Bromley
Primary Care Networks

Bromley PCNs

Annual Report 2023/24

A message from the Bromley PCN Clinical Directors

2023/24 was a packed year for Bromley Primary Care Networks. The dedication and hard work by PCN teams and practice staff – both clinical and non-clinical - have enabled us to continue to successfully develop and deliver integrated services, a vision first introduced five years ago in NHSE's PCN Network Direct Enhanced Service (DES) Contract. There has been much work happening behind the scenes to enhance the role of Bromley PCNs within the One Bromley partnership and ensure it plays a key role in the development of integrated neighbourhood working across the Borough.

We recognise that people are our superpower and continue to support them to provide the best healthcare possible. This financial year saw the largest increase ever in the recruitment of Additional Roles Reimbursement staff and PCN core staff, who are all working to relieve the workload pressures felt by every Bromley GP practice. We have supported transformation activities designed to improve capacity and access, including the roll-out of cloud telephony, the Modern General Practice Model, a new online consultation tool and digital inclusion projects. Numerous at-scale hubs have been developed to create more appointments across a multi-disciplinary team, with innovation at the heart of every new PCN project designed to reduce health inequalities and enhance proactive healthcare in Bromley.

In a year that witnessed escalating demands on general practice paired with changing national expectations on service delivery, this Annual Report aims to provide transparency, trust and credibility amongst our colleagues, One Bromley partners and key healthcare stakeholders.

We are proud of the role we play as both an advocate for GP practices, primary care networks and primary care, but also for population health as part of the broader vision for health in Bromley.

With best wishes,
The Bromley Primary Care Network Clinical Directors

Dr Nirav Amin
Dr Jonathan Anthonypillai
Dr Zia Buckhoree
Dr Michael Choong
Dr Addo Djangmah
Dr Chris Holdridge
Dr Chris Fatoyinbo
Dr Natasha Hoare
Dr Bridget Hopkins
Dr Maya Lasrado
Dr Claire Riley
Dr Emma Ryan
Dr Alka Sharma
Dr Bushra Yousuf

Bromley
Primary Care Networks

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Bromley Primary Care Networks

The 8 Bromley PCNs

Beckenham PCN
www.beckenhampcn.co.uk

Beckenham PCN
Primary Care Network

Bromley Connect PCN
www.bromleyconnectpcn.co.uk

Bromley Connect

Five Elms PCN
www.fiveelmspcn.co.uk

Five Elms PCN

Hayes Wick PCN
www.hayeswickpcn.co.uk

Hayes Wick PCN
www.hayeswickpcn.co.uk

MDC PCN
www. mdcpcn.gpweb.org.uk

MDC
PRIMARY CARE NETWORK
MOTTINGHAM | DOWNHAM | CHISLEHURST

Orpington PCN
www.orpingtoncn.co.uk

ORPINGTON
PCN

Penge PCN
www.pengepcn.co.uk

PENGE PCN
PRIMARY CARE NETWORK

The Crays Collaborative PCN
www.thecrayscollaborativepcn.co.uk

CRAYS
The Crays' Collaborative PCN

Bromley
Primary Care Networks

Bromley PCNs Map

Unity Cluster

Penge PCN
Population: 35,900

1. Oakfield
2. Park
3. Anerley
4. Robin Hood
5. Highland Road
6. Sundridge

Beckenham PCN
Population: 61,800

7. St James'
8. Eden Park
9. Elm House
10. Cator
11. Manor Road
12. Cornerways

Hayes Wick PCN
Population: 40,200

13. Wickham Park
14. Station Road
15. Pickhurst
16. Forge Close
17. Addington Road

Bromley Cluster

Bromley Connect PCN
Population: 40,300

18. London Lane
19. Dysart
20. South View

MDC Network PCN
Population: 35,300

21. Links Downham
A. Links Mottingham (Branch of Links Downham)
22. The Chislehurst Partnership
B. The Chislehurst Partnership (Woodlands Branch)

Five Elms PCN
Population: 44,800

23. Bromley Common
24. Southborough Lane
25. Summercroft
26. Norheads Lane
27. Stock Hill

1 A&E at PRUH
2 UTC at Beckenham Beacon
3 UTC at QMH Sidcup

Orpington Cluster

The Crays Collaborative PCN
Population: 35,400

28. Broomwood
29. Crescent
30. Poverest
31. St Mary Cray
32. Derry Downs
33. Gillmans Road

Orpington PCN
Population: 62,000

34. Tudor Way
C. Bromley Park (Branch of Tudor Way)
35. Whitehouse
36. Ballater
37. Knoll
D. Highland Orpington (Branch of Highland Road)
38. Bank House
39. Family
40. Green St Green
41. Chelsfield
42. Bromleag (virtual practice)

PCN Leadership Teams

The 8 PCNs within the borough of Bromley has a combined patient list size of **355,503**.

Each of the PCNs has a small team lead by one or more Clinical Directors who are supported by a Network Manager and Digital Transformation Lead.

	Clinical Directors	Network Manager	Digital Transformation Lead
Beckenham PCN	Dr Zia Buckhoree Dr Chris Holdridge	Viv Barnett	Viv Barnett Emily Cram
Bromley Connect PCN	Dr Emma Ryan Dr Addo Djangmah Dr Natasha Hoare	Nina Jenkin Victoria Reed Tom Whelan	Richard Ince
Crays PCN	Dr Bushra Yousuf Dr Maya Lasrado		Jessica Giwa-Osagi
Five Elms PCN	Dr Bridget Hopkins	Darren Girling	Darren Girling
Hayes Wick PCN	Dr Nirav Amin Dr Jonathan Anthonypillai	Mahmud Hasan	Mahmud Hasan Lisa Sutherland
MDC PCN	Dr Michael Choong Dr Chris Fatoyinbo	Sally Gaites	Silvia Vajzerova
Orpington PCN	Dr Claire Riley Dr Prema Ravi	Gabriel Olumide	Pierre Bay
Penge PCN	Dr Alka Sharma	Claire Tomkins	Selda Aslan

