

Cultural change at the heart of integrated care systems

As the themes of the NHS Long Term Plan start to become reality through plans for legislation to support integration, is it just legislation that will make this happen? Is this more about large scale change management or is it cultural change, rather than the creation of new bodies and boards?

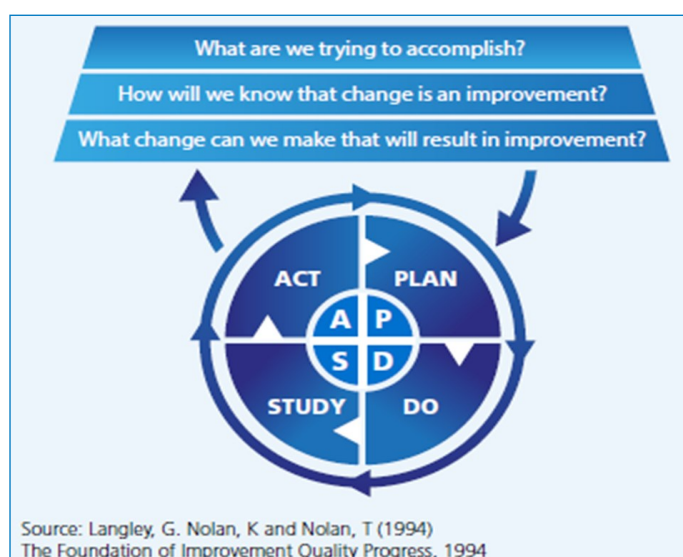
The direction has been clear for a long time - integrated care systems (ICS) are coming with joint working, sustainable use of resources, getting a focus on the system and not individual organisations. This is really a large-scale change programme, with changes in the way leaders and organisations work, at the heart of it. How could leaders' approach this?

There are lots of change models, and resources available on implementing large scale change in the NHS. These highlight that this is an emergent process:

- mobilising a large collection of individuals, groups, and organisations
- towards a vision of a new future state
- where there will be a shift towards more distributed leadership, and power
- with active, comprehensive engagement of stakeholders
- with mutually reinforcing changes in multiple systems and processes.

With the NHS model for large scale change the need for a clear vision – better and different, making it meaningful

for individuals and breaking the change down into smaller steps, best underpinned by improvement models, such as plan, do, study, act, [Langley, G, Nolan K, Nolan T \(1994\)](#).

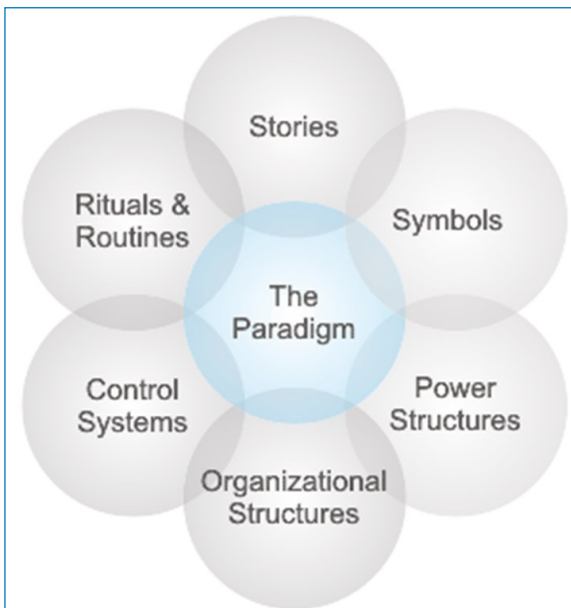


However, to make real change stick, it needs aligning with culture, and it is worth considering “[how things are done around here](#)” and how to make the change sustainable. Without making the change stick the programme could be amongst the two thirds of change projects that fail. Most fail at the embedding or “re-freezing” stage with behaviours reverting to old behaviours after a short time, and usually after the change has been heralded a success. This is where leaders, of all organisations, involved in collaboration across the ICS, need to focus, and personally demonstrate the changes that will make an ICS really work, for the future. Getting the underpinning

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culture right to support, and embed, the changes is one of the most important roles for leaders.

Gerry Johnson and Kevan Scholes developed the Cultural Web in 1992, which allows an approach for looking at and changing culture.



[The Cultural Web, Johnson, and Scholes 1992](#),

The Cultural Web identifies six interrelated elements that help make up the “paradigm”, the “how it is done around here”. Each of the six elements need to be considered to identify what isn’t working, needs to change and what can stay the same. For integration and collaboration to really make a difference and support the shift to successful ICS working what could be considered might be:

Stories – leaders talk about what they have seen as good, maybe, examples of how teams work together across organisational boundaries, with communities, making a difference and improving health and wellbeing for everyone in the community. Concrete examples of quick wins where the ICS is making a difference, and where behaviours support the system, not individual organisations.

Rituals and routines – how people should behave and what is valued. For example, leaders recognising staff for working across boundaries. Making it everyone’s business to empower patients and communities to improve their own health.

Symbols – the visual representation; focus on wellbeing, not illness, what can local networks achieve working with communities. Considering logos, pictures on documents,

websites, and presentations to represent inclusive services, celebrating diversity, local communities, and wellness.

Organisational structure – this isn’t just the organisational chart but is also the unwritten lines of power and influence. Leaders need to make sure they have routes hear individual contributions, from across the system, including those communities more difficult to reach, getting the input of frontline experience.

Control systems – the way the system is controlled, including how financial allocations are made, how performance is monitored, and quality recognised. Make the most of flexibilities that may be available to develop non-bureaucratic ways to support change to happen, whether that is enabling people to work across boundaries or allocation of resources in a timely way.

Power structures – the pockets of real power, those who have the greatest influence on decisions, operations, and direction. Leaders need to connect these individuals well with front line staff, ensuring they are visible throughout the ICS and to the local community.

Leaders need to take this approach forward to make real and sustainable change to fulfil the triple aim of:

- Better health and wellbeing for everyone
- Better quality of health services for all
- Sustainable use of NHS resources

Working together across the system, or at place level within it.

PCC supports leaders, not just with the theory, but through pre-work to understand the issues the system is facing, the priorities for change, and then bringing leaders together to work on these issues. Our leadership programmes consider how best to approach change, how understanding yourself and others is crucial, the importance of emotional intelligence for leaders and how to use it; as well as the skills of influencing and genuinely working with patients and communities. Contact enquiries@pcc-cic.org.uk to discuss how we can help you.



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Harnessing the patient resource

Helen Northall wrote encouragingly in February's edition of *Insight* about informing and engaging patients. I agree with her. But as a PPG chair, I think this can be taken one step further.

The last year has shown how much appetite there is in communities to help out. Whether it is volunteering via RVS and the national scheme; setting up local Facebook groups to coordinate neighbour support with e.g. shopping, prescriptions; organising a bank of volunteers to help out at vaccination sites; or just neighbours in a street looking out for one another.

It may be that some people at present have more time on their hands than before, but I suspect Covid has also shown there was always a latent volunteer resource on top of those who already offer their time to their community. And what can be great is that, as well as providing help to others, the people who have put themselves forward have probably themselves benefited: whether it is by simply filling time on their hands, or by feeling useful, or more generally by boosting their mental health and wellbeing. Indeed, getting more people involved in volunteering may amount to a form of social prescribing.

I am sure Helen is right in stressing the importance of engaging with patients and communities so they are more on board with how their practice is now operating, they understand the pressures, and their patience is hopefully better. (Indeed, I would support more training being offered to practice managers in patient communication: both in terms of technical options and patient friendly messaging.)

But, for me, it should be not just about practices communicating outwards to patients, but two-way communication and a two-way relationship which creates a community of patients and the whole practice team. And such a dialogue is more than the blunt instrument of patients occasionally being asked to rate the likelihood of recommending their surgery on a scale of 1-6. Or, equally blunt, patients being sent a text simply asking them not to contact the surgery about vaccination – sit tight and await your turn. Both keep patients at a distance.



