Tower Hamlets Primary Care Networks (PCN)

Introduction and Overview

Networks in Tower Hamlets were first formed in 2010. Tower Hamlets is cited as an example of best practice that is now being replicated nationally, through the introduction of PCNs. In 2010 the then Primary Care Trust (now Tower Hamlets, Newham and Waltham Forrest (TNW) Integrated Care Partnership), Local Medical Council and GP surgeries in Tower Hamlets set up eight Networks composed of member practices linked to a Network Incentive Scheme (NIS). The NIS is a contract for additional work over and above their standard GP contracts.

The reason for establishing the Tower Hamlets Networks was due to the high levels of deprivation in the borough and the chronic underfunding of primary care.

Since the implementation of the NIS, list sizes have increased by 26.2% between 2011 and 2019, or 3.3% on average per annum. List size growth has varied between Networks from 11% to 46%.

On the 1st April 2021 Networks 3 and 4 merged. A practice from Network 3 and one from Network 4 will merge shortly. This merger has impacted Network 4 PCN configuration and eligibility to operate as PCN (Network Contract DES Specification section 5. indicates that a PCN population must have a minimum of 30,000) and without East One Health, Network 4 falls below 30,000.

The Care Quality Commission (CQC) is the national body that assesses the quality and governance of NHS bodies including General Practices. All of Th Practices are currently rated good or Outstanding. Please see Appendix A for the full list.

The following sections provide examples of the excellent work undertaken by Networks.

Network 1	
Buddying System	In 2020 NW1 created a buddying system to increase resilience to COVID-19. A system which was later adopted more widely in Tower Hamlets and in TNW as well. The practices worked together to move their phone systems to a cloud-based system which became increasingly important for working through the pandemic.
Key Team	The clinical director used the Network Directly Enhanced Service (DES) funding to create a 'Key Team', a concept that has been used in Wales and Alaska. This involves a multidisciplinary team working together to deliver holistic care. The Network One Key Team started as an HCA/Phlebotomist, GP Registrar, 2 Occupational Therapists and a pharmacist, and worked on improving the long-term health outcomes of the network's complex care patients. There are now plans to expand this team to include care co-ordinators and social prescribers. A paramedic will also be working part time within this team, and more generally.
Inter-practice referral Scheme	The Network has had an inter-practice referral scheme in place since 2010, normally for specific procedures/services such as contraception. In 2020 this was taken to the next level by creating centralised flu clinics. These clinics were held completely at the network level, using the network infrastructure to manage bookings, flu stock and payment.

Network 2	
Centralised and integrated call/recall	Network 2 developed and pioneered centralised and integrated call/recall - the first Network to have successfully established this as a specific function in Tower Hamlets. Key components of this system is having a highly skilled and dedicated call/recall team to allow patients direct access to book annual/interim reviews. The team also provide basic level triage signposting to social prescribers, Clinical pharmacists, PCN FCP and Network LTC Nurse. This team have now developed specialism dealing with the needs/issues relating to the long term condition population and are able to provide a more personalised and holistic experience to patients (which includes addressing wider determinants of health via active signposting support). This coupled with the Network's dedicated central recall phone number and its Network Website (along with its Social Media platform) allows patients to conveniently access information and services, e.g. stop smoking referrals managed online, call back services to the Network team, where patients can directly discuss their LTC annual review appointment needs etc. Part of the call/recall offer is providing a dedicated support line for anxious patient's or those needing basic lifestyle advice, centrally supporting flu and vaccination campaigns as well as managing inter practice referrals for Sexual Health LARC services.
Online interactive dashboard	Developed and manage an online interactive dashboard primarily for NISs, that is used by all GP practices/PCNs and GPCG for hosting reporting data for things like e-consults, GP website analytics, SMS etc. The system is easy to access, with user driven visual diagram/charts and practice based dashboard reporting of KPIs. It is primarily used to help improve performance by showing where practices are with activity/targets, identifying patterns, correlations, comparisons, deviations to help better organise workforce and the attainment of NIS targets.
Shared cloud-based Telephony System	Shared cloud-based Telephony System was installed - the first Network to have done this in Tower Hamlets through the Network's digital transformation project. Primary objective was to alleviate issues with existing costly and technologically archaic phone systems (with complicated/non-existent reporting systems, coupled with minimal user control and access management and in most cases no call recording options). This was limiting and negatively impacting patient experience and access as well as practices ability to efficiently manage access demand. A number of practices have now adopted shared Telephony systems as a direct result of the benchmarking and analysis report produced by the PCN (along with live demonstrations and support).