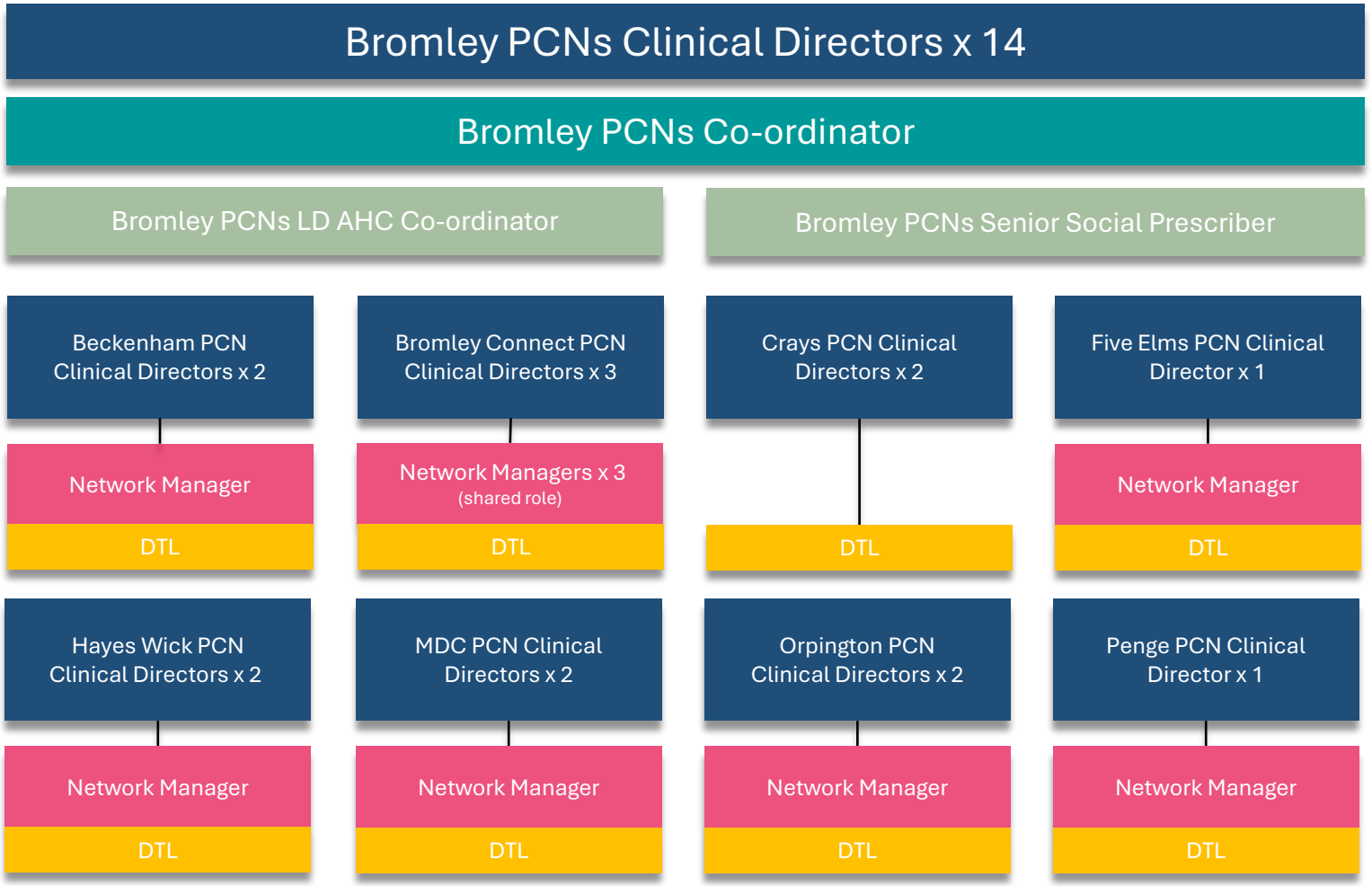
Bromley Primary Care Networks

PCN Core Roles

Clinical Director	PCN Clinical Director is a practicing clinician from within the PCN who provides leadership for the PCN's strategic plans, working with member practices to improve the quality and effectiveness of its delivery of the Network Contract DES to deliver services and co-ordinate initiatives that reflect local needs. The Bromley CDs meet every month and work collaboratively to support the development of local system plans. They represent the PCNs at place-level clinical meetings and the ICB, contributing to the strategy and wider work of the ICS.
Network Manager	The Primary Care Network Manager helps to build the business infrastructure of the PCN, working closely with the CDs, member practices and stakeholders. They manage contract specifications, projects, the ARRS roles and PCN funds to help the network reach its fullest potential. Network Managers increase the capacity of the CD so that they can focus on the clinical leadership, and may be supported by admin staff to organise meetings, and shape and implement health services, build relationships with practice managers and practice staff as well as with other PCNs. The Bromley PCN Network Managers meet monthly for peer support and collaborative working.
Digital Transformation Lead (DTL)	The DTL, a role funded by the Additional Roles Reimbursement Scheme, plays a key part in the delivery of healthcare services through the strategic development of robust digital infrastructure for the PCN, driving efficiency and integrated working. The DTL aims to enhance patient access to primary healthcare whilst protecting the workforce, developing the digital maturity of the PCN and the member practices, taking into consideration the population's health needs and health inequalities in the community.