I think the way to start is probably with having a fully engaged and embedded patient participation group (PPG). This will potentially offer to a practice a number of benefits. The committee members may have skills they are willing to offer to the practice. The committee is likely to have other patient contacts or mechanisms to recruit volunteers, access skills, and pick up on local vibes which might inform a practice's communications. And the committee will be able to offer a patient perspective – in the context of Covid, both in terms of understanding the anxieties people have and the sorts of things that people would like to know to reduce those anxieties.

In addition, messaging about practice pressures and the need to be patient may be better received if delivered by fellow patients rather than the practice. And patients who are brought into a practice via volunteering, and feel their efforts are valued by the practice, may be more likely to be cheerleaders for the practice in the local community and have a role in boosting morale among the staff.

So, as an alternative to the 'sit tight and wait', a PPG suggested to the practice that if patients had more

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things that they could helpfully contribute. And I know that not all practices have anything more than a so-called virtual PPG, or find it difficult recruiting enough patients capable of contributing in the way I describe above.

Second, there is the issue of the mindset of the practice. Do the GPs and practice manager see it as an important deliverer of services to patients or with patients? Do they see the practice as a key local provider or an integral part of the local community (or both)? We already have shared decision-making in relation to managing conditions, why not also a little of this in relation to managing the service as a whole? (I know GP practices are also businesses, but businesses have non-executive directors; although I'm not pushing this particular model, just the principle of independent engagement.) Perhaps the increased emphasis on integrated health and social care and on patient self-care will help break through such cultural norms where they exist.

Third, PPGs are intended to be critical friends. But there are some PPGs whose activities perhaps pay more attention to the 'critical' over the 'friend', and who might be more likely to prompt more impatience rather than less. I can understand a little wariness over this potential issue.

So, Covid has perhaps reinforced that there is scope in primary care to alter perspectives: the patient community as a potential part of the solution not just grateful consumers of health services.



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Chair of a PPG and founding member of his PCN's patient group

information about which groups should expect to be vaccinated when information (including, importantly, being up-front about the uncertainties), as well as clear advice about the different ways they would get a job invitation and different places that might be offered, they might be less anxious and ring the surgery less often. The suggestion included texting the 90% of patients contactable by SMS to ask them to read the website first and saying it would be updated frequently. This was done, the website was updated two or three times a week. The number of phone calls went down.

And to boost morale, a surgery PPG monitored local Facebook and passed on a series of favourable comments to the practice. It also sent regular supportive messages, including a message with a virtual bouquet of flowers which the practice put on its website.

It is important also to recognise that greater involvement of patients will not be entirely plain sailing.

First, it may need a bit of effort from the practice to kick-start things before recouping the benefits. Whether that is to identify patients likely to be able to offer constructive support who might be interested in joining the PPG. Or to prompt the PPG by identifying the sort of



Primary Care Networks: how to succeed in reducing inequalities

According to a recent report from the RCGP, developing the community health function of general practice is one of three features of the COVID-19 response that has the potential to transform general practice radically and permanently. And primary care networks (PCNs) are NHS England and NHS Improvement's chosen vehicle to drive engagement between primary care and communities, supported by the network directed enhanced services (DES) contract.

There is a problem, however, with how 'communities' are understood and with the tools that have been provided to do this job. The new roles available through the additional roles reimbursement scheme (ARRS) do help, but only a little. Here's how one local authority communities programme lead described the issue: "the DES contract has put the operational level in ... the social prescribing link worker is that connector. But the strategic role ... there's a gap between the clinical director and the strategic level".

In every place, beyond the boundaries of the NHS, there are many groups, organisations and networks that are fully bought into tackling health inequalities; addressing the wider determinants and supporting the social processes involved in creating health which mainly

happen in people's homes, neighbourhoods, workplaces and wider networks. They are enabling individuals and communities of all ages to have better physical and mental health and a good life and the networks between them have been strengthened, not weakened, through COVID-19.

Many within primary care are becoming more aware of the potential of connecting with this large pool of possibility. One PCN clinical director expressed this saying, "you need to be in the forum, to be in the conversations for all the other possibilities to emerge".

The Health Creation Alliance has set about unpacking this 'community layer' for the NHS and helping primary care to connect constructively with it. Our recent report 'How can Primary Care Networks succeed in reducing health inequalities?', jointly published with the RCGP, builds on the premise that 'lasting reductions in health inequalities will only be possible through working in genuine partnership with communities... by seeing them as part of the system and a significant part of the route to lasting solutions'.

'How can Primary Care Networks succeed in reducing health inequalities?' can be found [here](#).

A quick start guide for PCNs

1. Don't wait until the Tackling Neighbourhood Inequalities DES kicks-in, start now
2. Involve your local communities and local partners in shaping your PCN.
3. Make sure your PCN governance arrangements include people from diverse communities.
4. Share the process of developing your actions for tackling health inequalities with local partners.
5. Support member practices to work with communities as equal partners in pursuit of improved population health.



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The Health Creation Alliance

1. [general-practice-post-covid-rcgp.ashx](https://www.rcgp.org.uk/press-releases/2020/04/general-practice-post-covid-rcgp.aspx)



The new proposed NHS legislation and where this fits in the jigsaw of changes

The 80-page Integrated Care System (ICS) 'engagement' document resulted in the White Paper with no real surprises. For some time, the drive has been a move back towards regional control with local implementation; some may argue the Strategic Health Authority wheel has come back round.

The main thrust of the paper is to make ICSs, previously known as STPs (Sustainability & Transformation Partnership) statutory bodies as the foundation for the newest NHS reforms which are a progression of NHS England's 'Five Year Forward View' (actually published seven years ago) and the NHS Long Term Plan (published in 2019).

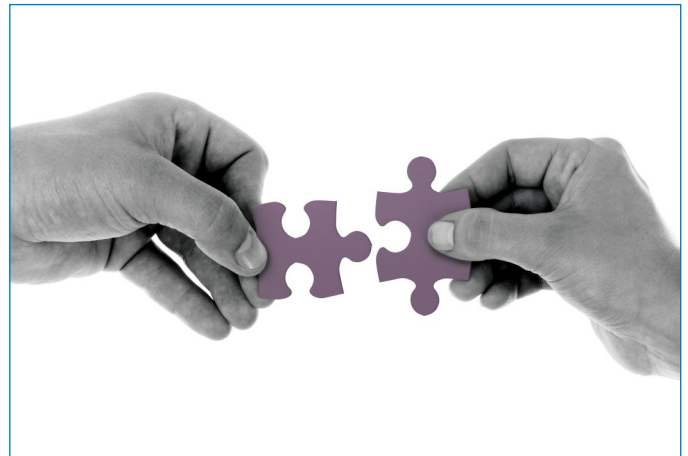
Several changes to the way the NHS is run and organised, are happening at the same time – legislation is required for some but not all so we will focus on the changes rather than the legislation.

The Objectives are:

- To return a degree of power to the Secretary of State (SoS) and Government in respect of the running of the NHS – the Lansley reforms created a quasi-independent NHS
- To simplify the NHS commissioning and regulatory framework – we currently have NHS England and NHS Improvement (NHSEI) and clinical commissioning groups (CCGs) as statutory bodies and ICSs that do not have formal (legal) legitimacy but are increasingly making decisions about strategy, budgets and services at a regional level. There are also integrated care partnerships developed at a "place" level.
- To provide flexibility in respect of competitive tendering and procurement rules – i.e. to allow the SoS and NHS to determine what and when to implement a competitive process.
- To reduce internal competition between NHS providers – to promote integrated working, this includes general practice.
- To refine some elements of the 'purchaser/

provider' split introduced in the 1980's – in particular reducing the reliance on 'payment by result' through changing to providers working together

- To promote more effective partnerships across Health and Social Care - in particular to strengthen the links between the NHS and Local Government



The way this will be achieved (according to the White Paper):

- A new Health and Social Care Act which will:
 - Return overall control back to the Government
 - Amend the competition rules
 - Simplify the NHS organisational arrangements – incorporate the roles of CCGs, and elements of regional NHSEI functions, into ICSs
- The development of an ICS (on regional footprints) and Integrated Care Partnership (ICPs) usually on local authority footprints. This 'new' organisation model will:
 - Incorporate the current NHSEI, ICS and CCG commissioning functions into the new ICS
 - Enable the tactical/local commission functions of the CCGs to be devolved to ICPs – although it is likely that some may be retained at an ICS level
- The promotion of integrated working. Examples of what will feature in and be pushed through the legislation include:
 - requirement for all provider trusts to work in partnership at an ICP level

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- development of primary care networks (PCNs), promoting integrated working between practices and providing the representation of general practice at an ICP and ICS level.
- requirement to further develop integrated working with local authorities and other partners.
- New financial systems which will increasingly be based on managing within set budgets across organisations.

