

PCN Conference workshop summaries



General practice
and PCN support

PCN Conference workshop summaries

On 5 June 2019, the BMA, NHS England and GPDF held the first Primary Care Network (PCN) Clinical Directors Conference. The aim was to bring these new medical managers together, provide them with pertinent information about their new role and the new landscape in which they will operate, and to hear from them directly about what is happening on the ground and how they see PCNs developing.

The conference included several talks in a plenary setting, which you can view [here](#). However, the real insight from clinical directors came from the workshops. Eight practical workshops were held concurrently on a variety of topics including leadership skills, workforce planning and collaborative working, facilitated by experts from the BMA, NHS England, LMCs and CCGs.

What follows is a summary of the discussions and interactions from those workshops (each of which had a different format/style). This is available to all PCN Clinical Directors, whether they attended to conference or not. The summaries do not represent BMA or NHS England policy or positions but are individual opinions of the facilitators and/or attendees.

Session title	Quality Improvement and QOF support for member practices
Facilitator(s)	Dr Andrew Green, BMA GPC clinical and prescribing policy lead Rachel Foskett-Tharby, NHS England

What do practices need to do?

QOF remains voluntary – a practice can choose not to engage, but the Clinical Director role is about bringing people on board. In essence, the changes are not about hitting targets but engagement with the issue. QOF topics change annually and are subject to negotiation.

- Evaluate the quality of current care and identify areas for improvement
- Identify quality improvement activities and set improvement goals relevant to the topic. This is not about everyone doing the same thing. Practices can adopt strategies that have been successful elsewhere
- Implement the improvement plan – it is okay to fail – if something doesn't work take the learnings and move forward
- Participate in a minimum of two network peer review meetings. There are no specifications on how long these should last, they could be held via skype
- Complete the QI monitoring template. This should simply be headlines and no more than a page. It should be available upon request, but there will not be a central repository.

Prescribing safety aims

- Reduce the rate of potentially hazardous prescribing with a focus on NSAIDs
- Better monitoring of potentially toxic medications and the creation of safe systems to support drug monitoring with a focus on lithium prescribing. The aim is to shift from specifics to the general – what structures in place monitor whether patients are potentially taking damaging drugs. Cohort size is not specified but must be credible.
- Better engagement of patients with their medication through a focus on valproate and pregnancy prevention
- Improve collaboration between practices, networks and community pharmacists to share learning and improve systems to reduce harm and improve safety – Practices don't have to take on the entire workload – e.g. they might draw on expertise from the clinical pharmacist,

End of life care aims

- Early identification and support for people with advanced progressive illness who might die within the next 12 months. This is not about creating a big new list with no underpinning support. Some patients may not wish to go on the palliative care register or have those conversations – this is not a target for practices to be measured on, however NHSE expect to see an increase in people moving through a palliative care journey on a national scale.
- Well planned and coordinated care that is responsive to the patient's changing needs with the aim of improving the experience of care
- Identification and support for family/informal care-givers
- Underpinned by a retrospective baseline audit of deaths. In terms of how extensive this should be, it is advisable to go beyond the patients on the register. For practices who do not code death this could be a QI activity in its own right

Practices can measure ELOC in various ways such as whether patients had a care plan in place or whether there were any unplanned and avoidable hospital attendances, whether the process was actively managed before the patient passed away or what support is being offered to relatives.

Practices should be contacting patients in a way that they are comfortable with and this should be contemporaneously recorded.

Session title	Strategic and Clinical Leadership
Facilitator(s)	Dr Mark Sanford-Wood, BMA GPC executive team member Dr Andrew Seymour, BMA committee of medical managers deputy chair

The clinical director role would potentially be the first step in a trajectory to very senior leadership positions within the NHS, for those that wish to choose that path.

It is very important to understand yourself as a leader and your leadership style. Individual and charismatic leadership is a style often celebrated in the NHS, however there are many different styles and leadership itself is difficult to define. Individuals can and should define their own leadership style, recognising natural attributes and identifying those which need to be developed. Strategic leadership involves developing a plan and implementing it and having an overview of what is going on in your system, region or PCN. Clinical directors are responsible not just for patients but for the whole population of the network.