Networks 3&4 (Now Network 9)	
Network Diabetes Specialist Nurse	A full time network sponsored role and the first network to have this role established in Tower Hamlets networks since the inception of Highway Network, working in all 4 practices sharing the sessions to manage Diabetes patients with LTC. The network's performance on the NIS Integrated Care Metrics continue to be one of the best and this is only possible buy having this focused Specialist Nurse monitoring and managing. This role is partly funded by the network management funds and the remaining from practices contributions.
Network Diabetes Advocate	This role was created to support the Diabetes Specialist Nurse clinics in all practices with a large number of network patients population is Bengali ad Sylheti speaking. This role has helped the DSN immensely to engage with patients and has helped the network to conduct many educational events twice a year in the locality during "Ramadan" period for many years. The cost of this role also funded by network management funds and practice contributions.
Network Phlebotomy	The network has recruited several HCAs to support with phlebotomy clinics in all practices and also domiciliary clinics. These roles are also partly funded by the

HCAs	network management funds and the remaining from NIS phlebotomy upfront funds practice contributions based on the sessions in each practice.
Centralised Call/Recall team	The first network to establish this centralised call/recall team within Tower Hamlets networks set up to support practices with searches, call/recalls. The network has taken a tailor made approach to help practices on the NIS focused metrics. The call/recall team will be working in all practices and the cost of these roles are funded 100% from network management funds. This project has been and it was a huge success for many years and now 2 other networks have adopted this model and established their own centralised call/recall teams.

Network 5	
Centralised Phone System	An ambitious digital transformation plan was set for the PCN before the pandemic and the first step towards this was to create a central telephone system that connects all five practices with one provider that would result in a cost effective, efficient telephone system which would also enhance the delivery of care package and NISs call recall at scale within the network. The Network team took on the entire responsibility of project initiation, mobilisation and delivery including: • Understand Terms of existing contracts • Scoped various Cloud based NHS telephone providers • Mobilisation and Installation of the new service • Service setup • Training and On-going Support The outcomes were: • Digitally joined up telephone system in the PCN enabling additional support line for practices and patients for booking of COVID vaccine • Supported for practices with overflow of calls and improving access for patients • Enabling Virtual reception support for practices
Reducing Child Poverty by improving the uptake of Health Start Vouchers (HSV)	The North East Locality Health team created a multidiscipline and multi-organisational team, consisting of Network teams, Social Prescribers, Health Visitors, Midwifery, benefits advisors, primary care reps and PH lead on child poverty. The project was led by the network team and supported by the PH leads and QI coach. Our greatest achievement of the local project team has been to change the national requirement of Health professional signoff on the application process. HSV required health professional signature as part of the application process. We spoke to the national team with evidence that the requirement of HP signature creates barrier for patients applying for this support hence this has now been removed which has not only benefitted TH residents but wider.
NIS App	Core deliverables for the Digital first strategy include the deployment of the NHS app. This project is focused on uptake of the NHS app via the repeat prescription ordering feature. The project was led by the network manager and Clinical director with support from the digital accelerate team. We had individual practice champions from all the five practices and input from PCN pharmacist and community pharmacist. Small pilot within Network 5 with a targeted, hands-on approach to educating patients and positioning of the service including formation of a small project management team at network level. Outcomes included:

	• NHS app prescription requests increased from 7% (April) of all electronic requests to 12% (August) • Cumulative NHS app registrations (From April) : 891 • NHS app prescription requests increased from 6% (April) of all electronic requests to 20% (August)

Network 6	
Health Champions	Network 6 holds the APMS contract for St Paul's Way Medical Centre which is a 15,500patient practice providing an innovative model of primary care integrating with local schools and other community organisations. We value our local community and work hard with our community partners to improve local services. We also value the individuals and families who are living in the community and can help shape and support the service we offer. In partnership with Morgan-Stanley we have expanded our patient engagement team, created a "Health Champions" project and are opening up the practice to volunteers who are also able to contribute to the service. The Health Champions project has now been developed across the Network.
Young Health Champions	Our work with schools underlines our commitment to supporting the next generation growing up within our community. We recognise the key role our young people play in supporting their families and acting as advocate and young carers. We have recently set up a "Young Health Champions" project providing learning opportunities and mentoring regarding about health and local health issues. We also provide work experience placements and mentoring for students applying for medicine and other allied health careers.
Link workers and Social prescribers	Our Social Prescribing service has been active within the PCN for many years and during the covid pandemic our Link workers have teamed up to look at our most vulnerable patients in Network 6. We had many patients who did not know where they would access benefits and health care during the pandemic. Network 6 had problems with patients who could no longer go to work, they needed help with finances, we also had patients who were elderly and vulnerable who were not able to get food into their homes.
Population Health	Network 6 has a strong history of patient and community engagement and are building on this collaborative approach to develop a population based model of healthcare to address both key health measures and targets together with the wider determinants of health. This will invest in initiatives to improve the lives of our community, reduce health inequalities and improve long term outcomes.