The potential implications for general practice

1. PCNs will become the primary mechanism for ensure general practice (as a provider) is represented at ICS and ICP level
2. Service changes will increasingly be organised and delivered through PCNs.
3. Commissioning and contracting for general practice services will be managed by the ICS (strategy/ general medical services (GMS) contract etc) and over time the ICP (local enhanced services, care pathways etc.). The pace

of devolution to ICPs will be determined by each ICS.

4. PCNs / federations/ Local Medical Committees will be the critical bodies in respect of nominating GP leaders to support and influence the system. CCG style governing body with elected representation will disappear
5. The ICS/ NHSEI will determine if and why to competitively tender services – there will be requirements with value for money being the key component.
6. The Government of the day will be more able to direct policy – this could include changes to general practice, including GMS. In particular it is likely that there will be a drive to reduce perceived monopoly provision.



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Upcoming PCC Events

Influencing skills— Thursday 22 April and Thursday 29 April 2021 (09.30-12.00) - online

Influencing is a vital part of communication in the workplace. Influencing is a combination of persuasion and negotiation - being able to persuade and negotiate with others to reach a win-win solution. Learning influencing techniques leads to smarter and more effective working. This session covers key principles of influence; how we are influenced and how to influence others, attitudinal change, the importance of active listening, and how showing empathy and building our emotional intelligence can increase our levels of persuasion.

<https://www.pccevents.co.uk/2485>

An introduction to new roles in general practice for practice staff— Tuesday 27 April 2021 (09.30-12.30) - online

This workshop for existing practice staff offers an overview of primary care networks (PCNs) and how they link to the aims of the NHS Long Term Plan. It introduces delegates to the additional specialist roles being recruited by PCNs, via the additional roles recruitment

scheme (ARRS) outlining the skills and expertise each role can offer into general practice, and highlights how they aim to reduce GP workload and increase patient choice. An ideal workshop for practice team leaders, who can then champion embedding the new roles in practice.

<https://www.pccevents.co.uk/2503>

Creating effective multi-disciplinary teams in primary care— Tuesday 4 May 2021 (09.30-12.30) - online

The additional roles reimbursement scheme (ARRS) provides a great opportunity for primary care networks (PCNs) to recruit clinical and non-clinical staff to create responsive multi-disciplinary teams to meet the specific needs of the populations they serve.

This workshop explores how primary care network leaders and practice managers can work collaboratively with practices to identify the additional mix of skills and expertise to bring into the network to increase choice for patients, provide specialist care closer to home and reduce the workload of GPs.

<https://www.pccevents.co.uk/2505>

Integration and Innovation: working together to improve health and social care for all

I support the overarching aim of this White Paper well described in its title. I quote from the White Paper; 'This paper sets out the legislative proposals for a Health and Care Bill. It aims to build on the incredible collaborations we have seen through Covid-19 and shape a system that is better able to serve people in a fast-changing world. At its heart, however, this Bill is about backing our health and care system and everyone who works in it. Our proposals build on the NHS's own – those in the Long Term Plan.



Integration and Innovation: working together to improve health and social care for all

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

February 2021

Indeed, what is there to oppose? My fear is that though the aims are laudable, the words encouraging and the thinking progressive, we do not have even as a beginning, an NHS culture that is enabling of such a vision. Of course the White Paper rightly embraces beyond health care but the sheer magnitude of the NHS can dominate if it so wishes.

Let me describe the context as I see it. Apart from the present incumbent Simon Stevens and to some extent Duncan Nichol (I go back a long way), no NHS CEO has shown any real understanding of or desire for a community based focus to the NHS. This despite it being the site for most of healthcare and more importantly if the pursuit of health and wellbeing is to be of any real meaning, where the community is. An area of contention in the White Paper is giving politicians a return to a bigger say in the running of the NHS. On this I am surprising ambivalent. In primary care since 1990 we have benefited in general from political leadership in

particular Conservative leadership. Fund-holding being the 'Jewel in the Crown' as it devolved power and leverage to primary care clinicians, a hitherto un-heard of concept. New Labour struggled and failed with politically acceptable alternatives.

The centre piece of the White Paper is the Integrated Care System (ICS) around which are centred the hopes and aspirations of those who wish the delivery of what is promised. Its planned governance structure is sensible, 'Statutory ICSs, made up of an ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS). This dual structure recognises that there are two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.'

A White Paper that promises much but a prevailing NHS culture that is over focused on hospitals, a top down hierarchical mode of leadership and favours big is beautiful will not be the enabler of the stated aspirations the country needs. Who can lead is the big question? And in what style of leadership?

Will the big beasts in the NHS define integration to produce the biggest provider capture ever with less choice and responsiveness? Integration will only mean something if the individual patient can feel the benefit. For the wider community can they perceive the ICS as the New Zealand Prime Minister describes her country a team of 5 million people? it is worth revisiting Philip Gould - '...must find a way of integrating the schism between the individual as consumer and the individual as citizen'. A challenge to NHS thinking as in any NHS 'pyramid' denoting influence, power and resource availability, hospitals would be at the top, lip service to a primary care led NHS and patients and the public at or near the bottom. In the NHS and for the community and the individual can we through the ICS deliver on those aspirations. If not it will be only yet another structural change which the authors of the White Paper certainly

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do not intend. It must be about the leadership and choosing new types of positional leaders and creating a culture of a dispersed leadership even beyond the professionals. As Disraeli said 'Next to knowing when to seize an opportunity, the most important thing in life is to know when to forgo an advantage'. Not a common NHS feature.

Primary care hitherto virtually excluded from system leadership has much to offer in talent and an experience of localism and working within the community. The ICS is proclaimed as the necessary devolution the NHS requires but they are still large in population size and many of its constituent organisations and essentially

distant from its community. And to whom we devolve often become the new centralists. We must systematically adopt the concept of concomitantly being 'big and little' as localism matters. Governance should major on behaviours rather than the over weening obsession with compliance and embrace subsidiarity. And the value of the ICS recognised by its community, then we might just have the ICS we need.



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Service improvement and change: it's the simple things that get in the way

Giles Kingsley-Pallant looks at how practices can rethink how they engage with change.

General practice is seeing some of the most challenging times, not least with the Covid pandemic, but also just delivering day to day care with what appears to be a tsunami of demand. What can often get lost in this scenario is how people respond to one another and inadvertently create difficulties within the practice and with colleagues. This article introduces the BECKS model to help you begin to unpick the dynamics that are behind some of the more frustrating behaviours you may see in your organisation.

The essential premise of the BECKS model is that recalcitrant behaviour we encounter in organisations often has its origins in the knowledge and skills individuals have, the clarity of the processes, procedures and tasks that they are working with and the environment the individuals work in. By using this framework, you can gain insight into why people do the things they do and why you experience increased friction within the team.

