PMA Webinar Questions answered

PCN Workforce Planning Template 2020/21

Scott McKenzie responds

1. We are a rural PCN where it is 30-45 minutes between practices so unfortunately staff are mainly from our village so they wouldn't be prepared to work across. I think this works so well for town practices. Any advice?

My sense is that this is all about how you advertise the role. If you advertise a role as a PCN role with a requirement to work across the patch, people will expect that outcome if they are successful in the recruitment process. I accept people who are in post now may be less likely to accept working across; however, what I would do is run a session with the existing staff and pose the question – we are looking at how we deploy the following services across the PCN and exploring how best to work with our existing teams to meet patient and NHS need. Then ask for pros, cons, reason why this could work, reasons why it may not work and a final recommendation from the existing team. You may be surprised at how innovative they become when given the chance to own the problem and the creation of the solution. Where this often goes wrong is we manage it top down and people resist the change, whereas if left to create their own change you get it implemented

2. How do we pay for the on costs for ARR roles above the pension and NI and In City and Hackney we are being asked to fund the employment gap from the development fund – any thoughts?

The short answer is the £1.50 is often used to fill that gap, unless the CCG is prepared to use a different "pot" to support the PCNs. This is often the case when it comes to London as the London Weighting has not been factored in. I am aware there is a document about to be submitted to NHSE explaining this and seeking additional "London Weighting" for ARR money in London

3. What are the VAT issues if we choose to buy a service from another organisation such as NHS Trust or private provider?

This needs formal accountancy advice and guidance; however, for many that I work with they have put in place VAT sharing groups/schemes and that appears to work well for those that have it

4. How do you square all of this with different ways practices work and have different ethos and that we are all independent businesses?

When I'm working with individual General Practices, Primary Care Networks and/or GP Federations, my focus is always to support the creation of one practice, network or federation with one vision. For me it's all about creating one organisation, with one vision and one voice. That one voice is a strong and coherent voice for General Practice within a health economy. Without that you end up with reduced share of voice and the risk of divide and conquer. That becomes a real risk in Networks and Federations, and I have seen many fall foul of this. My best example of this ethos in action lies in North Warwickshire, where I have worked with Primary Care Warwickshire (PCW) for a day a month for over 5 years. PCW

is a GP federation of 23 (of 28) Practices that works with the Primary Care Network Clinical Directors and Managers, the LMC and the Board of Directors for the federation, to create that one vison and one strong and coherent voice for General Practice. They work at different levels based upon what it is they are trying to achieve.

5. One of Scott's slides suggested to consider workforce vacancies/retirements in planning ARR workforce. Are we able to use ARR funding to replace retiring GP staff counted in the baseline?

No, you cannot use ARR funding to replace a retiring GP. This is about thinking outside the box and using the ARR money to recruit a team based upon a succession plan that is looking ahead 12 to 18 months at the retirements you have coming up. That way you are planning ahead so that when you have A, B and C retiring, you know what roles would be best to recruit for now in the event that you cannot replace them.

Tracy Dell – responds

1. *The national PCN picture is variable, given your experience across a range of PCNs - How are the best PCNs equipped for success?* And what are the key failings when it does go wrong…?

Tracy Dell responds

The key is trust, communication and transparency. If all these elements are in place it lays good foundations for success. Key members of the team need to be involved and take responsibility: GPs/ACPs/nurses, managers and having dedicated admin support is crucial. The CD cannot do it all alone.

Gary Hughes responds

Create that shared vision at the outset and remain focused on it. It must have everyone's buy-in and be agreed by all, the absence of this is a common factor when things don't work out. Make sure there is management and leadership in place that have the capacity and the capability to fulfil their responsibilities. The clinical director cannot do everything, and it is wrong to assume that clinicians will have the required leadership and management skills. In reality it is more likely they won't but invariably a Practice Manager will.

2. *What do clinical directors need to prioritise to create an effective PCN?*

Tracy Dell responds

They need to lead and direct ensuring they meet the contractual requirements and utilise the budget to maximise the benefits from the additional roles. They must horizon scan and networking outside the PCN too.

