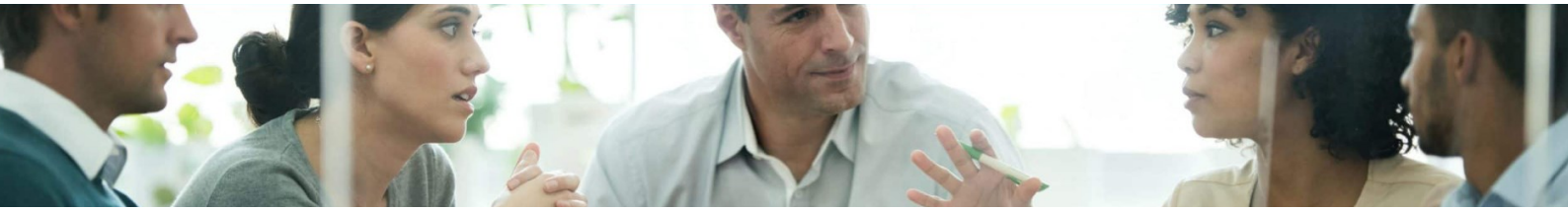
Insight

February 2024



Taking a strategic approach to primary care

Welcome to the February edition of PCC Insight. This edition considers premises investment, an example of the development of a provider collaborative to ensure that the voice of primary care is heard at the decision-making table; considerations on ensuring that business continuity plans are in place across primary care networks (PCNs) and an article exploring the contribution of optometry services.

The challenges for primary care are immense at the current time and with financial pressures affecting commissioners and providers alike it's important that integrated care boards have a strong primary care strategy to guide future decision making. The strategy should include all four primary care contractor groups. It should look at the wider links, such as supporting reductions in demand for A&E and enabling hospital discharges.

The strategy needs to be able to support ICB decision making. For example, will it help the ICB make decisions on the commissioning of additional primary care dental services from any underspends – to ensure that they link to population health improvements. If the strategy isn't robust enough there is a risk of commissioning services offered by dentists, rather than commissioning services to address priority areas where there is proven effectiveness.

Continued...

It's vital that the strategy thinks through the future footprint of primary care, considering what the ICB may do to secure primary medical care services should a practice hand back its contract. Would, for example, the ICB wish to work with a PCN to secure services in the first instance, being mindful of the contractual forms that they can use to commission primary medical care services. There then needs to be consideration if this can be enabled, including the impact of the new provider selection regime.

It's also a difficult time for community pharmacy. Although Pharmacy First is going live, and there are opportunities for pharmacists to develop their roles, the number of pharmacy closures, and reductions in opening hours, will impact on the ICB's strategic plan for primary care. To seek to address these issues it may be necessary to discuss bringing forward the pharmaceutical needs assessment refresh, for which the local authority's health and wellbeing board has responsibility.

There is also a requirement for ICBs to draft their infrastructure strategy. Primary care is integral to this strategy PCNs have developed their clinical and premises strategies, and these need reflecting in this document.

It is a busy time for ICBs – and they need to get the foundations right for future primary care decisions.

PCC supports the majority of ICBs, if your ICB needs help contact enquiries@pcc-cic.org.uk

Author
Helen Northall
Chief Executive, PCC

Supporting general practice in 2024 and beyond

At PCC we have been listening to general practice and PCNs about what affects them and the areas where support would be welcomed. As a result, from January, we have been sharing ways in which we can provide support that will deliver results. We have built on the national support that's available around access, but we are also focussing on three key areas that underpin sustainability – finance, workforce and premises. We'll provide updates in upcoming editions of Insight as well as in our weekly newsletters and on our website.

In this article we consider the importance of a well-constructed project initiation document (PID).

The PID

Once the need for a development has been identified, one of the most important steps is to develop the PID which demonstrates the case for change and the aims, objectives and benefits that a preferred premises solution would deliver. Having a compelling PID document can significantly increase the chances of securing support for your premises development ambitions.