Network 7	
Community Led health programme	Developed a community-led health programme, using an asset-based community development model to empower residents to take control of their own health and wellbeing. To implement a 'health creation' programme in which residents: • Identify issues impacting on health and wellbeing that matter to them. • Recruit other residents who have the energy/passion to make a difference. • Develop and lead new ways of improving health and wellbeing locally. Poplar & Limehouse Network were awarded a Public Health contract to employ a team to work with patients in two specific geographically defined areas (Teviot Estate and Poplar High Street West). Using a community-based approach to build esteem and a shared understanding through active participation, the team undertook: • door to door engagement with every household in each area being contacted.

	• Formed local resident steering groups. • developed an action plan of 'quick wins' developed to build momentum. created a Participatory Budgeting Process where residents vote on which local Health and community Programmes to be funded. Enabled delivery of programmes co-produced by residents driving the change in their community. Over 3000 residents were involved in the programme. Over 40 community-led health and wellbeing activities were delivered. Further data currently being analysed by the University of East London (UEL).
Wrap-around service for domiciliary patients	This involved providing a seamless multi- practitioner service, which provides the same equality and quality of health provision to housebound patients as that received by practice visitors, and also created time for GPs to make meaningful home visits. The service was developed by and through: • Network Conference session Dec 2019 – 18 Multi-disciplined colleagues "workshopped" the need and objectives of the programme. • Appointment of a GP and Practice Nurse to develop and devise the programme. • Support from Network Board. • Use of the DES ARRS provision. • Home visits for Vaccination of housebound patients • Recruitment of Care Co-ordinator. • Day in the life of the service published. • Recruitment of Nursing Associate (recruitment underway). • Recruitment of Podiatrist (sharing with Network 8).
Multi-Disciplinary Team	The creation of a Multi-disciplinary team to: • Assist practices to stay in contact and check on vulnerable patients during the covid-19 pandemic. • develop a pathway to support local organisations to support local residents. • create a conduit for local organisations to feed back into Primary Care. • take a practical approach to deliver essential items (food, medication, education packs) to residents. • The South East Locality Health Link Team (SELHLT) created a multidiscipline and multi-organisational team, consisting of four Social Prescribers, three Local Area Activators, Mental Health Liaison Nurse, Clinical Psychologist, managed by the Locality Wellbeing Manager and overseen by two local GPs. • The team buddied with individual Practices and started active engagement by ringing local patients who were shielding thereby ensuring that vulnerable patients were regularly monitored. • Training session were facilitated by GPs to identify and act on health 'red flags' that might occur when talking to isolated and medically vulnerable patients. • Checklist templates were developed to record issues/concerns/conversations. • Crib sheet with local community and statutory services was created. • Pharmacists were contacted to offer prescription delivery and partnership was developed with Bike Works to deliver medication. • The service started with 7 days a week plus Bank Holiday delivery. • The SEHL Team established links with local groups and LBTH to help distribute food supplies and to connect residents with shopping services. • Links with schools enabled education packs to be delivered.

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- Evaluation phone calls with residents were undertaken.

The team contacted over 600 patients and working with Bikeworks were responsible for over 170 medication deliveries and over 350 education packs were delivered to local schoolchildren. Welfare and Financial support given via Social Prescribers. Our evaluation calls showed excellent feedback from local residents.
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<tr><th colspan="2">Network 8</th></tr>
<tr><td>Healthy Island Partnership Community team</td><td>Network 8 has developed a Healthy Island Partnership Community team whereby existing clinicians within the Network can refer to 2 Health Coaches via the Social Prescribing Team. Patients can be referred if the clinician has identified a health and/or social need that might benefit from support of the Wellness team, which not only includes Health Coaches but also a Volunteer co-ordinator. The Health Coaches provide 1-1 support for people and link closely with the volunteer co-ordinator who supports patients to attend local community projects e.g. drop in coffee mornings, walking groups, exercise classes, and enable people to give back to their community, and who is also building a network of volunteers locally to support community projects. This innovative service could only have been developed by having a strong Network management structure.</td></tr>
<tr><td>Improving Primary Care Access</td><td>Well ahead of Covid lockdown, PCN 8 were working hard to develop new ways of giving primary care assess to local patients. With a young demographic on the Isle of Dogs, it was clear from patterns of engagement that the normal system of phoning for a GP appointment was not always the favoured choice of local residents. The Network Team also identified a low take up of Male users compared with the rest of the borough (33% against 35.1%).