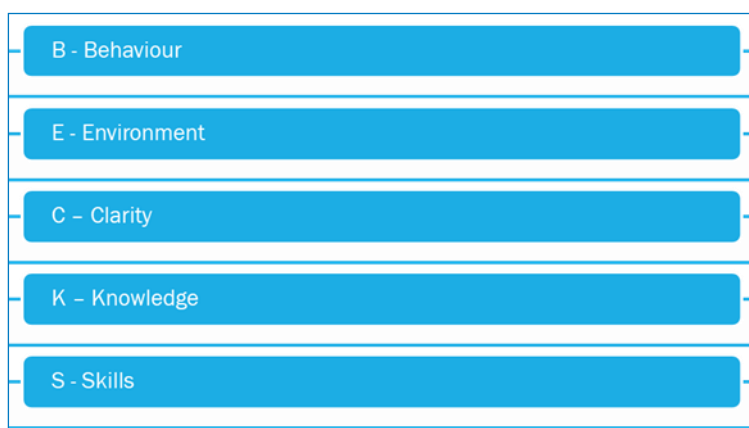
Let's start with Knowledge and Skills.

An individual who is embedded within the practice team has been for over 30 years. Let's call her Maureen. She is a senior administrator.

Fifteen years ago, Maureen began scanning with a single page scanner and was incredibly proficient. One day the practice manager asks Maureen to move to a multipage scanner, but Maureen is very keen not to do that. In fact, she puts up a number of opposing arguments as to why it is not a good idea.

Now you might ask what is causing Maureen to be so uncooperative. You may be thinking that she is being obstructive, negative, stubborn or is fearful of change.

There is a clue, however. Fifteen years ago, Maureen started scanning so we know she is not a technophobe so what is the cause of her resistance to using the newer technology? How can we begin to understand what may be behind her reticence to change? Often in these situations it is the lack of confidence, knowledge and skills to use the new equipment that drive her fear of change. The way to overcome this is simple: provide her with the



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knowledge and skills to use the new equipment.

This is one particular scenario typical of those found in general practice that occur on a day to day basis. We need to ensure that knowledge and skills are front and centre when trying to move individuals towards change.

Individuals also need to know what they are required to do. They need Clarity of task or activity. Let's take another scenario:

During a consultation the GP recognises that the patient needs an emergency ECG, so they message reception to book the patient in with a nurse that day. Despite the nurse's list being completely full, with no space for any additional patients, reception squeeze the patient in. The nurse who is working flat out, is furious that reception have added this patient to their list. So, they message reception to say that this is 'really not on' and they can't do it so could somebody else do it? The receptionist messages back to the GP to say the nurse can't do the urgent ECG because her list is full. The GP, who is now running behind, is infuriated because he just wants the nurse to do it.

The GP is now annoyed with both the nurse and the reception team for not sorting it. The nurse is annoyed at the reception team and the GP for asking her to do it. And the poor reception team are in the middle thinking that they can't do anything right.

The way this scenario plays out is nothing to do with the individuals involved. Each one of them is trying to do the right thing for the patient and the organisation. But all of them are overrun by the constant demand on the service and, in order to cope, they try to push things to another part of the system.

To understand what has happened here we need to appreciate that there was no clarity in responsibility, no clarity in protocol or expectations around meeting the urgent request. This starts with an agreement that an emergency ECG is just that and should override routine work. However, without an agreed process up front that specifies which person carries out the ECGs, that the urgent overrides the list and what happens to their work when this type of event occurs: i.e. the nurse is responsible for the ECG and when that comes in he or she knows that is what is expected of them and the support they can expect from the rest of the practice team.

In this scenario lack of clarity of process causes friction between three separate groups of people, who are all creating bad feeling against one another and yet they are all trying their best to run the system smoothly. So, there is something to be said about working towards clarity from the outset: getting all your processes aligned early on to reduce unnecessary friction in the organisation.

Moving on to Environment or what we are working with. Lets look at another scenario.

In some localities in order for referrals to be processed through Choose and Book, the administrative team need the patient's BMI recorded on the referral form generated by the GP. Unfortunately, it's not always recorded at the point the GP sees the patient and this can result in the hospital rejecting the referral.

So, the administrative lead, Sarah, goes in to see the GP and says "I'm really sorry, but you haven't filled in this box here for the BMI. Would you mind filling it in?" And the GP, very keen to do the right thing says "Yes. No problem at all" and she goes back into the admin office where she bumps into the Practice Manager. The practice manager is annoyed pointing out they have had 10 rejected referrals. "Yes, yes, I know that." says Sarah. "Well, have you thought of telling the GPs?" the practice manager asks. Sarah feels exasperated and replies "Well yes. I have told them repeatedly until I am blue in the face."

We can keep asking the same thing and we can keep failing to get the response we need and we can keep getting cross with other team members or we can try and understand where the problem lies. The question is what is breaking down in this situation?

The system the GP uses does not automatically flag up the BMI or prompt for height and weight to be recorded, so this information is not readily to hand when the referral request is raised. But there is a relatively simple solution: by

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using the technology available you can create a form that auto extracts from the patient record the height and weight data to generate the BMI on the referral form. If the data is not there you can also design into the process a flag to alert the GP of the need to capture the patient's height and weight before they leave the building.

There are a lot of things that work against us in the environment we work in and combined with lack of clarity, knowledge and skills this can increase stress, undermine performance and lead to people feeling like they are not part of a team.

And that leaves you with Behaviour. And behaviour in the BECKS models really looks at recalcitrant behaviour, where people absolutely don't want to do something and 'come to work, not to work'. It provides a constructive framework which you can use to check that you are

supporting individuals to change. By noticing difficult behaviours around change or just within day to day working, be aware of how the environment, clarity, knowledge and skills may be impacting the individual. The BECKS model is an effective way to support teams to change within a safe non-judgemental process.



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More Pension Changes for GPs – know the scheme you're in

Back in 2015, the most recent revision to the NHS pension scheme took place, with the majority of GPs being obliged to become members of a revised scheme.

The newer scheme has, for example, a higher retirement age, no lump sum as standard, and is based, in very simple terms, on an aggregation of each year's annual earnings divided by 54.

Any GP with a date of birth of August 1965 or later was immediately transferred to the new scheme from 1 April 2015, with a gradual transition for those born between April 1962 and August 1965. Those born before this date remained in the older scheme.

In practice, this results in many GPs having two separate pension pots, one in the older scheme subject to those rules, and another subject to the new scheme rules.

So, you are likely to have part of your pension you can take at 60, and some perhaps as late as 68.

There are many GPs who do not even realise that they have been members of the newer scheme and get quite surprised when it is pointed out that it cannot all be taken at age 60.



A recent legal case (the McCloud judgement) upheld the charge that this effectively discriminated against younger members, and a public consultation has been held to come up with a way forward.

Although the detail is yet to be released, what is most likely is that there will be another new scheme from April 2022, which all current scheme members will be required to join.

Where a member commenced NHS pension membership before March 2012, and has had to transfer to the newer scheme, then for the period from 2015 to 2022, the member will effectively be able to nominate whether their pension benefits will be accrued in the

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older 1995 or 2008 schemes, or remain in the 2015 version.

This will have far reaching effects on GPs, not least completely changing previously calculated tax annual allowance charges, as well as fundamentally altering likely pension benefits.

There has been a feeling amongst GPs for some years that their pension will take care of itself and that the relevant bodies are on top of its administration. From our years of experience, we know this is not the case and it is vital that you take conscious steps to ensure that you know your position.

We have letters of authority in place with NHS pensions for our GP clients so that we can deal with them directly on your behalf. We don't shy away from giving business and tax advice and have a working knowledge of all sections of the NHS pension scheme. We also work closely with a close network of specialist IFAs to bring enduring benefit to our clients.

We can guide you through this complex area to assess exactly where you are and how the new measures may

affect you. Contact our experts for further advice in this area.

Moore Scarrott are currently working with PCC to run workshops about how these pension changes may affect you. More details can be found at:

<https://www.pccevents.co.uk/2523>

This article was written by Chris Clark and Rob Glentworth, specialist medical accountants at Moore Scarrott Healthcare.



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Population Health Management

What is Population Health Management?