The purpose of the PID is to ensure that your integrated care board and other stakeholders are aware and can commit to support, in principle, the development of the proposed scheme and that the GPs are prepared, as appropriate, to commit to relevant costs associated with the next stage of the scheme development or any abortive costs arising should the scheme not progress.

Completion of the PID should be undertaken as soon as the themes and main details of the proposed scheme are known.

The completed PID will:

1. Set out the context: size and location of the GP practice, training and CQC status

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2. Confirm the registered population including historic growth, future housing development that might impact on future demand
3. Describe the existing premises: type of building, number of clinical rooms, existing space constraints – articulating what is wrong with the current arrangements and how does this negatively impact on service delivery to patients
4. Identify the workforce: current and future, including hosted ARRS roles
5. Confirm the opening hours and any plans to change
6. Reference the status of PCN / Place / ICB estate strategies - will this practice's premises improvement needs be seen as a local priority?
7. Set out clear objectives, service improvements and benefits the practice are trying to secure (including net zero and digital ambitions)
8. Identify the preferred premises solution, including:
   a. scope: include high level (1:200 scale) architects layout plans
   b. scale: increase in key functional content i.e. how many additional clinical rooms
   c. costs: capital costs including construction, professional fees, equipment, contingency, VAT
   d. implications for commissioners i.e. what is the likely level of rent reimbursement compared with current.
   e. indicative timescales
   f. likely risks and how these will be mitigated
9. Set out the procurement strategy and delivery model i.e. is this to be a GP- led 'self-develop' scheme or will the practice procure a third party developer to fund and manage the development process to completion. If GP led, will the partners be seeking a capital grant from the NHS (up to 66% of total development costs)?

PCC can help you with the development of your PID to ensure that you present the best possible case for the funding for your premises development project. Our expert team has a proven track record in helping practices develop credible and compelling PIDs.

To find out more information please contact enquiries@pcc-cic.org.uk or see https://www.pcc-cic.org.uk/practice-support/ to find out more.

Author
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Making the system work - general medical practice representative and formal structures in Cheshire

Introduction

This short paper highlights the key developments in Cheshire to ensure there is an active and effective interface between general medical practice service (GMS) providers and the Integrated Care Board (ICB) of the Cheshire and Merseyside Integrated Care System (ICS).

Background

Cheshire was previously divided into four former Clinical Commissioning Group (CCG) footprints. In 2019 and following a detailed communication and engagement exercise the four CCGs merged into a single CCG for the whole of Cheshire. This did cause some local concern at the loss of the 'member' practice interface arrangements with the principal NHS commissioner of services.

The former CCGs would have had between 18- 25 practices each and this changed to around 80 with the single CCG. Many GPs feared a loss of 'voice' with the commissioner especially as Cheshire has a diverse geography with city and rural areas, and pockets of deprivation which due to the area did not always show up in statistical reviews. The same can be said for our traveller and 'boat people' (those living on canal boats) populations.

Local representative and commissioning links were well managed and most GPs fears were resolved due to the work the new merged CCG put into the process.

Just over 18 months ago we saw the disestablishment of CCGs and the emergence of the ICS structures. In Cheshire's case an ICS for Cheshire and Merseyside with nine former local authority areas and significantly different former approaches to developing and financing general medical practice development.

Former CCG member fora and representative links with LMCs, GP federations and primary care network (PCN) clinical directors (CDs) were replaced by new arrangements either at a 'Place' (local authority level) mainly for PCN CDs or via an ICS developed Primary Care Provider Forum. The GP voice in commissioning appeared to have virtually disappeared except via Local Medical Committees place within the NHS Acts and Place arrangements with PCN CDs.

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Most practices felt distanced from the ICB central primary care team and having to work through very small Place teams with no direct contact to the ICB or NHS England.

Why do anything (and developing arrangements)?

It was clear the ICB found the thought of having to work with over 350 individual practices across Cheshire and Merseyside as too much for them. This was aided by the centrally commissioned Fuller Stocktake Report which was written for an ICB audience. PCNs were to be front and centre in future planning even though they had no statutory legal structure; being a voluntary add on to the national GMS contract arrangements.

