worked as a policy implementation specialist and communications advisor to senior leaders at the Department of Health, NHS England and other health arms-length bodies. For the last few years he has been working as a consultant to NHS England's equalities and health inequalities teams.

Author
John Paul Maytum MBE
Associate, PCC

[1] Currently under https://www.england.nhs.uk/publication/nhs-england-public-board-meeting-agenda-and-papers-18-may-2023/

South West dental stabilisation programme

During the pandemic demand for urgent care increased significantly. NHS England South West commissioned additional urgent care during this time through a variety of models to try and best meet demand. Unfortunately, for those receiving treatment through an urgent care pathway, they are often unable to then find a dentist to complete a more permanent solution, which can lead to them accessing urgent care on numerous occasions. This reduces the number of appointments available to other patients and is unsatisfactory - for patients repeatedly accessing urgent care and for the staff treating them.

In addition, many people also suffer from dental pain or other issues which do not meet the threshold for urgent dental care and do not have access to a regular NHS dentist.

Over spring and summer 2022, NHS England commissioners, clinicians and career development fellows developed a stabilisation pathway, which would ensure patients were able to access care that would stabilise their oral health and would reduce the likelihood of people going in and out of the urgent care system, or of receiving no treatment at all – providing a more permanent solution, improving patient care and improving satisfaction for clinicians.

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It is believed that stabilisation will, in time, reduce demand on the urgent care system, ensuring those needing urgent care are able to access the service when they need it most.

Benefits of stabilisation

Stabilisation supports the current demand for urgent care, improves oral health and ensures improved access to dental services for those patients who currently don't meet the urgent care criteria.

It is hoped, over time, that provision of stabilisation will be of benefit because it will/may:

- reduce the number of people repeatedly accessing urgent care
- release more urgent care capacity to other patients
- reduce the number of people waiting in pain for their dental problem to meet the criteria for urgent care
- improve the oral health of the population in the South West
- improve the oral health of individuals, which could lead to them being found a permanent dental home with a high street practice.

Service provision

The proposed model was originally two pronged – utilising both the community providers, and high street practices, providing more choice/accessibility for patients.

Community providers – salaried model

The proposal was to fund an additional salaried post in each integrated care board (ICB) area to provide stabilisation services within the community provider. Unfortunately, no community providers have been able to progress with the stabilisation programme as they have been unable to recruit to these salaried posts.

High street model

Interested contractors were asked provide stabilisation on a sessional basis within high

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street practices. There are two sub-elements to this offer:

1. stabilisation for those without a regular dentist who require dental treatment (i.e. general access stabilisation)

Since the commencement of the pilot programme 37 practices across the South West have participated and over 450 patients are seen each week.

Positive feedback has been received from the clinicians involved in the stabilisation pilot so far – the sessional rate and model allows for more time with patients; the work is varied; and there is satisfaction in providing treatment with stabilises the dental and oral health of the patient.

2. stabilisation focussed on our health inequalities groups, with additional support from a practice-based champion and local voluntary, community and social enterprise (VCSE) partner organisation

This element of the programme has commenced but has had less pickup than standard stabilisation for the general population due to the need to involve the voluntary sector and the additional time this takes, but a homelessness initiative and an asylum seekers programme has started.

Patient pathway

Access to stabilisation is through NHS 111, dedicated local dental helplines where in place, or direct via the practice, for the general population, but through a more tailored and supportive outreach route for the health inequalities groups.

Urgent care need

Patients meeting the criteria for urgent care are booked an appointment and, following clinical assessment, may be selected for stabilisation. For example, the clinician may notice a further problem, which although not qualifying for urgent care now, may require the patient to attempt to access urgent care in the near future. Following clinical assessment, the patient may be offered stabilisation to provide a more permanent solution to other dental issues they may have. They, of course, have the right to refuse further treatment.

Non-urgent care need

- Patients accessing care via NHS 111 (or dedicated local dental helpline) and who

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do not meet the urgent care criteria may be selected for stabilisation for the following reasons:

- mild or moderate pain that is not associated with an urgent care condition and responds to pain relief measures
- loose, broken or displaced crowns, bridges or veneers
- broken, lost or ill-fitting dentures
- broken or loose fillings

Health inequalities groups

This uses a high street practice model, working in collaboration with a local VCSE partner organisation. The practice delivers one session of stabilisation a week. A practice-based champion (dental care professional) delivers 2.5 hours of outreach once a week – they are responsible for raising the profile of the service and developing the integrated pathway with a partner VCSE organisation in the locality. The VCSE organisation identifies patients requiring dental treatment, liaises with the practice-based champion, makes the dental appointment and can provide chaperoning.

The pilot is continuing into 2023/2024. If you would like more information on the programme please contact Jo Lawton on jo.lawton2@nhs.net.

Rural practices in Malling PCN share CPCS rollout success

Two practices in the Malling Primary Care Network (PCN) have demonstrated the benefit of rural dispensing practices referring to the Community Pharmacist Consultation Service (CPCS).

Malling PCN in Kent and Medway was one of the first PCNs to go live with the CPCS in July 2021. The CPCS enables GP practices to refer patients with minor illnesses and self-limiting conditions to a community pharmacist that day or the next day.

Referrals to the CPCS have saved and repurposed clinical time in Malling PCN, releasing 40 hours for healthcare professionals at the five practices over the first

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four months. The service has also freed the capacity for complex cases, strengthened links with pharmacists, improved patient access, and ensured patients receive swift support for minor illnesses without adding to reception teams' workload.

Positive mindset helps practice teams get on board

The PCN consists of five surgeries serving around 60,000 people. Snodland, Thornhills, Medical Practices and West Malling Group Practices are in the urban area of Aylesford in West Kent. The other two are the semi-rural Wateringbury Surgery near Maidstone and the rural Phoenix Medical Practice in Burham – both dispensing practices.