Population health management (PHM) is a way to improve the current and future health and well-being of people within and across a defined local, regional and national population while reducing health inequalities. It includes action:

- To reduce the occurrence of ill health
- To deliver appropriate health and care services
- On the wider determinants of health.

The way in which communities and partner agencies connect and work together defines a population health system. This means:

- Getting the right people to the right resources
- Getting the right outcomes for the right people with the least waste
- Doing the right things to protect resources for

future generations (sustainability)

- Ensuring fairness and justice (equity)
- Supporting the whole population
- Creating population based integrated systems.

Population health management is one of many tools using data to guide the planning and delivery of care to achieve maximum impact on population health. It often includes segmentation and stratification techniques to identify people at risk of ill health and to focus on interventions that can prevent that ill health or equip them to manage it.

The Social Care Institute for Excellence (SCIE 2018) describes PHM as a methodology to put together a comprehensive understanding of population health needs by joining up data about:

- Health behaviours and status
- Clinical care access

[Continued...](#)



- Use and quality of available services
- Social determinants of health.

These four areas combine to provide comprehensive baseline information about the locality in terms of health and other challenges faced by residents. This is then analysed to gain further understanding about the levels of current and future need by segmenting the data broadly along the following lines:

- Those who are generally well and who will benefit from health interventions to maintain their general good health – for example screening programmes for hypertension;
- Those who are currently well but have been identified as being at risk of developing long term conditions – for example people who may have mobility problems;
- People with long term conditions who will benefit from early interventions and secondary prevention services to stop or delay progression – for example people with diabetes or cardiac problems;
- People with complex needs or frailty who need individualised co-ordinated care with a high level of continuity.

Factors associated with success are high quality local data and effective information management systems. The statistical analysis used to model future projections must be robust and supported by credible algorithms which incorporate tacit knowledge from service users and professional staff involved in care delivery. When modelling future demand, allowance must be made for levels of uncertainty and scenario plans should

model the possible interactions of various parameters with audit trails of assumptions made.

PHM, if used correctly, is an important enabler to improve care outcomes for the locality population. The quality of the information produced is only as good as the quality of the data used, the way in which it is used and the extent to which information produced is regarded as credible and useful by both service users and front-line staff.

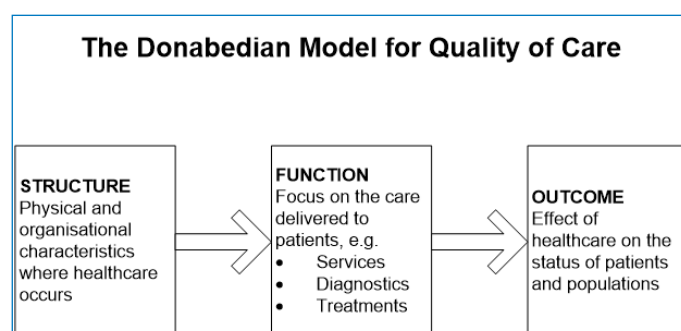
Resources to meet current and future health and wellbeing needs depend on collaborative planning between health and social care organisations both for the day to day running of services and for workforce planning to ensure that the right numbers of appropriately trained staff are available at the right times to deliver care.

Planning involves thinking in different ways about physical characteristics (structure), services (function) and impact on the health and well-being of the local population (outcomes) and can be summarized using the Donabedian model (NHS England 2019) in set out below in diagram 1 below.

The structure relates to the legislative framework underpinning national health care provision as well as the location and design of the buildings where health, social and other care is delivered. The proposals for the new legislative Health and Care Bill published on 11 March 2021 draw heavily on population health, using the collective resources of the local systems, NHS, local authorities, the voluntary sector and unspecified others to improve the health of local areas. (UK Gov 2021).

The outcomes of care are more than the numbers of people treated, it refers to the impact of care given on the health and well-being of the individual receiving the care.

Diagram 1.



Continued...

Why is it Population Health Management Important?

PHM is important because it informs how we design and implement integrated care systems. It is fundamental to how health care will be delivered in community settings and enable primary care networks (PCNs) to deliver care as close to home as possible in line with the NHS Long Term Plan (NHS England 2019).

PHM provides support for local teams to understand and look for the best way to meet the medical, social and wellbeing care needs of both individuals and communities within a defined population. It also provides a strong link to public health data to predict the likelihood of patterns of disease occurring. The recent COVID-19 pandemics is an example of where predictive data has been crucial to policy decisions about how services, diagnostics and treatment should be provided. One way of thinking about public health and PHM is to “join the dots” where dots is an acronym for duration, opportunity, transmission and susceptibility to understand risk and predict important consequences such as patterns of disease, impact of disease and service requirements.

Ideally this should happen in a timeframe that allows for appropriate forward planning and resourcing. In the case of COVID-19,

The “D” in dots relates to the duration of contact with an infected person, as well as the duration of infectivity and illness.

The “O” in dots relates to the opportunity for transmission and has been a key driver policy decision such as lockdown and social distancing.

The “T” in dots relates to the transmissibility of the disease, which in the case of COVID-19, refers to the virus.

The “S” in dots relates to the susceptibility of people to the disease. Susceptibility may be linked to age, sex, existing health conditions or co-morbidities and social determinants of health. Deprivation issues such as poor housing, poverty or social isolation can have serious consequences for physical and mental health and often contribute significantly to co-morbidities (Kings Fund 2018).

How Does Population Health Management Work?

Data is the fundamental building block of PHM. Data is used to model current states of health care in given locations and, often by using modelling techniques, predict future demands and likely impacts of interventions (for example screening) or unexpected events (such as COVID-19) on given populations. This modelling helps to identify local or national ‘at risk’ cohorts. The potential impact of interventions can be tested against the models to assess the likelihood of proposed interventions improving health outcomes of people already affected or preventing illness from occurring. Further details of how PHM can support healthcare can be found at the PHM Academy at www.england.nhs.uk/integratedcare/phm/ (NHS England 2021).

Although, given current circumstances, COVID-19 has been the focus of a great deal of PHM work, it is not the only driver for PHM. Better partnership working using PHM to join up the right person with the right care solution helps us to improve outcomes, reduce duplication and use our resources more effectively. PHM means NHS staff will work more closely with colleagues from other disciplines and organisations including social care to redesign their services and take a more proactive approach to supporting their local population live healthier lives. This transformational change means



Continued...

that leadership styles need to focus on consensus rather than organisationally driven targets. It requires a new way of thinking about how to build and maintain relationships across organisations that are focussed on collaborative working to improve health and wellbeing in the locality. It also means thinking about how interprofessional teams can articulate their goals and share both knowledge and data from their different perspectives to improve their response to local needs.

Conclusion

In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. PHM is a fundamental building block for integrated care systems because it provides the baseline information of local needs by joining up data about social determinants of health, health behaviours and status, access to services and ways in which existing services are used. This baseline information can then be used to model predictions about how current services can be better aligned and resourced to meet the needs of current and future service users.

Local services can provide better and more joined-up care for patients when different organisations work collaboratively in an integrated system. Improved

collaboration can help to make it easier for staff to work with colleagues from other organisations to meet the needs of the people they are trying to help. PHM provides the shared data about local people's current and future health and wellbeing needs. Joint care-planning and support addresses both the psychological and physical needs of an individual recognising the huge overlap between mental and physical wellbeing. Joint posts and joint organisational development are likely to become more commonplace and community nurses will have a vital contribution to planning and delivery of integrated care to improve health and care outcomes for their local populations.

Reflective Questions

- How are community, primary, social care and other systems currently working together in your locality?
- How well does your leadership style fit with the collaborative style of leadership that will be necessary to work closely with colleagues from other disciplines and organisations?
- How are you preparing yourself and your teams to understand the current and future structure, functions and outcomes of care for your locality.