Bromley Primary Care Networks

Structure

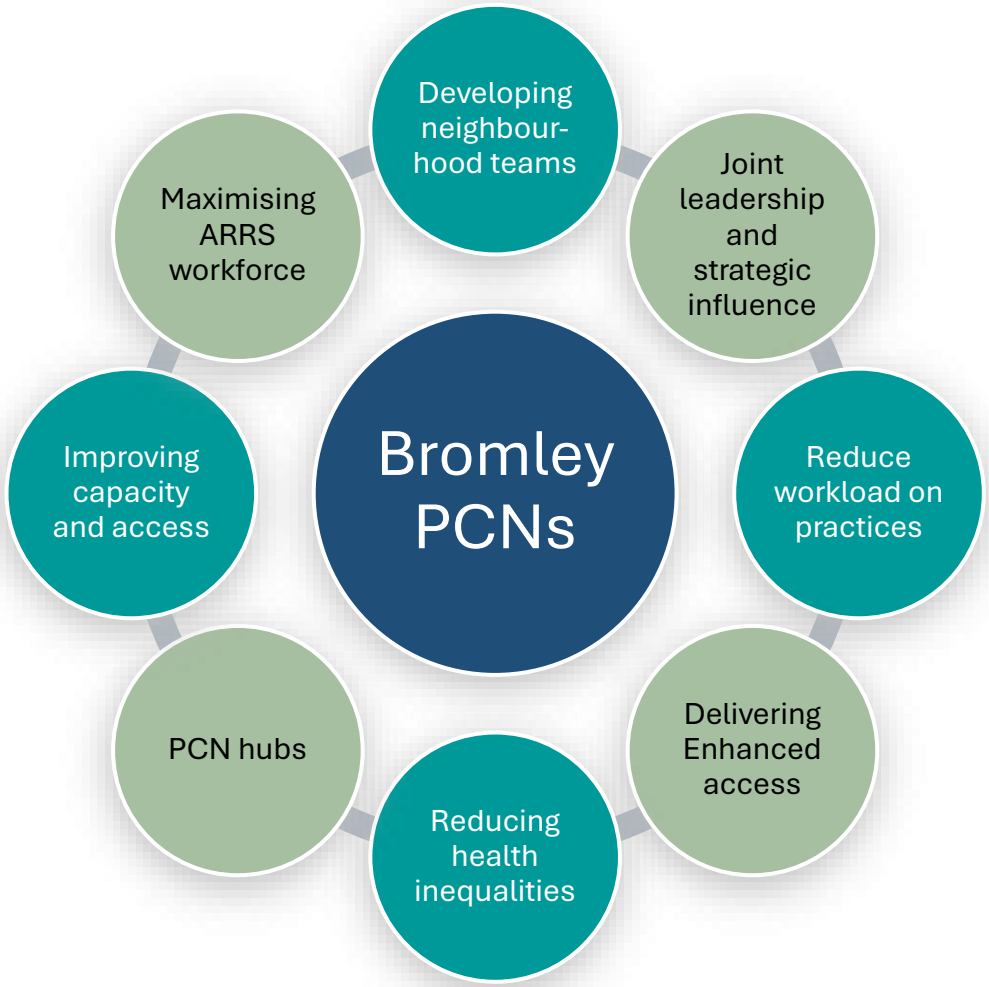


BPCN CDs Forum

The monthly Bromley PCN CDs Forum serves as the strategic platform for information sharing, collaboration and joint decision-making on issues and local system plans affecting or involving Bromley PCNs and practices.

Individual CDs are nominated to represent Bromley PCNs at wider system meetings (see page 10) and are responsible for feeding back to the CDs Forum for consensus and action where appropriate.

Aims


Bromley PCNs
Developing neighbour-hood teams
Joint leadership and strategic influence
Reduce workload on practices
Delivering Enhanced access
Reducing health inequalities
PCN hubs
Improving capacity and access
Maximising ARRS workforce

Representation

As contract holders and service providers, PCN CDs play a critical part in contributing to the strategy and wider work of the ICS by attending place level meetings to help ensure the voice of general practice is heard, provide clinical input and primary care perspective.

SE London ICB Bromley Representation

Strategic governance

- Primary Care Leadership Group
- Local Care Partnership Board
- One Bromley Executive
- Clinical and Professional Advisory Group
- One Bromley Primary Care Group
- ICB/PCNs/BGPA Meeting

Long term conditions

- Bromley CVD Transformation Group
- Bromley Cancer Working Group
- SMI Taskforce
- CESEL Steering Group
- One Bromley Diabetes Partnership Group
- Bromley Immunisation Board

Enablers

- Pharmacy First Steering Group
- Primary and Secondary Care Task & Finish Group
- One Bromley Comms & Engagement Workstream
- One Bromley Workforce Strategy Group
- Mental Health Practitioner Meeting

Bromley Primary Care Networks

2023/24 Network Contract Direct Enhanced Service (DES)

The role of PCNs is underpinned by the Network Contract DES which was introduced to empower general practice within the wider NHS by bringing significant investment, recruiting additional staff, encouraging primary care at scale and improving access to a wider range of support and resources.

Network Contract DES Service Specifications

- Enhanced Access
- Medication Review and Medicines Optimisation
- Enhanced Health in Care Homes
- Early Cancer Diagnosis
- Social Prescribing Service
- Cardiovascular Disease Prevention and Diagnosis
- Tackling Neighbourhood Health Inequalities
- Anticipatory Care
- Personalised Care

These services were delivered with the utilisation of the following funding streams available to Bromley PCNs.

Clinical Director payment: £0.729 per registered patient
Core PCN funding: £1.50 x PCN registered list size
ARRS roles: specified maximum limit per role
IIF: incentive payments calculated according to level of achievement
Enhanced Access payment: £7.578 x PCN adjusted population
Care Home Premium: £120 per CQC registered bed
PCN Leadership and Management payment: £0.684 x PCN adjusted population
Capacity and Access Support payment: £2.765 x PCN adjusted population
Capacity and Access Improvement payment: payable upon proven improvements in 3 key areas relating to capacity and access

The total investment into Bromley PCNs through the 2023/24 Network Contract DES was £12,982,489.

Bromley Primary Care Networks

Additional Roles Reimbursement Scheme (ARRS)

The Additional Roles Reimbursement Scheme, first introduced in 2019, aims to grow additional capacity through new roles in general practice, and by doing so, help to solve the workforce shortage.