Attendees identified a list of attributes they would expect from a PCN clinical director; these were then assessed against the 'insights' model; the majority of attributes suggested fell into the 'cool blue' and 'earth green' categories.

Cool blue – intellectual, reach logical conclusions, analyse and reflect

Fiery red – Out front, command and control, authoritative

Earth greens – into personal relationships, supporting colleagues, reaching consensus and finding solutions to problems collectively

Sunny yellows – Drawn to an inspirational approach, intuitive, charismatic, lead from the front in an encouraging style

Attendees discussed the pros and cons of three different leadership styles:

– **Command and Control**

Pros included: clarity, responsibility, quick decisions, clear vision, efficient, inherited legacy culture, results driven, goal orientated, accountable, uniformity, can be replicated
Cons included: lack of ownership, not long-term, disenfranchising, undemocratic, lonely, demotivating, rigid, risk of burnout, personal agenda, egotistical

– **Delegated**

Pros included: empowering, transparent, balanced, sustainable, ownership, inclusiveness, realistic, more efficient, responsive, prevents burnout for individual, expansive, builds teams, maximising skills sets, shared risk and responsibility, builds social relationships
Cons included: aggregation, lack of accountability/ownership, too many cooks, indecisive, risk of inefficiency, multi-focus/too many focuses, potential for conflict, lack of direction, more meetings, handoffs, relying on ability of others, lack of control, need for wider training, confusion of responsibility

– **Distributive**

Pros included: democratic, supportive, shared workload, increased contacts, better communication, using best person for task and using people's strengths, flexibility, resilient, succession planning, identifiable responsibility, greater skills mix, team spirit
Cons included: 'not my problem' attitudes, siloed thinking, lack of accountability and personality, lack of clarity, potential indecision, conflict, exclusion and perception of exclusion, risk of inconsistency of messages, dilution, disorganisation, funding issues, blurring of lines/accountability, loss of vision, muddled leadership

No single one is right for all – need to decide what works best for you and your network.

Session title	Building local relationships and collaborative working
Facilitator(s)	Peter Higgins, Lancashire & Cumbria Consortium of LMCs CEO

PCNs are the main delivery vehicle for the NHS long-term plan, one of the major themes of which is integration (both vertical and horizontal) to better support population health management. PCNs also provide economies of scale for smaller practices and might assist with their sustainability and provide protection against larger provider take-overs. That being said, it is not the intention that PCNs are there simply to assist struggling practices by sharing the struggles with others.

Key to the sustainability of PCNs is relationships. Collaboration and relationships are important to practices and should be the first priority of any PCN and clinical director. Practices should not be able to police or manage each other but work together to share best practice and improve. Nor is it the intention that one practice will lead and make decisions that affect all practices.

The Network Agreement should lay out the arrangements between practices, so in the formation stage it will be important that each practice is appropriately represented at Network level and that relationships are collegiate and fair.

There is a continuum of what a PCN can look like from a loose collaboration of GP practices to a fully functioning population health management system. It will be important for PCNs as a whole to assess where they are on that spectrum, where they want to be and how they might get there (together).

2019/20 is intended to be the year to imbed working relationships within Networks. Part of a clinical director's role is to elicit enthusiasm from GPs and practices; once they are involved and engaged collaboration becomes more manageable. However, it is not just up to the clinical directors; they are the conductors – others within the PCN have to get involved too. However, PCNs are intended to be made up of practices and other organisations, to ensure that all organisations involved in population health management are coordinated and integrated.

Community and mental health providers have a requirement to align their resources with the PCN. Clinical directors will need to pull together different skills from different agencies and organisations that will benefit the PCN and its patients. This will largely take place through good working relationships and collaborating. The Network Agreement, schedule 7, provides space for detailing arrangements between the PCN practices and other organisations. Clinical directors and PCN leadership might benefit from a stakeholder mapping exercise (who do you need to talk to and engage with, who are the core providers that you rely on, who do you need to complete your PCN's objectives, who has strong influence with your geographic PCN area?).