Whilst there was no suggestion this would change the direction of travel was clearly “let’s see how things develop ‘organically’ at a local level.” Mature PCNs might incorporate and become super practices or similar without the need for NHS England or ICBs to dictate it. Increasing the proportion of funding going direct to PCNs rather than via the GP national contract was obviously aimed at achieving this outcome.

In Cheshire two Place structures were established to match local authority areas. Each with its own small ICB outposted staff and a senior accountable officer (Place director) who was part of the ICB senior structures. The GP practices were aligned to each of these dependent on geography.

Above this structure sits the ICB of the ICS. The ICB being responsible for GP contracts and the PCN directed enhanced service (DES) amongst other roles. Places have delegated authority and funding from the central Cheshire and Merseyside resource.

Separate to these structures sit NHS England (Cheshire and Merseyside) a subset of NHSE North West England.

Shortly after its establishment the ICB established a Primary Care Providers Forum which included all four-family health service independent provider professions (each local representative committee having one representative and two for the LMCs), plus representatives for PCN CDs and GP federations. This was not a decision-making committee but one which fed into the ICB making recommendations and putting forward proposals. After 18 months this was not felt to be adding value and so a proposal is currently being discussed to modify the terms of reference and structure of this set up.

Separate to the above ICB led forum the following structures are in place (as they relate to GMS).

Cheshire LMC reformed its constitution so that it’s 18 constituencies reflected the 18

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groupings of GP practices making up the 18 PCNs. (note each of the GP federations has a co-opted seat on the LMC as do the two PCN CDs who sit on the ICBs Primary Care Provider Forum).

The LMC, GP federations and PCN CDs agreed to form to GP provider collaboratives, or confederations, (one per local authority area) to act as a single voice for general practice locally. Mandates were obtained from all practices in each area and steering groups set up to develop the structures and support. These two confederations meet monthly to discuss a range of issues and outputs are agreed and fed up to Place, the ICB and Local Authorities as required. Discussions are also fed into other fora as required (such as via the LMC to the Cheshire and Merseyside Association of LMCs). This multi-LMC arrangement was set up by the five local LMCs within the ICB geographic footprint just before the ICB came into existence.

Each Place has been tasked with establishing strong interface links between primary and secondary care. This work incorporates the ICB document 'Consensus on Primary and Secondary Care Interface'.

The LMC in Cheshire is central to many of these new arrangements as it had existing formal and informal links to the organisations across Cheshire.

Summary

Work on the two Confederations is still in its early phases. All practices have provided a remit for their respective Confederation to act on their behalf in matters discussed with Place and the ICB. Each Confederation has established a programme of monthly meetings involving all local GP practices and PCNs. They have been recognised by the ICB as part of the local engagement and collaborative working arrangements as described above.

Work is underway to put in place a GP capacity in primary care alert system (like the GPAS system used in Devon). This is fed into the two local Place teams and shared with LMC, PCN CDs and GP federations. The ICB has been asked to agree supporting the establishment of the Confederations by providing time from the two Place teams. This has been agreed.

It is not perfect but we do have a functioning way in which all local practices and their PCNs can engage at ICB Place level. The Confederation steering groups can then agree on which part of the general practice 'family' can best take the matter forward e.g., LMC/ PCN CDs etc.