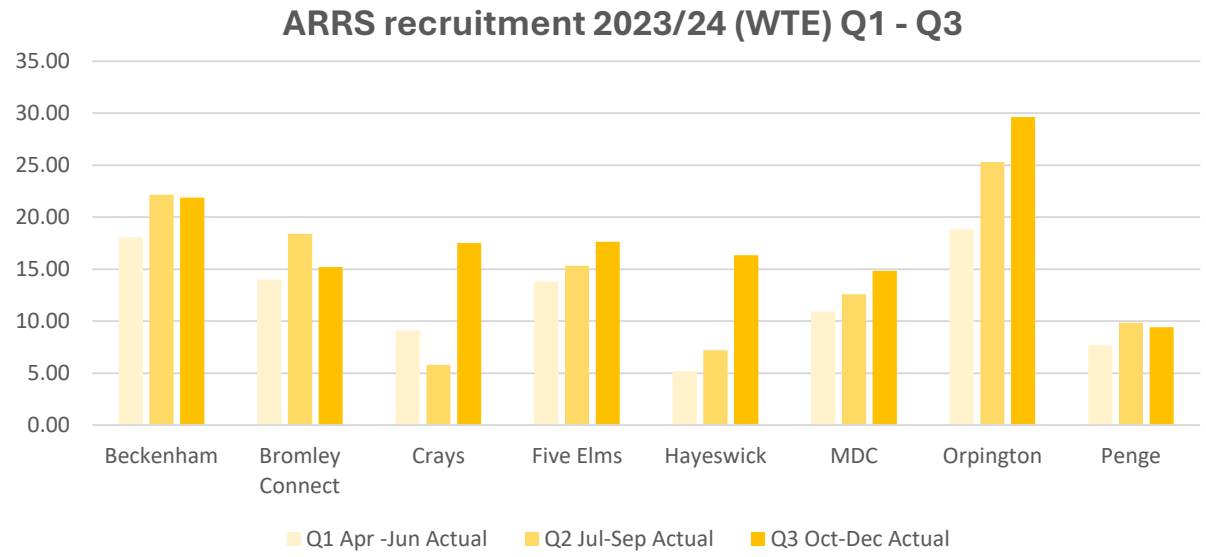
Bromley PCNs have utilised the ARRS funding to support recruitment across a specific set of reimbursable roles to support and enable the development of new ways of working, such as multidisciplinary working and integrated neighbourhood teams.

At the start of the financial year, all Bromley PCNs commissioned Bromley GP Alliance (BGPA) to employ their ARRS staff. Some PCNs have more recently incorporated into limited company status and have since transferred the employment of their staff to the PCN. **The total amount allocated for Bromley PCNs ARRS recruitment in 2023/24 was £7,531,053.**

ARRS Recruitment

At a starting point in April 2023 of 96.5 whole time equivalent (WTE) ARRS staff, Bromley PCNs have worked hard to recruit staff to benefit member practice staff and patients. The end of December 2023 saw an increase to 142 WTE ARRS staff, representing a total increase of 48% across Bromley. Year end recruitment data will become available from July 2024.

(ARRS recruitment figures as per information provided by PCNs)*



PCN	FTE in post 31.3 23	Q1 Apr -Jun	Q2 Jul-Sep	Q3 Oct-Dec
Beckenham PCN	18.90	18.05	22.18	21.90
Bromley Connect PCN	15.20	14.00	18.40	15.20
Crays PCN	9.12	9.12	5.80	17.52
Five Elms PCN	12.00	13.80	15.33	17.63
Hayes Wick PCN	7.04	5.20	7.20	16.35
MDC PCN	10.27	10.94	12.58	14.83
Orpington PCN	16.30	18.83	25.30	29.64
Penge PCN	7.67	7.67	9.84	9.42
Total	**96.50**	**97.61**	**116.63**	**142.49**
% increase since 31.3.23		1%	21%	48%

Bromley Primary Care Networks

ARRS Funding Utilisation

Bromley PCNs have worked hard to utilise ARRS funding to recruit a wide variety of roles to support member practices.

There has been a sharp increase of ARRS provision, increasing from 96.5 WTE at the beginning of the financial year, to 142.3 WTE recorded in December 2023.

Recruitment data for the final quarter of the financial year will become available from July 2024.

(ARRS recruitment figures as per information provided by PCNs)*

Rank	ARRS role	Mar 2023 WTE	Dec 2023 WTE
1	Clinical Pharmacists	26.7	36.5
2	Care Co-ordinators	9.2	17.1
3	GP Assistants	2.0	12.6
4	Social Prescribing Link Workers	11.5	12.5
5	Pharmacy Technicians	8.6	11.2
6	Mental Health Practitoners (Bands 6, 7 & 8)	10.0	11.0
7	First Contact Physiotherapists	8.2	9.8
8	Digital and Transformation Lead	3.7	7.9
9	Paramedic	6.3	6.5
10	Physician Associates	3.0	3.6
11	Dietician	2.3	3.3
12	Health and Wellbeing Coaches		2.7
13	Podiatrists	1.6	2.6
14	Trainee Nursing Associates	1.0	2.0
15	Nursing Associates	2.5	1.0
16	Advanced Practitioner Clinical Practitioner Nurses		1.0
17	Advanced Practitioner First Contact Physiotherapist		0.95
	Total	**96.5**	**142.3**

Cross-PCN Roles

Bromley PCNs Co-ordinator

The Network Co-ordinator works across the Bromley Primary Care Networks to provide managerial administration and project planning and works closely with the Clinical Directors to provide a range of business and strategic support.

The Co-ordinator has played a key role in supporting primary care innovation through the PCNs, supporting new areas in the Network DES Contract, population health management and the successful introduction of roles into primary care, and monitors and provides visibility of PCN achievements across a range of performance indicators.

The role is responsible for effective communication and relationship building with One Bromley stakeholders and is a key contact for PCNs for wider system partners. The Co-ordinator is responsible for collating information from PCNs to enable a Bromley-wide view for reporting, analysis and identification of support needs.

Bromley Lead Social Prescriber

Bromley PCNs jointly invested in a Bromley Lead Social Prescriber role to work across all PCNs to provide valuable support by supervising and mentoring the social prescribing team, identifying training opportunities and ensuring best practice across the borough.

The growing team of Social Prescribing Link Workers in Bromley are responsible for connecting patients to groups, activities and services in their communities to meet their social, emotional and practical needs that affect their health and wellbeing.