But remember that building relationships takes time; it requires shared vision and focus. Use existing structures. Develop already existing community networks. Acknowledge your differences. Find common ground.

Attendees recognised the difficulties there may be in working together where there are tensions and historical barriers, especially where one practice doesn't sign up to the PCN. The clinical director will be instrumental in these discussions and will need to adapt their leadership style (see strategic and clinical leadership section). But remember, LMCs, BMA and others are able to assist with issues between practices and between PCNs.

Session title	Workforce development
Facilitator(s)	Dr Krishna Kasaraneni, BMA GPC executive team member

Attendees discussed the five reimbursable roles for PCNs and the different funding streams for networks. The floor was then opened for general discussion and questions. The following themes were drawn out:

Theme 1: Additionality

What counts as 'additional workforce'? To be eligible for workforce reimbursement, staff employed under the DES must be 'additional' to the existing workforce employed by the network's member practices, as measured at 31st March 2019 (NHS England is preparing a measure of existing workforce). The exception to this is for Clinical Pharmacists on the existing NHS England schemes. Approval to recruit these must have been received and the employee must have been in post prior to 31st March 2019, allowing clinical pharmacists who finished on the scheme between 31st March and July 2019 to be eligible for reimbursement once the DES starts.

Theme 2: Funding

The 70/30 funding split in 2019/20 would apply to the additional workforce (with the above exception) – 70% will be provided by NHS England (up to the maximums) with the other 30% being found by the PCNs themselves.

From 2020 onward PCNs would receive a lump sum capitated by list size – information about this will be made available ASAP to help PCNs to plan ahead. The intention is that PCNs could substitute others from the additional workforce roles if they don't need/ can't recruit others.

Theme 3: Pensions

Whether or not the additional staff are eligible for the NHS pension scheme will depend on the model the PCN adopts. The [BMA PCN handbook](#) was suggested as a good source of information but individual legal advice should also be sought, as well as liaison with LMCs. The employing body must qualify as an 'employing authority' under the scheme, i.e. hold an NHS contract. For networks operating under a lead employer or flat practice model, or where staff are seconded from another NHS organisation such as a community trust, this will not be an issue. The situation will probably be different if a limited liability vehicle is used and legal and accountancy advice was recommended.

Theme 4: Training

NHS England has published its interim NHS People Plan. BMA, HEE and RCGP will also be discussing training for the additional staff.

Theme 5: Clinical Directors

PCNs will decide for themselves how the clinical directors are employed/engaged and remunerated (and need to bear in mind any tax implications).

Clinical directors are accountable to the network, via the practices (likely via a Board made up of practice representatives), and to the leader of the PCN

Theme 6: Recruitment issues

Recruitment might be difficult in different areas of the country – hopefully this will be dealt with from 2020 when different roles can be supplemented. We hear a lot about difficulty in recruiting Clinical Pharmacists as they are already well paid in secondary care – we don't want to have a great impact on another part of the system by transferring them from one part to another, however a lot of CPs in secondary care are not clinical/patient facing, so they may wish to move.

Session title	IT and Data governance
Facilitator(s)	Dr Farah Jameel, BMA GPC executive team member Dr Damien Williams, Digital Clinical Champion for Primary Care Digital Transformation Michelle McDermott, Project Manager NHS Digital

Data Sharing between practices within a PCN: This is a very important, not only to protect patients and practices but to support population needs assessments and reduce variation. A national data sharing template will be provided as a tool to build a shared understanding. PCNs don't have to use the national template if they already have something in place. It will be challenging to complete the data sharing requirements by 30 June.

GP Connect is seeking to address the challenges of securing access with a multiple sign-in process required on many occasions across multiple systems; the feasibility of a single sign-in process is being investigated, while future proofing GP Connect so that GPs could feel assured on the sustainability of the work. PCN practices do not need smart cards to access GP Connect but do need them to be able to prescribe. NHS England had written to all CCGs on this issue to reinforce the importance of GP Connect as a system being rolled out nationally. CCGs need to be supporting individual practices in this area.