The Network looked at how we could promote the take up of E-consults and importantly how each practice would cope with any influx of e-consult consultations. Marketing Plans were updated. Weekly reports were produced and circulated to all Network Practices. The E-consult programme was reviewed regularly in Network Meetings.

Patients reacted favourably with the following take up results
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<tr><th><u>Network 8</u>
Month</th><th>No of e-consults</th><th>% of Borough up-take</th><th>% of Male take up</th></tr>
<tr><td>March 19</td><td>1283</td><td>13.6%</td><td>33%</td></tr>
<tr><td>Aug 19 initiative start</td><td>1954</td><td>24.7%</td><td>33.3%</td></tr>
<tr><td>March 20</td><td>8417</td><td>25.56%</td><td>34.4%</td></tr>
<tr><td>March 21</td><td>12 881</td><td>26.00%</td><td>34.9%</td></tr>
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Highest take up from 24 and 25 yr olds (borough 29 and 30yr olds)
Higher percentage of Male take-up overtaking the borough averages.
PCN 8 now has the highest take up across Tower Hamlets.

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<tr><td>Integrated Physio Service</td><td>Musculoskeletal related consultations make up to 30% of a GPs workload.
GP workload had increased during the pandemic particularly with the increase in MSK e-consults.
The secondary care physiotherapy service was suspended during the peak waves of the pandemic which resulted in less support for patients with musculoskeletal diagnoses. We identified this as an area of patient need, with</td></tr>
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	a limited secondary care service provision during the pandemic. This was consistent across all practices in the network. We designed a first contact physiotherapy service for the network. We recruited 2 experienced FCPs to the network. The FCPs now offer regular clinics at the practice. We established a weekly peer support group and offered mentorship to the FCPs. The peer groups have provided a platform for case discussion and ongoing CPD (including external speakers. A patient feedback survey after 3 months of the FCP service showed: 89% were very satisfied with the FCP service; 89% were vey satisfied with the FCP consultation skills and the holistic care; 77% were very satisfied that their concerns had been managed in the consultations; 100% were very satisfied that the management plan had involved joint decision making.

Appendix A - Tower Hamlets Practice CQC Ratings

Practice	PCN	CQC rating
Aberfeldy Practice	7	Good
Albion HC	2	Good
Barkantine	8	Good
Bethnal Green Health Centre	1	Good
Blitehale	2	Good
Brayford Sq	3	Good
Chrisp St	7	Good
City Well Being	3	Good
Docklands Medical Centre	8	Good
East One Health & Cable St	4	Good
Globe Town	1	Good
Gough Walk	7	Good
Grove Road	5	Good
Harford HC	3	Good
Harley Grove	5	Good
Health E1	2	Good
Island Health	8	Good
Island Medical	8	Good
Jubilee St	4	Outstanding
Limehouse	7	Good
Merchant St	6	Good
Mission	1	Good
Pollard Row	1	Good
Ruston St	5	Good
Spitalfields	2	Good
St Andrews	6	Outstanding
St Katharines Dock Practice	4	Good
St Pauls Way	6	Outstanding
St Stephens HC	5	Good
Wellington Way/Stroudley Walk	6	Good
Strouts Place	1	Good
Tredegar	5	Good
Wapping	4	Good
Whitechapel	3	Good
XX Place	6	Good

Supporting practices is the core job of the Networks. For common issues such as mandatory training or QOF QI projects the Networks provide the support and/or infrastructure that enables greater efficiency and better outcomes. Networks also provide direct support to practices on everyday issues, whether that is clarifying a policy is most up-to-date or running a report on potentially uncoded patients with dementia.

Typically when a practice is told that they will be having a CQC inspection they will contact the Network team and other Network practices for support in making sure their governance etc is up to date. CQC like to see evidence of high-quality audits and projects that practices have embarked on that has improved the outcomes for their six groups of patients. Practices often use work they have done as part of the Network to demonstrate this.