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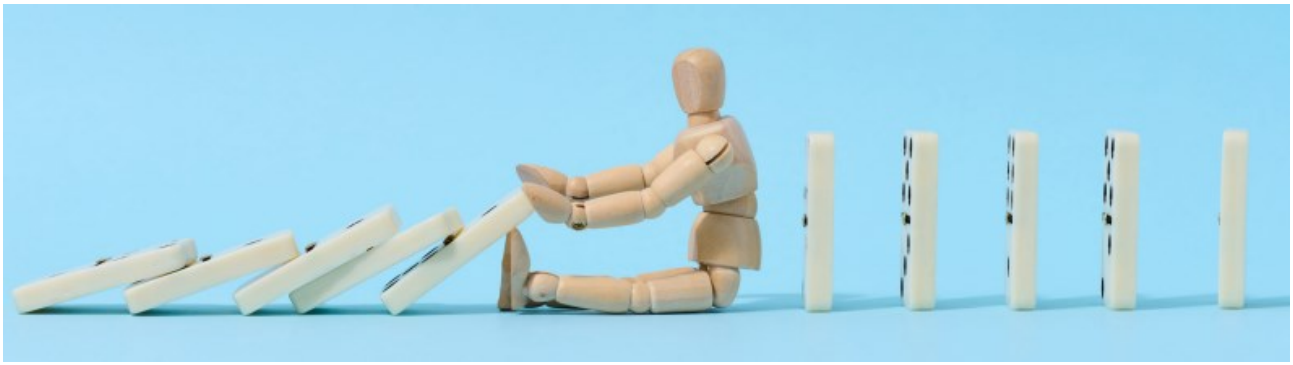
One current area of development is a prospectus of what GPs can and will do; what they won't do; and what they might do if the funding is agreed.

We will continue to learn form our experience and develop a flexible approach to ensure all our practices feel engaged in future decisions and planning across Cheshire.

Author
William Greenwood, governing body member of PCC and Chief Executive Officer for Cheshire Local Medical Committee.

Develop your personal resilience

Our lives are filled with highs and lows, accomplishments, and hardships. Throughout them all one quality can helpfully surface: personal resilience. Resilience is a skill that can be developed and strengthened over time. By assessing and recognising your current resilience, you can take steps for transformation which can help you to tackle challenges with courage and determination.



Here are my top five suggestions for developing your personal resilience

Tip one: Creating a positive mindset.

Learn to challenge negative thoughts. Creating a positive internal dialogue can increase your confidence and help you maintain a resilient outlook.

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Tip two: Increasing adaptability.

The only constant is change. Acknowledging that change is inevitable allows you to react in a professional and constructive fashion.

Tip three: Having a realistic outlook.

Take time to find a new perspective – think about what the most probable outcome may be. Breaking down challenges into more manageable steps can help build confidence and cement your sense of resilience.

Tip four: Leaning on your support network.

When faced with a challenging situation, remember there are colleagues, friends, or family to support you along the way.

Tip five: Look after yourself.

Personal wellbeing can suffer when we are faced with a challenge or set back. It is important to look at what helps you, for instance exercise, diet, and sleep to maintain a healthy body and resilient mind.

Develop your personal resilience is one of the workshops PCC offers. See our event calendar for more details.

Author
Barrie Sample
Personal and team development trainer, PCC

Uncovering optometry's valuable role within the NHS

The combination of an ageing population and technological advancements means that the optometry sector is experiencing its highest demand to date. Accounting for one of the four key pillars of primary care, optometry plays a not just a vital role but makes crucial financial efficiencies within the NHS.

This article uncovers how Primary Eyecare Services, England's leading not-for-profit provider of NHS-funded enhanced eye care services, is benefitting the wider NHS by alleviating GP and hospital pressures, reducing health inequalities and utilising the Making Every Contact Count initiative.

Primary Eyecare Services uses a collaborative approach to deliver primary and community eye care. This collaboration across optometry's primary and community care is demonstrated through the delivery of 504 service pathways, working in partnership with 28 integrated care boards, 52 local optical committees and 2350 optometry practices.

Acting as a multi-field contribution to the NHS by providing urgent and emergency eye care in addition to supporting routine elective care, Primary Eyecare plays a core role in minimising the need for patients to seek eye care support via their GP or hospital, thus alleviating the pressure on both primary and secondary care systems.

The community urgent eye care service and its contribution to alleviating pressures

Primary Eyecare Services supports the delivery of urgent and emergency care through its Community Urgent Eye Care Service (CUES), which provides assessment, treatment and referral for sudden onset eye problems. CUES enables patient access in primary care where approximately 85% of cases can be managed to resolution. When referral into hospital services is indicated, the service delivers imaging and other diagnostic data to assist with the triage and clinic allocation processes.