Gary Hughes comments

They need to be the leader and all that entails in heading a large organisation with multiple stakeholders and complex relationships. This includes recognising where they need support and assistance from others and ensuring they get it.

3. *Is opting out of the DES an option?*

Tracy Dell responds

Yes, but in my opinion, it is financial suicide! More and more services will be commissioned at PCN level going forward. Unless practices can survive on GMS/PMS/APMS funding it will hit them hard.

Gary Hughes comments

For all but the most independent and financially strong practices, it does not make strategic sense to opt out. Even for those that may be in a position now to opt out, it is likely they will find being outside a PCN more and more difficult as times goes by. It is far wiser and better to be in at the start, taking the opportunity to shape the future.

4. Any tips for creating and building effective relationships?

Tracy Dell responds

With other practices and service providers? Business and Practice Managers have forged good relationships for years. Build on their success and apply the principles across the practices. A lead manager model may help to coordinate this. Delivering joint training/development sessions in protected learning time (if you have this) helps. Remember to involve the whole team and PPGs not just clinical and management staff. Independent facilitation may work better for this type of approach.

Gary Hughes comments

Know your stakeholders, and who is most important. Make sure you have wide and effective networks with openness and trust. You should always aim for a win-win, the relationship will not last, or be built on trust, if one sides feels they are not receiving an equal value. Also recognise that building and maintain relationships is a skill and takes time. Make sure you have the right people, with the right skills, finding and forging the relationships; it does not have to be the clinical director and especially if they are not equipped to perform this important role.

5. How should we prioritise the new services/ skills to bring into the PCNs?

Tracy Dell responds

Don't just go for the familiar roles and services like Pharmacists. Data is the key. Population health management will drive this. Assess your activity, reason for appointments (via signposting) and read code/template all consultations including video, telephone and eConsult so you can audit your data easily. We did this in our practice. An audit of MSK related activity resulted in us diverting approximately 10% of our appointments to a MSK Practitioner releasing GP time amounting to nearly 12 hours per week. We have now carried out the same exercise for our Mental Health FCP and anticipate saving nearly double this amount of time.

6. What protected funding will be available for PCNs to develop their workforce and to develop the integrated care systems (ICSs)?

Tracy Dell responds

Funding is already there we just need to know how to find it and access it. Your CD should lead or your GP Federation if they are managing your PCN. For example: SPLW additional funding recently announced. Got to be signed up to every newsletter you can find and pounce on these opportunities quickly.

7. *Can you offer any clarity on PCN funding – and how do we access a fair allocation of funding in line with local needs?*

Tracy Dell responds

PCNs need to take control and be involved in all aspects of finance. Some PCNs have leads or steering groups. This facilitates robust processes for making decisions. Having access to the income and input into budget setting is vital. So many members of PCNs have no idea how funding is being allocated or spent

Gary Hughes responds

1. We are a rural PCN where it is 30-45 minutes between practices so unfortunately staff are mainly from our village so they wouldn't be prepared to work across. I think this works so well for town practices. Any advise?

You know your staff best, but don't assume they won't agree if the question hasn't been asked. If working across the sites is crucial then you can always incentivise the role with an increased rate and/or travelling costs. If it's a new recruitment, then the working across sites can be made a requirement of the role. The key is don't think you have to be constrained and restricted by what has happened before. All this said, it could equally be that you can achieve what you need by not working across the patch. Look at all the options and what would be needed to make them happen.

2. How do we ensure that our workload is also aligned and supported from a PM perspective? No roles seem to support the 'admin' type roles within general practice and we need to support this team along with the clinical team?

It's certainly true that the PCN will inevitably bring work to the PM's because there will be some things that only they and their skill set can do. For me, the answer is the PM's need to make their voice heard and make it clear that they do not have any unused capacity and that if their time is used on PCN commitments then it will mean a loss at practice level. Get their Partners to understand and support this and either:

- ·Get funding for their time, assuming they have the capacity available. If not they must make it clear the time they spend on PCN responsibilities will mean something isn't done at the practice.
- ·The PCN recruit and employ a Project Manager/ PCN Manager to do the work needed. In my view this is almost certainly the better and more sensible option.