Coding and the fact that there were significant variations across practices was seen as a barrier to data sharing; this would be addressed as part of the wider project work on GP Connect.

PCNs, working with CCGs, and once system suppliers have enabled the functionality, would need to ensure interoperability between the four separate systems being used in general practice.

Digitalisation was a theme running throughout the session; the BMA and NHS England would welcome information on the challenges being experienced in this area so that we can work together to ensure a solution is fit for purpose and fit for all.

Educating patients about their rights and responsibilities about data sharing would be important; some suggested including information on websites, using patient participation groups etc.

The GP IT Futures workstream is using the principle of building on successful local systems like a 'lego model' and ensuring interoperability and access to records within federated models.

The GP Operating Model and the provision of resources for information governance support are currently being discussed between BMA and NHS England.

Session title	Implementation of service changes and pathways
Facilitator(s)	Dr Abid Irfan, NHS Berkshire West CCGs Chair

Five new service specifications will be added to the PCN DES for April 2020; the themes of these services have been agreed but the detail is still to be negotiated. Attendees discussed what the five services might include, based on existing examples of where this already happens:

Enhanced health in care homes

Enhanced primary care support (every care home to have a dedicated nurse and GP on behalf of the network); MDT support including coordinated health and social care; reablement and rehabilitation – managing acutely to prevent patients going into hospital; high quality end of life care and dementia care; Joined up commissioning and collaboration between health and social care; Workforce development; Data, IT and technology i.e. all practices having access to records. Opportunity to use the additional workforce to reconfigure and offer what patients need

Anticipatory Care

Avoid unplanned admissions by carrying out face to face consultation, medication reviews, development of a care plan if the patient does not have one already; produce online care plan template for network to use; Realigned multi-disciplinary teams and have regular virtual meetings – working with community social services; Partnership working to introduce proactive and intensive care for high risk patients

Structured Meds reviews/optimisation

5-8% preventable hospital admissions; can link to QOF QI modules; Asthma, COPD, Learning disability, Frail/Elderly; Tackling over medication/inappropriate use of antibiotics/withdrawing medication no longer required/supporting meds optimisation more widely

Early cancer diagnosis

Promoting the uptake of screening; Supporting prevention lifestyles; Looking at referrals – check they have been seen; Care after recovery – holistic cancer care reviews

Personalised care

Shared decision making; Personalised care and support planning; Enabling choice, including legal rights to choose; Social prescribing and community-based support; Supported self-management – peer support, educational schemes; Personalised health budgets and integrated personal budgets

It was made clear that there is no specific funding attached to these services, but CCGs can expand on these, providing additional resources as necessary. The additional workforce, the general increase in funding for PCNs, as well as working at scale and with other organisations, should mean no additional funding is required.

Truly integrating services at PCN level will require different organisations working together. Some have arranged joint workshops/events with community trusts and others to discuss how service changes can be implemented.

Session title	Working with LMCs, CCGs and ICSs
Facilitator(s)	Cathy Winfield, NHS Berkshire West CCGs chief officer

Using NHS Berkshire West as an example, Cathy provided some insights into collaborative working between providers and commissioners.

General: Delegates typically felt that there were lots of potential positives for primary care from PCNs, primarily greater resilience. However, they also appear to some as a panacea for every issue.

Proactive, planned population health management (with risk stratification, care planning etc) will be important to PCNs and so they will need support from the rest of the system. Health population data can help decide who to place into the MDT system at which level.

Attendees discussed the role of the clinical director – it could be a pathway lead for a CCG but may not be appropriate to be on a CCG board.

ICSs/STPs: PCNs should be part of ICS/STP governance structures but will need to collaborate between themselves to determine who leads engagement. In Berkshire West, there are 14 PCNs, with two clinical directors representing at senior management/governance level.

PCNs can decide collectively, with the ICS/STP, how they engage (ie number of CDs on Boards etc). PCNs could divide engagement across the system – so have individual CDs representing the collective in various positions, to give everyone a role.