Results from patient-reported outcome measures evidence that over 65% of patients would have seen their GP, gone to A&E or attended a walk-in centre if the CUES service wasn't available. These results demonstrate how the service has reduced burden on secondary care, whilst being more cost efficient.

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Emphasising the positive impact of CUES, Manisha Kumar, Chief Medical Officer at NHS Greater Manchester, commented:

"CUES provides patients accessible urgent eye care in the community, meaning patients can see an eye care specialist right away and reduce pressure on GPs and hospitals. The service shows the difference collaborative working across primary and secondary care can make, allowing us to treat residents with timely, high-quality care in the community."

Reducing Health Inequalities

Demonstrating Primary Eyecare Services' contribution to the wider NHS landscape is its partnerships in delivering services with charity organisations such as SeeAbility and the Royal National Institute for the Blind (RNIB). The mutual objective in each case has been to focus on making services more accessible and inclusive, aiming to mitigate health inequalities.

Working with SeeAbility, a charity for those living with learning disabilities, the Easy Eye Care pathway has been designed to make getting an NHS-funded, specially adapted eye test available in a community setting.

Commenting on the Easy Eye Care pathway, clinical lead, Tom Mackley, said:

"Easy Eye Care delivers the necessary adjustments to perform a successful sight test for someone with a learning disability or autism. A little more time, pre-appointment preparation, alternative testing techniques, and an easy-to-read outcome report can make the world of difference and help to address a fundamental health inequality: everyone should be able to have a sight test."

More recently, Primary Eyecare Services launched a pilot with the RNIB charity, aiming to improve the lives of individuals being referred to hospital eye care services by providing early support from the third sector.

The collaboration means that patients can directly access RNIB's range of support services in addition to other local charity services via introductions co-ordinated by the RNIB.

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Commenting on the RNIB collaboration, Clinical Director, Wendy Craven said:

"The partnership between RNIB and Primary Eyecare Services signifies a shared commitment to addressing the challenges faced by individuals with sight loss and ensuring they receive the multi-faceted help they need."

Making Every Contact Count

The NHS Making Every Contact Count (MECC) initiative aims to encourage practitioners working across every sector of healthcare to engage their patients in conversation about their overall health and wellbeing.

Primary Eyecare Services provide information resources going beyond just eye conditions, which optometrists can share with their patients.

Speaking about the MECC initiative, Professional Services Director, Rupesh Bagdai, commented:

"Making Every Contact Count enables clinicians to deliver targeted health information supporting their patients to live healthier lives."

Embedding MECC in practice ensures that patients can discuss their wider health in their local optometry practice, where before they may have visited their GP or other healthcare professional for advice.

Primary Eyecare Services' and optometry's contribution to the NHS aids in improving experiences and clinical outcomes for patients, driving positive change and shaping a healthier future for everyone. Most significantly, these programmes reduce the burden on resources, enhance the quality of care and encourage a more sustainable NHS.

Clinically-led and excellence driven, Primary Eyecare Services is an established not-for-profit organisation managing NHS eye care contracts across England. To find out more and to get in touch, click here.

Author
Megan Lock

Primary Eyecare Services

A BUSINESS CONTINUITY…Really is as easy as ABC

The importance of international standards for business continuity:

Origin of the ISO 22301 standard heralds back to the ISO technical committee ISO/TC 23, which focussed on addressing concerns related to societal security. The standard is now managed by ISO/TC 292 - Security and Resilience. The first iteration of the ISO 22301 standard was published in 2012. The second edition was published in October 2019, and is more flexible in the approach of documented information, though clearly defines the requirement to effectively plan changes to business continuity through a clear strategy and forms the basis of the delivery model that PCC offer to its customers, which includes an ISO_22031:2019 standard pack for completion by healthcare providers.