Contact enquiries@pcc-cic.org.uk if you would like a local workshop or support on PHM

Key points

- Joined up thinking and information about local health, social care and wellbeing needs is an essential enabler for population health management.
- Importance of involvement of tacit knowledge from service users and front-line staff who deliver care



Author

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Community-Oriented Integrated Care



Community-Oriented Integrated Care (COIC) provides a vision for society where people of all backgrounds contribute to the health of whole populations. We think of it as whole system integration for health and care where everything comes together through geographic areas of about 50,000 population - in the UK, this is primary care networks.

COIC concepts promote cycles of collaborative learning and coordinated change within and between areas, to facilitate organic emergence of innovation, social cohesion and systems-thinking. Across the community, policy ensures that different stories and cultures are valued; and positive, trusted relationships are built through deep listening, shared vision and broad participation in improvement projects. This is different to traditional hierarchical approaches to policy.

Policy for COIC is different from the usual stereotype of 'top-down' implementation of evidence-based solutions – that 'tells people what to do'. Policy for COIC 'helps people to think for themselves'. It facilitates creative interaction between people from different backgrounds that helps them to better see how individual and collective actions can affect 'bigger pictures'. It establishes infrastructure that facilitates the emergence of innovation. It requires 'village-size' localities that are small enough to feel you belong and large enough to have political impact. It empowers more than controls people. It is a form of local participatory democracy.

Between 2007 and 2013 Ealing piloted and implemented policy for COIC, drawing on theories of organisational learning, generalists as sense-makers and fourth

generation evaluation. Outcomes were good, as evaluated by routinely gathered data for diabetes care.

The work in Ealing shows that cycles of learning and change within geographic areas can bond and bridge. The 2011 video of the Southall Initiative for Integrated Care shows one of a sequence of meetings at which people of different backgrounds reviewed progress of four service improvement projects. You can see it at: https://www.youtube.com/watch?v=-u40x7-76iU&feature=player_detailpage. The video shows participation of lay people, primary, secondary and community care practitioners, policy makers and public health practitioners.

The acceptability of the approach is revealed in the comment by a voluntary sector participant:

"It's not revolutionary; Yet it is revolutionary... If it is institutionalised, that would be incredible for our healthcare services"

The ability of the approach to energise people and help them to interact creatively across disciplinary boundaries is revealed in the comment by the dementia project lead:

"I've never had so much access and opportunity to talk across primary care and secondary care about mental health services.... and I find that the most exciting thing I have experienced in my professional life"

In 2012 learning was applied from this Initiative throughout Ealing. We:

- developed localities within which stakeholders (generalist & specialist clinicians, public health & social care practitioners, and others) met monthly to develop care plans for frail patients, to learn, and to co-create innovations
- aligned hospital-led diabetes clinics to these localities
- targeted resources to reverse inequalities
- supported a multidisciplinary team to co-design a new system for diabetes, including primary & community care practitioners, 'expert patients' and diabetes specialists

Continued...

- provided education courses for GPs to lead diabetes clinics within their practices
- provided structured education for patients to contribute to their diabetes care

The COIC concept proposes policy in five areas to develop this approach

- Build structures to support whole system learning and change
- Facilitate local engagement in local developments
- Develop case studies
- Teach theory and practice of integration
- Support multidisciplinary leadership teams.

The approach can be used, at scale, in different contexts and at different speeds. Primary care networks (PCNs) could use this approach and so move towards community-oriented integrated care.

This is an extract from an article by:

Paul Thomas, Raj Chandok, David Colin-Thomé and Laura Calamos

The full article is available [here](#)



Author

Professor David Colin-Thomé, OBE
Chair, PCC

Saving you time, and developing your team

As clinical commissioning groups (CCGs) merge and NHS England and CCGs start to prepare primary care contracting responsibilities to transfer to integrated care systems it has never been more important to ensure your primary care contracts are up to date and effective. PCC has supported primary care commissioners to do this for over ten years. Getting it right helps limit the risk of legal challenge and therefore anxiety and cost, as well as ensuring resources are well used. Our team of expert advisers provide workshop and helpdesk support as well as exclusive surgery sessions to discuss your contracting issues if you enter into one of our annual contracts. Secure your support now for the year ahead.

Its not just the contracts, are they supported by an effective premises strategy? Are the right reimbursements being made for primary medical care premises? Do have you effective estate plans in place that support local clinical strategies?

Our annual contract support allows access to our helpdesk, events, workshops and e-learning programmes, supporting you and your team to be up to date on the technical issues and access valuable personal development and leadership courses to support individuals through the changes ahead.

As change continues at pace, our affordable support can make sure you and your team are in the best position for the future. Contact enquiries@pcc-cic.org.uk and your local adviser will be pleased to outline how we can help.

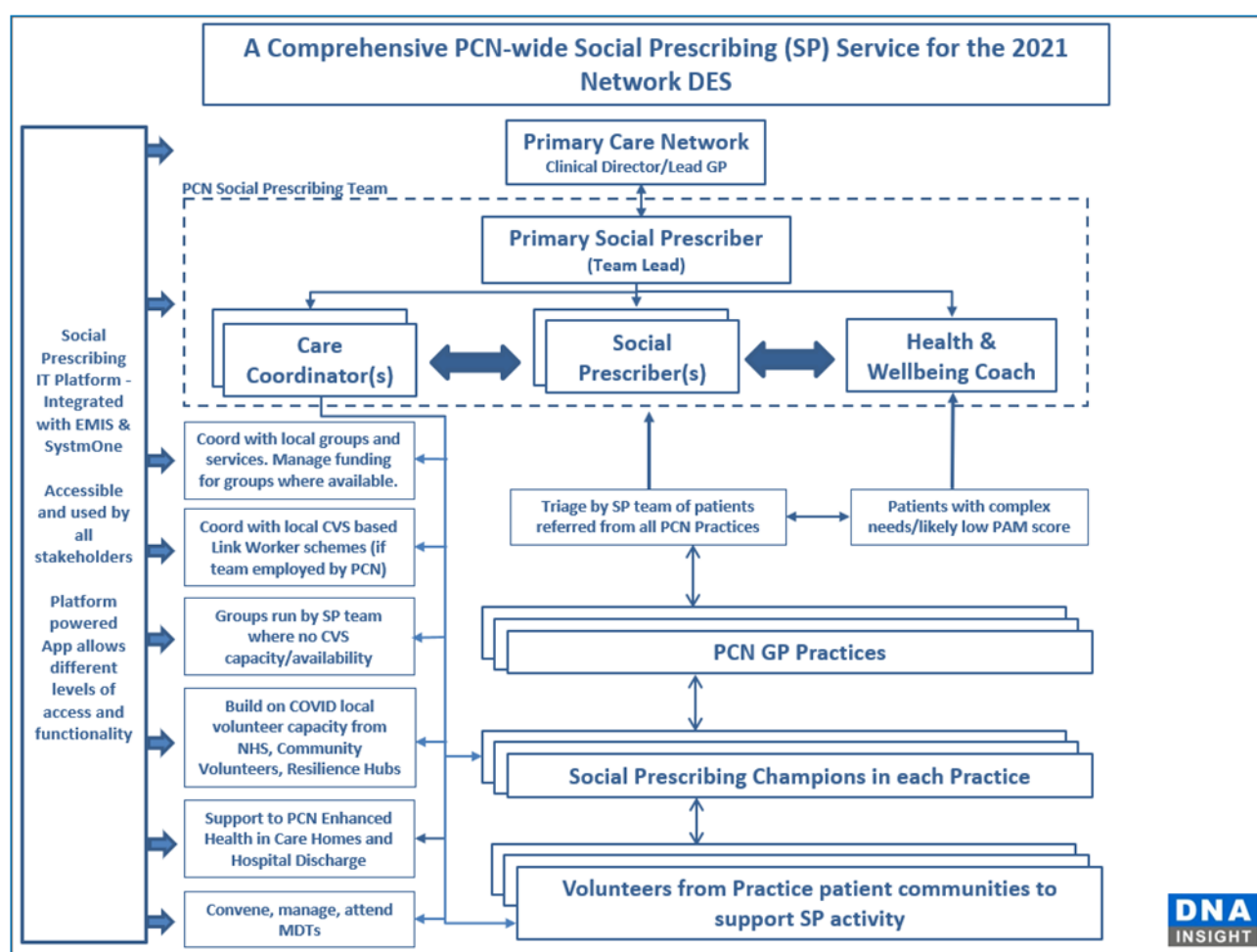


Structuring a PCN Social Prescribing Service for the post COVID world

Workforce planning for the social prescribing team

With the increased flexibility offered by the GP Contract update of February 2020, primary care networks (PCNs) can now recruit two additional roles to the social prescribing team – a care coordinator and a health and wellbeing coach, in addition to another nine roles in 2021. It also allows PCNs to determine for themselves how many of each of the available allied health professional (AHP) roles they recruit to meet the needs of their patient community, within the overall financial ceiling of the Additional Roles Reimbursement Scheme (ARRS). With a ‘use it or lose it’ approach to funding, there has never been a better time to plan ahead to ensure that the social prescribing team staffing and structure meets the needs of the PCN going forward.