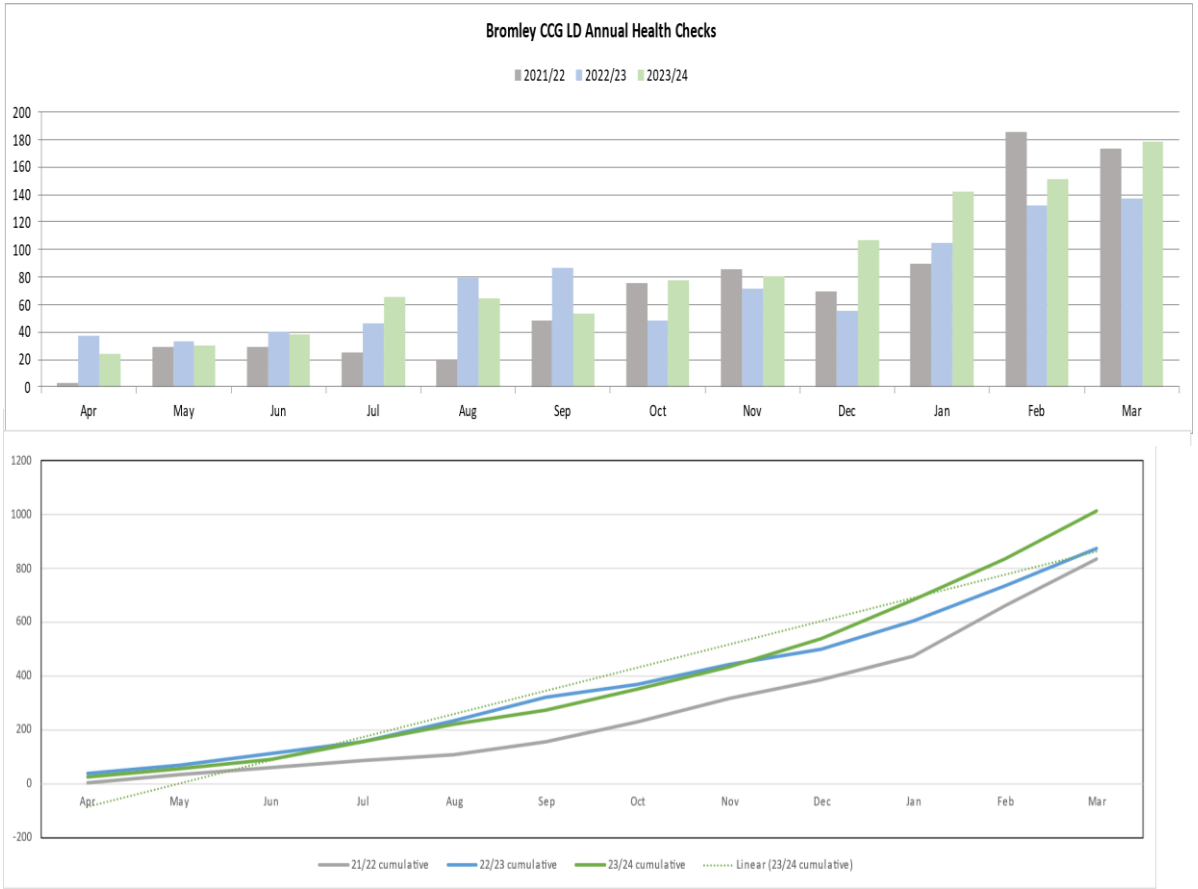
Cross-PCN Roles

Bromley Learning Disabilities Co-ordinator

As a result of SE London Learning Disabilities and Autism Programme funding for a 12 month pilot, a new Bromley PCNs Learning Disabilities Annual Health Check Co-Ordinator was recruited in December 2023. Employed by BGPA on behalf of Bromley PCNs, the role aimed to support practices by contacting patients on the Learning Disabilities (LD) register and booking the Annual Health Check (AHC) appointments.

In December 2023, Bromley had completed 40% of LD AHCs. Priority was towards the most vulnerable patients who had not had a LD AHC for 2 years or more - 8% of the total Bromley LD register. These patients tend to need more time to for engagement, understand barriers to attending and address reasonable adjustment and facilitate any required additional support, and this became an important aspect of the LD co-ordinator role to help ease the time pressures in general practice in Bromley. **In Bromley, a total of 82% of AHCs were completed in 2023/24, compared to 72% in 2022/23.**

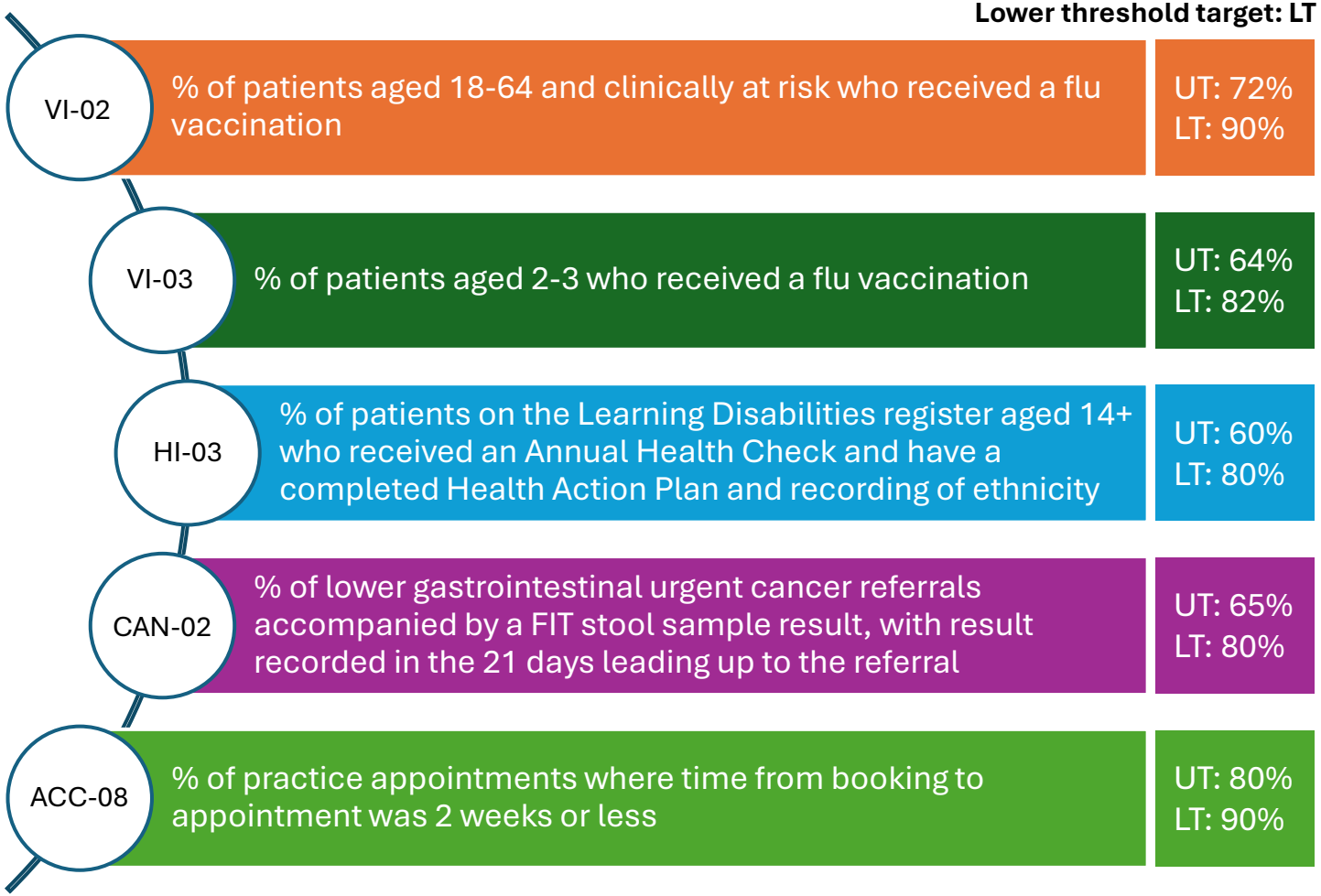
The LD Co-ordinator also supported the achievement of PCNs' IIF LD indicator. A highly targeted approach was successfully deployed, with indications showing that **all 8 Bromley PCNs reached their LD upper threshold payment targets (80%)**.