ISO 22031 and the link to plan, do, study, act (PDSA)

The PDSA cycle, also known as the Deming wheel or the Shewhart cycle has become a regular fixture in healthcare, with many now recognising its value in managing successful services or being utilised for service redesign exercises. The PDSA cycle can be applied not only to the management system but to each individual element detailed below, to provide an ongoing focus on continuing improvement.

The 11 key elements to the business continuity management strategy (BCMS) :

This aims to keep the standard simplified in bite sized chunks that can be implemented and managed ongoing, by the multiple persons involved. This includes:

Scope of the strategy document	What the document means The importance of it
Normative referencing	What else does the BCMP link to in an organisation, system, or even legal context
Terms and definitions	Remember not everyone understands acronyms Simplify technical jargon so people can follow the flow of actions required
Context of the organisation	Size, sites, services, populations, personnel numbers
Leadership approach	Roles and competency Chain of command, communications leads, key contacts
Planning	Considerations of master events lists, estimations of maximum tolerated period of disruptions), recovery time objectives
Support requirements	Who else externally to link with e.g., IT infrastructure, ICS, local authority, as well as referring to the level of competence in delivery of BCMP

Continued...

Operational	Business impact analysis, risk assessment (safety), response structure, training programmes
Performance appraise/audit	Management review, internal audits, simulations, and exercise programmes
Improvement(s) implemented.	Non conformities and corrective action Root cause analysis, with a human factors' lens.

Business continuity planning at a primary care network level:

In general practice business continuity management planning (BCMP) may be familiar, with most practice managers conducting updates to their internal documents, not least to keep them aligned to being well led, and safe, which sits within their commitment to a regulatory umbrella within Care Quality Commission (CQC) requirements.

BCMP in healthcare is the process of preparing for and responding to major events and potential disruptions to the organisation's operations, and could affect the delivery of health services, and impact patient care.

The most common examples that we observe in GP practices, when delivering training on this subject matter is, but not limited to; pandemics, cyber-attacks, power outages, or staff shortages.

There is a common misconception that trainers often hear, during training sessions; whereby business continuity is seen a formality centred around risk assessment. It is something that is viewed occasionally, by a select few and updated annually by even less, that staff are trained in upon commencement of employment but seldom encounter again.

In truth BCMP is more than a process security blanket, as plans offer reproducibility across different teams, and the opportunity to systemically reduce mistakes and introduce improvements.

The clear benefits of having a sound BCMS:

Peace of mind: it minimises the reputational damage caused by disruptions. It involves identifying and assessing the risks, implementing safeguards and procedures, and testing and updating the plan regularly. A business continuity plan can help an organisation maintain its key services and operations in the event of a disruption, such as a natural disaster, a cyber-attack, or an economic downturn.

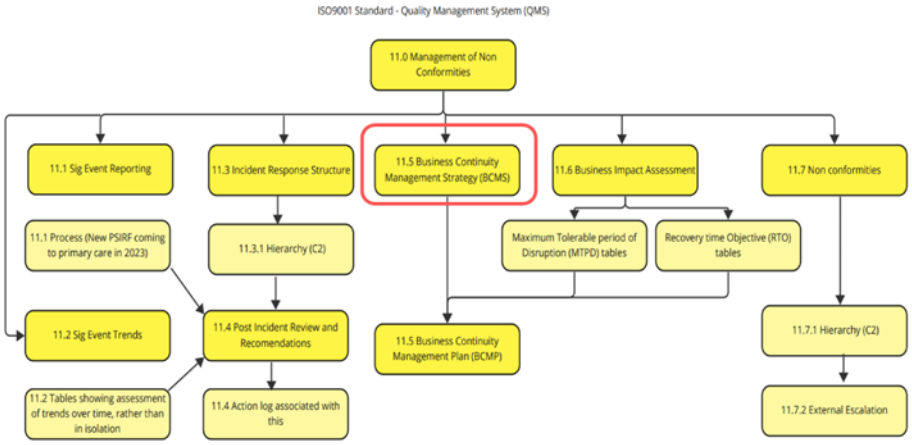
Visible resilience: demonstrating a preparedness for disruption to services. Also

Continued...

enhances the confidence and trust of the stakeholders such as patients, commissioners, and partners in the wider healthcare organisations in your ability to cope with challenges while minimising the ripple effects on the wider health eco system.