The structural diagram below suggests one way in which the social prescribing team might be structured to support the PCN and shows the relationships between the social prescribing team and other stakeholders within the wider PCN community.



Changing reporting responsibilities

Where solo social prescribers are employed by the PCN, the default deployment model, whilst not universal, is one in which the social prescribing link worker (SPLW) divides their time amongst the PCN's practices, in rough proportion to the list size of the practice. This takes no account of the relative needs of the patient community in each practice and is inefficient in terms of travel time and administrative load. With a minimum team of three SPLWs, this model becomes logistically complex and even more inefficient.

Continued...

By working for the PCN as an entity, using a hub model, the social prescribing team can take referrals from each practice, triage the referrals for PCN priority/urgency and then allocate each patient to the appropriate member of the team.

Recruitment of new roles

The directed enhanced service (DES) states that the care coordinator is a band 4, whilst the social prescribing link worker and health coach are both band 5. This presents something of a dilemma. Do you avoid recruiting a care coordinator all together and avoid the potential conflict when the whole team, with minor variations, are doing essentially the same job? Or do you seize the opportunity to create a sensible organisational structure within the social prescribing team – one that allows for different roles and responsibilities, succession planning and the potential for promotion for care coordinators into one of the other roles?

The key to maintaining harmony within a team where people are on different salaries, yet carrying out broadly similar roles, is to have clearly defined roles and responsibilities, aligned to the salary level for that role. The DES has tried to provide detailed job descriptions for each role, but they are very similar, and it is difficult to identify any major differences that would justify different salaries.

So here are our thoughts on how you might structure a social prescribing team for 2021 and beyond, looking at each role in turn and ending with an 'at a glance' table to show the differences.

The social prescribing link worker (SPLW)

The SPLW is likely to be the longest serving member of the team, potentially with up to 10 months in post if their PCN moved quickly in 2019. As such, they will be experienced in the ways of the PCN, will have built the key relationships needed and will almost certainly have a referral, evaluation, and management system up and running. By default, therefore, they are likely to become the lead within the team, helping new members with induction and familiarisation. They will already have built up a sizeable case load, so it makes sense that they continue with that and become the main link worker in the PCN with the largest caseload. They will also use

their experience to allocate referred patients to members of the team based on the mix of skillsets available.

The health and wellbeing coach

Those recruited into the health coach role may or may not already be qualified as health coaches. As there are probably not around 1,200 health coaches around the country waiting to be recruited, they may well be recruited from complementary roles or express a desire to move into that role.

Regardless of coaching experience, the new health coach recruit should undertake the foundation training and induction for a social prescriber - getting them up to a baseline knowledge of how primary care works and how the social prescribing team operates within the PCN.

Then, at some later stage, the non-accredited health coach can undertake one of the two or four day health coach online courses available and accredited by the Personalised Care Institute. The choice of length of the course will depend on the percentage of their time they will spend on coaching. This will equip them to start using health coaching with the more challenging cases referred to the SP team.

Health coaches will focus their skills on helping those patients with a number of long term conditions that would benefit from supported self-management, or on those with complex conditions.

There will be a need therefore for initial triaging of referred patients by the team lead to assess the patient's conditions, prior to allocation to one of the social prescribing team. It is crucial to take a view at the triage stage, as changing responsibility for a patient from social prescriber to health coach after the patient's initial assessment is not best practice.

The care coordinator

Given that the care coordinator is a band 4, whilst the rest of the team are band 5, it is essential to identify a distinct role from the rest of the team to avoid comparison of what may be perceived as very similar roles and responsibilities.

This can be achieved by focusing on the coordinator role of the job title. The care coordinator should still be trained as a social prescriber and will take on a caseload

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(albeit a smaller one). They will however become the default stand-in to pick up new referrals for all colleagues when on holiday and will become the main coordinator and point of contact with the voluntary and community organisations and groups to which the team refers patients. The coordination part of the role can also include:

- Coordination across the PCN, team cohesion and support.
- Team lead for evaluation efficiency and reporting.
- Management of the social prescribing IT platform and integration/alignment with practice's EMIS/SystemOne.
- Team lead in building out and supporting voluntary groups/organisations.
- Team lead in building a social prescribing champion and volunteer structure within PCN practices, including working with those who had volunteered during COVID and who still wish to volunteer their time.
- Liaison with the patient participation group.
- Team lead in developing content and maintaining the accuracy of the directory of services.
- Setting up and managing a group for patients where the demand is not met by community or voluntary sector or local groups (e.g. a walking group or coffee morning for the lonely).
- Working with care home residents as part of the PCN's Enhanced Health in Care Homes programme or with those patients needing support following discharge from hospital
- Convening, managing or attending a variety of practice, care home or external multi- disciplinary teams (MDTs).

Type of Activity	Roles and Responsibilities		
	Social Prescribing Link Worker	Health & Wellbeing Coach	Care Coordinator
Prescribing Role	<p>Assessment of referred patients and allocation to team.</p> <p>Takes on caseload comprising bulk of non-complex patients.</p>	<p>Hold a mixed caseload of complex and non-complex cases with priority on complex cases and LTCs.</p>	<p>Holds smaller caseload.</p> <p>Focus on patients likely to require more simple or straightforward signposting to groups.</p> <p>May specialise in working with care home residents or those discharged from hospital.</p> <p>Picks up additional cases when other members of team on holiday/sick.</p>
Coordination Role	<p>Team lead.</p> <p>Point of contact with Clinical Director/Lead GPs</p> <p>Receipt and allocation of referrals to team members.</p>	<p>Take on those who have more complex or a multiplicity of needs or are likely, on assessment of the referral, to have a number of long-term conditions that would benefit from supported self-management.</p> <p>Provide professional support to the team in coaching skills and upskill the team in coaching techniques.</p>	<p>Coordinates team engagement with voluntary groups/service providers.</p> <p>Coordinates team engagement with practices – admin and logistics requirements incl EMIS/SystemOne integration and SP Referral Platform Lead.</p> <p>Coordinates evaluation/reporting to stakeholders.</p> <p>Coordination of and champion for volunteers.</p> <p>Convenes, manages or attends practice, care home or external multi-disciplinary meetings.</p>

Continued...

Type of Activity	Roles and Responsibilities		
	Social Prescribing Link Worker	Health & Wellbeing Coach	Care Coordinator
Training Requirement	Foundation social prescriber training – online or face to face.	Foundation social prescriber training – online or face to face. PCI accredited health coach course. Duration depending on the amount of time they will be coaching as part of their role.	Foundation social prescriber training – online or face to face.



Nick Sharples is a PCC associate and highly experienced social prescribing lead. He facilitates PCC's SocialPrescriberPlus programme and is passionate about the many benefits that social prescribing can bring to

patients and to the wider community. Nick also runs training programmes in care navigation and active signposting, digital group consultations and health coaching for social prescribing team members.