Impact and Investment Fund (IIF)

The Investment and Impact Fund (IIF) is an incentive scheme focussed on encouraging PCNs to support practices in the delivery of high quality care to their population using priority objectives as set out in the NHS Long Term Plan.

In 2023/24, there were five IIF targets, each with an upper threshold and lower threshold of achievement to indicate the level of payment each PCN is eligible to receive if reached.



Bromley Primary Care Networks

IIF Targets

% of patients aged 18-64 and clinically at risk who received a flu vaccination	% of patients aged 2-3 who received a flu vaccination	% of patients on the Learning Disabilities register aged 14+ who received an Annual Health Check and have a completed Health Action Plan and recording of ethnicity	% of lower gastrointestinal urgent cancer referrals accompanied by a FIT result, with result recorded in the 21 days leading up to the referral	% of appointments where time from booking to appointment was 2 weeks or less
Clinical leadership promoted uptake, working with member practices to identify areas for improvement and collaboration to increase vaccination rates and reduce variation across eligible patient cohorts. Practices advertised via letter, text message, practice websites or social media channels to encourage patients to book appointments at vaccination clinics held at the surgery.	Achieving well on this indicator was made possible by practices regularly running searches to identify patients not yet vaccinated, sending invitations to parents/carers and recording vaccinations appropriately, ensuring patients are recorded as declined if appropriate.	This target addressed the causes of morbidity and preventable deaths in people with a learning disability (LD), and reiterated the importance of identifying LD patients and completing health checks. Practice teams spent dedicated time contacting LD patients or their carers to ensure reasonable adjustments were made and supported individuals in any actions or follow up to support their health and wellbeing.	Practices raised awareness of the importance of patients completing a faecal immunochemical test (FIT) and returning it as quickly as possible. Text message reminders were sent and public awareness materials used to support uptake, and practices worked closely with secondary care using specialist advice where it is unclear if a patient requires an urgent referral based on their FIT result and symptoms.	Designed to reduce waiting times for a range of appointment categories including acute consultations, routine consultations, home visits and walk-ins, this indicator was deemed achieved by all PCNs following NHSE issues in retrieving appointment data.

Bromley Primary Care Networks

IIF Achievement

Bromley PCNs worked closely with their member practices throughout the year to support existing work on the five IIF targets, with particular focus on clinical education and strategy support on, for example, recalls for immunisations and health checks.

Indications are that all PCNs were successful in reaching all targets, either at the lower or upper payment thresholds. Each PCN commits to then reinvesting the payments into additional workforce, primary medical services and/or other areas in a Core Network Practice that support patient care.

	Flu vaccin-ations given age 18-64y + at risk	Flu vaccin-ations given age 2-3y	Learning Disabilities Annual Health Checks	Cancer | Lower GI referrals with FIT test 21 days before referral	% appoint-ments where booking to appoint-ment was 2 weeks or less
Beckenham PCN	89%	98%	83%	78.8%	Following NHSE guidance issued in June 2024, all PCNs are considered to have earned 100% of the points available for this indicator.
Bromley Connect PCN	92%	95%	97%	85%	
Crays PCN	92%	93%	90%	79.9%	
Five Elms PCN	93%	91%	90%	89%	
Hayes Wick PCN	88%	84%	81%	78%	
MDC PCN	88%	96%	83%	83%	
Orpington PCN	88%	92%	90%	72%	
Penge PCN	88%	95%	85%	74%	
Total	**90%**	**93%**	**88%**	**79%**	**100%**

*(*figures according to EMIS Ardens searches)*

Delivery of Recovering Access to Primary Care

In May 2023, the publication of NHSE's 'Delivery of Recovering Access to Primary Care' set out expectations for GP practices to 'tackle the 8am rush' and make it easier for patients to get the help they need. Four areas of focus were identified.

1	2	3	4
Empower patients to manage their own health	Implement Modern General Practice to tackle the 8am rush	Build capacity to deliver more appointments	Cut bureaucracy across the primary and secondary care interface

As part of supporting achievement of the Delivery Plan, NHS England reshaped other funding streams to provide investment to PCNs to improve capacity and access.

Capacity and Access

In 2023/24, a key part of PCN business focussed on improving capacity and access, working with member practices to plan and implement changes, utilising funding, totalling £632,750 across Bromley, to support these improvement plans

Capacity and Access Support Funding (70%)

(£2,765 x PCN adjusted population) paid unconditionally every month to PCNs

Capacity and Access Improvement Payment (30%)

(£1.185 x PCN adjusted population) paid to PCNs upon evidence of improvement in the following 3 key areas:

- **Patient experience of contact**
- **Ease of access and demand management**
- **Accuracy of recording in appointment books**

Bromley PCNs have worked hard to support practices with the introduction of new cloud telephony and online triage systems by the end of March 2024, with PCN Digital Transformation Leads looking at new ways of working with better care navigation, more data-driven decision-making around the way appointment are offered and increasing awareness of services offered by the NHS App and Pharmacy First. Engagement with patients has been a key part of this work with patient surveys, awareness campaigns of self-referral options and talking to patient participation groups.