Protects organisational values: it ensures the safety and well-being of the employee's patients and public, during and after an event. In some cases, it also reduced the financial losses that may be incurred.

Enhanced security: It enables the organisation to seize opportunities and scale effectively during periods of growth or recovery. It also allows organisations to really challenge the IT infrastructure afforded to them to manage disruption, especially those which are digitally technical and cyber related.



PCC deliver workshops: in business continuity, because we understand the importance of compliance, the delivery methodology is that of a humanistic approach, we create psychological safe spaces for attendees to be open about the work they currently do, and we inspire them towards congruence, with out being too prescriptive or theoretical, our aim is to keep the sessions balance and delivered based on real world situations that may arise locally, that our participants may not have considered the impact of or the consequence to their delivery of services.

If you would like to find out more about PCC workshops on business continuity management strategy and planning, please get in touch enquiries@pcc-cic.org.uk

I found it very engaging, and the facilitator was fantastic.

I am not as worried about my level of understanding now. Thank you.

The trainer was engaging, fun and kept a boring subject interesting.

Brilliant practical session but backed with resources. The trainer was great.

Author
Joanna Fox CMgr FCMI, FREC, FPMA, ACIEHF, PGCert, CEBA, ACIPD, ACCA Cert, IOSH, HND Sc, Prince2, MSP & QSIR Practitioner. MSc Y2 Patient Safety and Clinical Human Factors

Test your knowledge

Questions from our primary care helpdesk. Do you agree with our answers? See the link below.

Dentistry

Pensions

An individual contract holder wants to take partial retirement, they are in the 1995 scheme. Do they need to retire from their contract?

Medical

Parental leave

Maternity reimbursement payments where a practice GP is on parental leave. A practice has been working on the basis that all maternity claims are only payable up to 26 weeks. Policy and Guidance Manual (PGM) page 410 and a discretionary payment is applicable if the practice meets certain criteria- PGM page 413.

However the "up to 26 weeks" is not in the statement of financial entitlements (SFE).

Can you confirm if maternity payments in regard to locum reimbursement can go beyond 26 weeks and is non-discretionary?

Sickness payments

A GP at a practice has taken sick leave four times in the past year so far, each time for a two-week period. Because of the two-week period, the practice has not claimed for locum cover – as reimbursement starts after two weeks.

Could this sickness be treated as one long sickness period, it relates to the same condition?

Pharmaceutical services

Superintendent pharmacist

Is there a limit as to how many companies a pharmacist can be the superintendent of?

Continued...

Application to change directors and superintendent

Can the pharmaceutical services regulations committee (PSRC) refuse an application to change the directors and superintendent of a body corporate?

Eyecare

Dispensing only optometry services

How do we contract with an NHS dispensing only optometry service?

Premises

Rent review appeal

A contractor initially accepted their notional rent offer but 12 weeks later have submitted an appeal. Are they within their rights to submit an appeal even after accepting the rent offer?

For answers to these questions see here.

Our contracting helpdesk is open to commissioners who are annual contract holders with helpdesk included in their contract. For details on annual contracts visit https://www.pcc-cic.org.uk/annual-contracts/ or contact enquiries@pcc-cic.org.uk

Upcoming PCC Events

The art of effective negotiation

Tuesday 27 February 2024, 09.30-12.30

Online training session

https://www.pccevents.co.uk/3088

Primary care dental contracts - contract notices

Tuesday 5 and Thursday 7 March 2024 (09.30-12.00)

Online training session

https://www.pccevents.co.uk/2993

Combating imposter syndrome

Wednesday 6 March 2024 (13.00-16.00)

Online training session

https://www.pccevents.co.uk/3094

Primary medical services: Contract management and dispute resolution

Tuesday 12 and Thursday 14 March 2024 (14.00-16.30)

Online training session

https://www.pccevents.co.uk/3112

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

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

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