Some dispensing practices in rural locations and, therefore, not close to pharmacies wondered whether people would want to travel to them. However, Phoenix and Wateringbury had no problems implementing referrals to CPCS.

Senior care coordinator Pam Lake, who managed the implementation across the PCN, said: "We can attribute this to how we rolled out CPCS and how both practices made sure staff were on board and understood the positives. We also held meetings with pharmacy leads and agreed on how the service would be rolled out."

Practices/PCNs and local pharmacists worked together to agree how the service would work, ensuring the service rollout was straightforward. Regular communication and feedback from each remains a vital part of how the CPCS works successfully.

Ongoing training vital to successful implementation

Before the CPCS went live, one of the PCN's training afternoons was to advise clinical and reception staff on what CPCS was about and how it could be beneficial and fulfilling to work with pharmacy colleagues to help manage the practice workload. Protected learning time was also ringfenced for training delivered virtually and face-to-face.

It's vital to ensure ongoing training, says Senior programme manager Nicola Flisher, part of the Primary Care Transformation Development and Improvement team.

She said: "We recognise that perhaps because of Covid, general practice has seen a high turnover of reception staff, and some of their knowledge and understanding

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was lost. So, we're re-engaging and have started refresher training for the whole PCN."

Rural practices rise to the access challenge

The initial concern of the two rural practices was whether their patients could access a pharmacy. While pharmacies are usually close to a GP practice in urban areas, patients in rural locations may not be able to access a pharmacy easily without travelling to a town or city.

The question was uppermost in Nicola's mind when she looked at the service specification with the CEO of Kent Local Pharmaceutical Committee (LPC) at the start of the PCN's CPCS journey.

Nicola said: "The patient receives a telephone consultation from the pharmacist in the first instance. In most cases, the pharmacist can deal with the patient's condition with advice and guidance over the phone. If a face-to-face appointment is required, the pharmacist will arrange this with the patient. This was a local agreement between pharmacy contractors and the practices."

Although patients can always see a pharmacist face to face for CPCS, national CPCS data shows that three-quarters of CPCS consultations are held by telephone when referred by a GP.

The phone consultation process is seamless: the patient contacts the GP practice, which generates a referral, and the pharmacy calls the patient. If the pharmacist needs to escalate back to the practice, the pharmacist takes ownership of that escalation. The patient then gets a return call from the practice.

Patient-led choice helps improve referrals

Wateringbury and Phoenix are increasing referrals because they are led by patient choice and convenience and refer across the board to various pharmacists.

Referrals generated*

- Phoenix – 188
- Wateringbury – 85

*Between July 2021 and May 2022

CPCS supports patients to access the most appropriate service at the right time.

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CPCS champion helps to drive referrals

According to Nicola, the PCN owes its CPCS success to a strong leader like Pam. She said: “I encourage every practice to have a CPCS champion to encourage receptionists to do at least one referral per session. That’s why it worked in Malling.”

Nicola also packaged all the information required by the practices, making implementation as simple as it could be from a practice management perspective. The pack included content for their websites, scripts to read to patients, and FAQs for patient participation groups.

In addition, at Malling, the LPC plays a crucial role in providing training to the pharmacies. It sends updates and a weekly newsletter to improve learning by responding to feedback and to ensure messages such as the need to close off referrals are cascaded to the people delivering the service.

What next? With the GP CPCS Investment and Impact Fund (IIF) PCN target achieved, the focus at Kent and Medway is now on reviewing and improving the quality of referrals and ensuring pharmacies and practices have the tools and resources to support them.

This toolkit is available to support general practices and PCNs.

Access the CPCS service specification.

Download the toolkit for pharmacy staff.

Primary care contract question – ask a friend….

Q. Do you know if a breach notice be issued for failure to satisfy a remedial notice for a dental contractor?

PCC does. We are a social enterprise that has supported the health and care service since 2009. Our team have supported NHS England at a local level, and nationally, including work to draft policy and guidance manuals for primary care contracts. We have affordable annual contracts that include helpdesk support to answer these types of questions as well as providing discounted access to training, events, bespoke facilitation, leadership development, e-learning, and consultancy.

A. In answer to the question…..

When issuing a remedial notice for a contract breach, the notice must specify what the remedy is, such as providing information, meeting contracted hours, updating equipment. At times the contractor may not complete the remedial actions (fully or partially). When the actions aren't completed, the commissioner has various options available to them, including extending the time period to satisfy the notice or even terminating the contract. However, in the past some commissioners have looked to issue a breach notice for the failure to satisfy the remedial notice. This was looked at by NHS Resolution in case SHA 19988 (January 2019) where it stated in the ruling "…it is clear to me that the Regulations envisage a specific possible consequence of non-compliance of a remedial notice. This consequence is not the issue of a breach notice."

If you would like to discuss how you can access trusted affordable support, contact enquiries@pcc-cic.org.uk.

Upcoming PCC Events

GP premises - the rent reimbursement process

Tuesday 19 and Thursday 21 September 2023 (14.00-16.30)

Online training session

https://www.pccevents.co.uk/2998

The Confident Leader Programme

Tuesday 19 September 2023 to Thursday 25 April 2024 (13.00-16.00)

Online training session

https://www.pccevents.co.uk/2938

Understanding the voluntary and community sector

Tuesday 19 September 2023 (13.00-16.00)

Online training session

https://www.pccevents.co.uk/2870

Improving your presentation skills

Wednesday 20 September 2023 (09.30-12.30)

Online training session

https://www.pccevents.co.uk/3023

Full events calendar https://www.pccevents.co.uk/calendar

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