Cutting Bureaucracy at the Primary and Secondary Care Interface

The NHSE's Delivery of Recovering Access to Primary Care, required actions to be taken on the four priority areas for reducing bureaucracy at the Primary and Secondary Care interface.

1 Onward referral

- Secondary care should make onward referrals rather than sending back to general practice.

2 Complete care

- Trusts should provide patients with everything that they need rather than leaving patients to return prematurely to their practice.

3 Call and recall

- Trusts should establish their own call/recall systems for patients for follow-up tests or appointments to prevent having to ask their practice to follow up on their behalf.

4 Clear points of contact

- ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly.

Bromley PCNs are at the forefront of efforts to collaborate on ways to reduce bureaucracy at the Primary and Secondary Care interface. PCN CDs have initiated conversations with the PRUH and engaged with practices, including presenting at the Bromley Cluster meetings, to bring into sharp focus the improvements needed for better patient and staff experience.

Bromley Round Table event

The first Primary and Secondary Care Round Table event, attended by PCN Clinical Directors and PRUH Clinical Directors, was held at the Princess Royal University Hospital to agree future engagement and action plans across the interface.

PCSC Interface Task and Finish Group

A regular Task and Finish Group was established with colleagues from Bromley PCNs and the PRUH coming together, with the initial focus on onward referrals and discharge summaries.

Bromley GP/Consultant Exchange visits

A series of GP/Consultant Exchange visits were completed. CDs spent time at the Emergency Department and the Medical Ambulatory Unit, with visits planned for secondary care colleagues to visit Bromley general practices.

Bromley Primary Care Networks

Summary of Services

Beckenham PCN

Enhanced Access
Bromley Children's Health Integrated Partnership (B-CHIP)
Health and Wellbeing Hub

Bromley Connect PCN

Enhanced Access
eHub
B-CHIP
Remote BP Monitoring
Housebound Project
Chronic Kidney Disease Hub
Patient Engagement Sessions

Crays PCN

Enhanced Access
Health and Wellbeing Hub
B-CHIP
Wellbeing Cafe (over 65s)
BP@Home
Anticipatory Care Team

Five Elms PCN

Enhanced Access
Health and Wellbeing Hub
Digital Inclusion Sessions,
B-CHIP
Housebound Visits (dementia and diabetic foot checks)
BP@Home

Hayes Wick PCN

Enhanced Access
Same Day Access Hub
Diabetes Hub
B-CHIP

MDC PCN

Enhanced Access
Renal Cardiometabolic Hub
Young Mums Hub
BP@Home
Pathology Results Service
eHub

Orpington PCN

Enhanced Access
E-Hub
Health and Wellbeing Hub
Menopause Group Consultations
Carers Café
Anticipatory Care Team
Healthcare Assistant Hub

Penge PCN

Enhanced Access
Health and Wellbeing Hub
Renal Cardiometabolic Hub
Diabetes Hub
B_CHIP

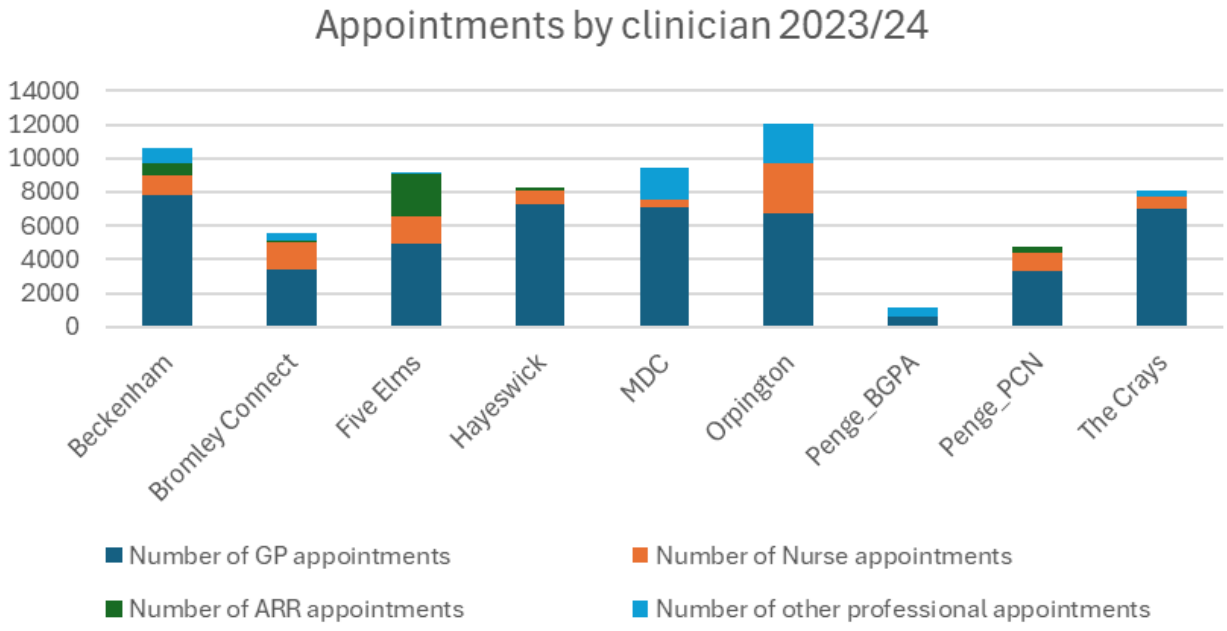
Enhanced Access

A core requirement for PCNs is to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays ('Network Standard Hours').

Bromley PCNs have continued to fine tune their Enhanced Access services to best suit local population health needs, offering a range of appointment types (in person, telephone or online) for patients from all member practices to see a GP, nurse or ARRS healthcare professional such as a clinical pharmacist or social prescriber.

In 2023/24, Bromley PCNs offered a total of 66,728 extra bookable appointments.