In Berkshire West, GPs involved with the ICS/STP are providers and not from local CCGs or LMCs. Their involvement is also at a 'Unified Exec' and 'Clinical Delivery Team' level – where most service redesign is developed and agreed. LMCs are engaged as part of a Primary Care transformation board

PCN Clinical Directors should become involved at the same levels in their areas; especially important at the place level in terms of changes to primary care pathways etc, and at the neighbourhood level re delivery

LMCs: Some LMCs are planning to restructure/re-map to match new ICS/STP plans, potentially to have 1 LMC per place

The full system working together: Concerns were raised about funding and supporting from/to elsewhere in the health and care system (eg financial performance of secondary care impacting negatively on system control totals and therefore on primary care).

However, systems are increasingly operating an 'open book' model, with sharing of financial performance info to assist system-wide financial planning. Berkshire West has a joint recovery group, which makes 'difficult decisions' around funding across the system, but with decision making shared between CCGs, Trusts and others engaged in the local system. Sometimes hard decisions need to be made with a longer-term view rather than the short-term view that some systems often take.

Future developments: Various concerns have been raised about PCNs and ICSs eventually leading to ICPs, with loss of GMS contracts, however there is no national agenda for PCNs and ICSs to become ICPs. If they do emerge it won't be for at least 5+ years. If ICPs do emerge it will be through engagement with all providers and commissioners within the area, and is unlikely to be in the next five years.

Session title	It's not just GPs – engaging the wider Primary Care sector
Facilitator(s)	Ravi Sharma, Royal Pharmaceutical Society director for England Dr Mohan Sekeram, GP, Wide Way Medical Centre

The session started by a discussion on the additional non-clinical workforce who will be embedded in PCNs from 1st July 2019. NHS England has committed to invest £2.8bn to fund the expanded community multidisciplinary teams (MDTs) which corresponds to the recruitment of over 20k additional staff by 2023/24.

Mohan reminded Clinical Directors that the development of these MDTs will start for the first year with the recruitment by each network of 1 pharmacist and 1 social prescribing link worker. NHSE will respectively contribute to 70 and 100% of the reimbursement for these new roles.

Over the next few years, the MDTs will further expand through the recruitment of physiotherapists (2020/21), physician associates (2021/21) and community paramedics (2021/22). It was made clear that the networks could decide how the new workforce would be employed and deployed across practices and should seize this opportunity to innovate.

The presentation then discussed the future benefits and challenges related to the new development of social prescribing within PCNs, in comparison to the existing models. Among the benefits identified were a better utilisation of existing resources, a better collaboration between GPs and other allied healthcare professionals, the reduction of GP workload and improvement of their health and wellbeing. The challenges which were discussed were funding and evaluation of the schemes as well as that supervision and support provided to social prescribers.

The second presentation focused on the future roles of pharmacists within PCNs going forward. It was suggested that pharmacists should have clinical patients facing and medicines optimisation roles, as well as contributing to better access and integration with community and hospital pharmacy. Clinical directors were also invited to reflect on the most innovative ways to ensure the clinical skills and knowledge of pharmacists were well used across PCNs and ICSS.

The second part of the session was an open discussion during which clinical directors got an opportunity to ask questions to the two speakers. The first series of questions focused on the background of social prescribers and the level of investment in the short-term. The speakers informed the audience that link workers would often have experience of psychology, community and social work. They also indicated that evidence had shown that insufficiently funded schemes could lead to extended waiting lists and associated perverse consequences. On the question of support and integration of link workers within MDTs, Mohan insisted on the need to nurture positive professional relationships, by for instance, inviting these colleagues to practice meetings where possible.

The group then engaged in conversation on the challenges of situations where pharmacists cannot be permanently present on site due to training obligations and other professional commitments. One of the suggested solutions was to train another member of the MDT to dispense repeat prescriptions. There was finally a short discussion about an apparent lack of consistency in terms of the proficiency of newly trained pharmacists. The response from Ravi suggested that better, more uniformed accreditation was going to be introduced soon.

British Medical Association
BMA House, Tavistock Square,
London WC1H 9JP
bma.org.uk

© British Medical Association, 2019

BMA 20190403