SocialPrescriberPlus – essential training for social prescribing link workers, care coordinators and health coaches

10, 15, and 29 June 2021

<https://www.pccevents.co.uk/2521>

If you would like a programme run locally for your social prescribing team or you are interested in any of the other programmes Nick runs contact events@pcc-cic.org.uk

Welsh Dental Contract Reform

With the key aims of providing a preventive focussed approach to dental care, making use of the wide and varied skill set within the dental team and using evidenced approach to dental care the Welsh Government, led by Chief Dental Officer in Wales, Colette Bridgman, commenced a contract reform programme in September 2017. The reform programme would change the focus of delivery of care from being based on activity to being based on risk and need with a focus on prevention and patient centred care and improving access to care. These aims will lead to improving the overall health and wellbeing of Welsh citizens.

In the first six months of the programme 21 practices joined the programme and this has continued to increase and now 173 practices, 40% of NHS dental practices in Wales are participating in the programme. There is representation across all seven local health boards.

Clinical care - Practices who have joined the programme now base their care around a patient centred risk and need based assessment. Practices were provided with the Assessment of Clinical Oral Risks & Needs (ACORN) toolkit which provides an annual assessment of the patient. The assessment leads to a personalised care plan both for what the dental team will do but also what the patient can do for themselves as well. Patients who are low risk are now encouraged to attend annually but patients with dental need or risk can be seen more frequently, based on their personalised plan.

What we will do for you

- ☐ Advice on what to eat or drink to improve your oral health
- ☐ Advice on cleaning your teeth
- ☐ Smoking cessation advice
- ☐ Apply fluoride varnish/fissure sealant
- ☐ Dental treatment as advised
- ☐ Prescription for a high fluoride toothpaste or rinse

What we expect you to do/continue doing

☐ Brush twice per day, at night and one other time. Spit don't rinse.

☐ Use a family fluoride toothpaste (1,350 – 1,500 ppm fluoride)

☐ Keep sugary food and drinks to mealtimes. Don't eat or drink anything sugary in the hour before bed.

☐ Contact Help Me Quit 0800 085 2219 www.helpmequit.wales

☐ Use interdental brushes.

☐ Attend your appointments when advised. Inform the practice if you cannot attend.

You will need a review in:

☐ 3 months ☐ 6 months ☐ 12 months ☐ Other _____

Continued...

Whole team working - A key aim of reform was also to better utilise the skill mix of the whole dental team. Health Education and Improvement Wales (HEIW) alongside the programme team have implemented a Making Prevention Work in Practice Course. This course was originally developed by PCC and we were delighted to be able to support the roll out of this course by HEIW dental educators. This course means that staff members can be trained on preventive messaging, allowing them to provide tailored and personalised messaging to their patient. Additional training on the application of fluoride varnish is also included which enables them to provide this preventive treatment.

The clinical care becomes a pathway for the patient and the whole dental team.



Dental access to patients – During reform it is key that dental access remains available to patients in Wales and there was an expectation of practices that access did not decrease and would look to increase when the practices were established in the programme.

To support the new clinical approach and to help support access, practices in the reform programme initially had a 10% reduction of the expected activity that practices were contractually obliged to deliver, which could increase to a 20% reduction when practices were more established in the programme. This reduction created the freedom within practices to implement the new approach.

Outcomes – The first annual report on the programme was published in 2019 (data based on a full year of programme activity) and was able to show the risk and need status of patients seen within that year, that access is maintaining or improving and that for children is at it's highest level. Clinically the level of Fluoride varnish has increased in both adults and children with the latter increased to 45%. There is encouraging signs that the oral health is improving with decreases in active disease.

Impact of Covid-19 – With the pandemic all dental care had to change and the programme was suspended in March 2020. With all practices using the principles of a risk and need assessment for prioritising patients during the pandemic it will support all dental practices from being familiar with this way of working when services resume fully. The aim is that the programme will restart in October 2021.

Further information on the Welsh reform programme including programme updates, annual report and patient survey can be found <https://primarycareone.nhs.wales/topics1/dental-public-health/dental-reform/>



Author
Wendy Crew
Adviser, PCC

A day in the life of a PCC expert adviser – Sarah Jones

Hello, I'm Sarah Jones and I've been with PCC for 12 years. I live in the Yorkshire and the Humber area and I'm the regional lead for North West of England and Isle of Man. I lead our eye care work and I'm a member of the medical team.

I worked with my colleagues to develop our eye care and medical work programmes which are delivered as part of our national events programme and as local workshops for annual contract holders. When the pandemic hit our face to face national events programme and local workshops were suspended. We quickly reviewed and converted our training sessions to a virtual platform delivery, using MS Teams and Zoom. Virtual sessions have received positive feedback. We review and amend the sessions based on feedback from clients.

The eye care work programme has been transformed and adapted to provide training to individuals who are completely new to eye care contracting and commissioning, some who have a little knowledge or need a refresher and those who are experienced at managing their contracts. Our support is layered to cover introduction through to deep dive sessions, which are a mix and theory and group work to drill down and consider specific scenarios they may face, giving delegates the opportunity to discuss these in a safe environment. Our training is delivered in such a way it enables individuals to review and reflect between each session. As part of our eye care support we deliver eye care virtual surgeries available to annual contract holders. These are an opportunity to share what's happening across the country for those who are supporting the commissioning and contracting of eye health services. It gives individuals the opportunity to ask questions, seek advice and guidance, and share learning.

My work is varied and consists of supporting clients with contractual queries, discussing how they can get the most from their PCC annual support contract this was particularly important last year with Covid-19. I worked with my clients to understand their support needs and how their contract could be flexed to be more responsive to address and meet their individual support needs, developing and agreeing work programmes against their



contract and 'checking in' to see if clients are okay given the reduced capacity of commissioning teams, the uncertainty and increased stress and pressure brought about by the pandemic.

Here's an example of feedback received from my clients 'Please can I thank both you and the team at PCC for the help and guidance given in helping us to utilise our contract allocation for 2019/20, especially at the latter end of the contract and in such a short timeframe and all the while ensuring we got value for money and for the support provided by your facilitators and tutors during the planning of and the running of our recent bespoke webinars, which made the process for us less demanding and saved us a lot of time' and 'PCC provides a range of training and support opportunities that are very relevant to CCG staff working in primary care commissioning. We value our subscription and the opportunities for staff learning and development provided by PCC.'

Daily I respond to helpdesk queries. Queries cover a range of complexities, requiring additional research to be undertaken and sometimes one to one calls to gain a better understanding on the query and following this up with a quality assured response. One client said 'We have used the help desk more of late, especially contracting colleagues. The quality of the responses have been very useful and as such has given us greater confidence in continuing to subscribe to PCC for this type of support, I would like to personally say thank you

Continued...

for the effort that has been made and I look forward to continuing to work with you and your colleagues over the coming year.'

I work with our team of associates to develop new products for example, procurement and bid writing training, workforce planning. I have also worked with my clients to provide 'added capacity' to identify their specific eye care contract requirements and taking forward the identified areas of work on their behalf. One of my clients provided the following feedback 'PCC was approached to support our eye care team to add remote capacity due to the current pressures resulting from Covid-19. The team was very responsive, understood from the outset the requirements, kept our team fully up to date on progress and carried out and completed work within agreed timescales. PCC are very supportive and allowed our annual contract to be utilised more flexibly to avoid a delay in delivering this support, PCC provided

much needed help to our team freeing us up to focus on other areas of work.'

I have also provided capacity to support extremely complex general ophthalmic service contract queries between contracting parties, the support consisted of; virtual meetings with the client, a review of archived files and documents, review and drafting of communication with affected parties, pulling together a chronological timeline of activity, drafting reports and identifying risks for consideration by client and preparing report and supporting evidence for submission to the clients legal services for review.

Our consultancy work provides much needed capacity for clients, especially with the current challenges and workload pressures facing commissioning teams.

Contact enquiries@pcc-cic.org.uk to find out how we can help you.

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