3. Do we give 12-month contracts to staff to give flexibility for year 2 if we wish to change skill mix

You should give the contract length that you feel would be the most appropriate taking into account all the benefits and risks. For example, a longer contract may make the role more attractive, and therefore

recruitment easier. However, should the need for the role end before the term of the contract, then redundancy may be required, although that may not be the case and it still does not mean it's wise to rule out a longer contract. The important thing is to consider everything and don't think it has to be a one size for all or the same as you've done before.

4. How do you square all of this with different ways practices work and have different ethos and that we are all independent businesses?

Independence is very important and it's incorrect to think that by committing to a PCN you will, or should give, that up. There are plenty of examples where businesses have joined together to achieve an advantage for them, and their customers (in our case patients), and their independence is not affected. As an example, I can order my KFC from Deliveroo but I don't feel it's any less a KFC product when it arrives. Equally, if everything is done properly, KFC will not feel their brand or independence is affected by the order being taken and delivered by Deliveroo. Whether it's fast food or healthcare the key thing is to take a broad strategic view and consider how working together can benefit all parties and, vitally important, make sure there is a shared vision.

Useful time times from the end of August 2020 onwards

PCN Workforce Planning Template 2020/21: Guidance notes for completion
This workforce planning template is designed to support primary care workforce planning activity at Primary Care Network (PCN) level. Two parts of the template are included (see tabs 'Part A' and Part B'), which should be completed in line with the expected timescales set out below. The additional workforce available to PCNs to recruit under the Network DES Additional Roles Reimbursement Scheme (ARRS) has the potential to provide additional capacity to support primary care during the response to COVID-19. However, we recognise that PCNs may need more time to consider their workforce needs. We have therefore delayed the deadline for submitting 2020/21 recruitment intentions until 31 August, and indicative intentions for 2021/22 and beyond until 31 October. This will be kept under review as the COVID-19 emergency response progresses. The associated requirements on CCGs to redistribute unused additional roles funding to other PCNs has been postponed until the end of September 2020.

Part A covers ARRS recruitment only. Working closely with their CCG and the local primary care training hub, PCNs should use this to indicate the number of staff they intend to recruit through the scheme in 2020/21, as well as emerging recruitment intentions for 2021/22 and beyond to support workforce planning activity. For 2020/21, the template will calculate the indicative spend against the financial allocation available to the PCN, and highlight any remaining allocation that could be lost to the PCN if not used. Once submitted, PCNs are free to change their workforce plan at any stage. To support local flexibility, the process for submission will be defined and communicated by the receiving CCG.

Part B covers indicative recruitment intentions for the wider team. In light of the COVID-19 response, use of this section is voluntary to support discussions between the PCN and their training hub on available local supply, and the education, clinical supervision and ongoing career support and development needs of all staff groups within the PCN team. This will include retention and the support available to PCNs to introduce new roles and ways of working. CCGs and systems will similarly use PCN workforce plans to consider support required for recruitment activity, including opportunities to broker arrangements across PCNs. ICSs, STPs and CCGs may additionally agree local processes to make use of the tool for workforce planning.

Expected timescales (please review against latest guidance in light of ongoing COVID-19 response)

As soon as possible, taking into account COVID-19 response: Lead CCGs and primary care training hubs to liaise with PCNs (and other local health, social and community care stakeholders) to discuss their recruitment plans for 2020/21. In consultation with their training hub, CCG and other stakeholders, PCNs should develop and adjust their workforce plans as needed going forwards, seeking to maximise recruitment through the ARRS scheme.

From 01 April, taking into account latest NHS Digital guidance during COVID-19 response: PCNs / practices to update the National Workforce Reporting System with workforce changes on a monthly basis, in line with Network Contract DES.

By 31 August: PCN to formally submit recruitment intentions for 2020/21 to its CCG in accordance with locally defined process. Any changes to this plan should then be notified on an ongoing basis.

By 30 September: CCGs to agree an aggregate local plan with PCN clinical directors and consider amounts for in-year redistribution to other PCNs (if required).

By 31 October: PCNs to provide indicative recruitment intentions for 2021/22 and beyond under the ARRS scheme to their CCG.