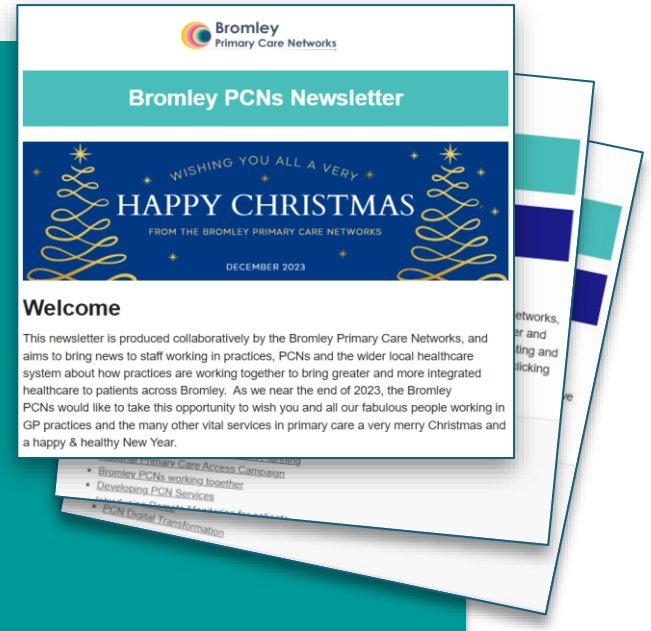
Demand & Capacity, Bromley Enhanced Access totals 2023/24	
Total number of PCN EA hours offered	17393.66
Number of bookable appointments offered	66728
Number of booked appointments	57531
DNA appointments	3174
Total appointments attended	52964
Total unused appointments	9390



Please note: PCNs are different sizes which reflects the difference in the number of appointments they can offer.

Communication and Engagement

Bromley PCNs launched a collaboratively-produced quarterly Newsletter which aims to bring news to staff working in practices, PCNs and the wider local healthcare system about how practices are working together to bring greater and more integrated healthcare to patients across Bromley.



As practices move towards the Modern General Practice model in compliance with NHSE's Delivery of Recovering Access to Primary Care, Bromley PCNs have undertaken a raft of activities this year to communicate and engage with patients to support changes to improve access to general practice services, such as new cloud telephony systems offering patient callback, expanded online services and front desk care navigation.

Orpington PCN gave a presentation to their Patient Participation Groups to talk about the new Accurx online consultation request system, the NHS App and practice websites, and provided patients with an opportunity to ask questions about access and digital inclusivity. A PCN community event will take place later in the year. team to work with the Health and Wellbeing

The Crays PCN Digital Transformation Lead shared guidance to patients at their PPG meeting about using digital tools instead of the phone to obtain blood test results, order repeat prescriptions and book appointments. Patients were also informed about ARRS roles, One Bromley Community Health Champions and are engaging with their local park run team to work with the Health and Wellbeing

Communication and Engagement

Individual Bromley PCNs have produced Newsletters providing information about new PCN services such as BP@Home, Health and Wellbeing Cafes and Enhanced Access, as well as self-referral services such as the social prescriber or physiotherapist.

Opinion surveys. such as the Friends and Family Survey and the General Practice Patient Survey, as well as PCNs' own surveys, have played a key part in informing service improvement strategies. For example, MDC PCN conducted two surveys via text message and in person at surgeries, using the responses as a metric of patient experience improvement alongside national survey results. Patient feedback on practice and PCN websites resulted in positive changes to website wording and navigation.

Bromley Connect PCN launched a Facebook page, Posting national and bespoke local campaigns and health messages. A recent campaign to staff and patients aimed at building the page profile and reach across Bromley Facebook groups, resulted in 160 followers already, with further plans to increase its reach to Bromley residents.

MDC PCN engaged with patients to offer support to patients who feel digitally excluded by holding a regular training session on how to use technology to access healthcare.

Five Elms PCN hold a regular PCN wide PPG meeting where current projects and recruitment are discussed. The members are all keen volunteers at the PCN mobile Wellbeing Cafes, are visible in practice reception areas to promote digital services and have held workshops to demonstrate how to use the NHS App. Reception areas are well equipped with posters, and leaflets are distributed highlighting PCN services.

PCN Websites

Each PCN has successfully created its own website, providing information on PCN services, ARRS staff, patient events and talks and how to get involved with Patient Participation Groups.

Healthwatch

Healthwatch Bromley, the local health and social care champion, provided patient experience reports for PCNs to offer an understanding about patient access and experience, such as ease of booking appointments, getting through on the telephone and overall experience.

Future Plans for Engagement

We are committed to enhancing our future engagement with patients in the development of Primary Care Network (PCN) services. Our plans for 2024/25 focus on expanding and developing patient involvement in line with the South East London People and Communities Framework and NHS England guidance and best practice.

PCNs are part of the One Bromley Local Care Partnership, which has a long and successful history of working collaboratively to communicate and engage with people and communities. We are dedicated to ensuring that local voices are heard and incorporated into the ongoing development and delivery of health and care services in Bromley.

Key commitments:

Enhanced Patient and Public Engagement	• Provide more opportunities to gather direct input from patients and the community, including those under-represented who often experience poorer health.
Priority Setting	• Greater use of qualitative patient and carer feedback to inform priority setting, particularly those aimed at addressing health inequalities.
Collaboration with Stakeholders	• Strengthen partnerships with local health and social care organisations, community groups, and the voluntary sector.
Adopting Best Practice	• Ensure our methods are effective, transparent, and inclusive.
Monitoring and Evaluation	• Monitor and evaluate the impact of our engagement to ensure it is effective.

Through these commitments, we aim to create a more inclusive, patient-focused approach to PCN service development, ensuring that patient voices are integral to our decision-making process.

People and Communities Strategic Framework

Our approach to engaging with Bromley people and communities is informed by the South East London Integrated Care System's People and Communities Strategic Framework.

This framework outlines the ambition and approach for working with people and communities across south east London and is based on the following foundations:

- being accountable to local people and ensuring we are transparent
- making decisions, setting direction and priorities in partnership with people and communities
- working with people and communities in new ways to transform health and care and support health and wellbeing.

Collaborative Funding

Bromley PCNs contributed a total of £14,057 (proportional to patient list size) to the Bromley PCNs collaborative fund in 2023/24.

The fund is used to reimburse CDs' attendance at an agreed list of wider system meetings and interview panels for cross-PCN roles, totalling just under 100 hours throughout the year.

Also funded was a leadership development away day, a networking event and a facilitated Bromley PCNs development session.

	INCOME	EXPENDITURE
Carried over from 2022.23	£1,821	
PCN payments to pooled fund		
Beckenham PCN	£2,303.65	
Bromley Connect PCN	£1,592.81	
Crays PCN	£1,481.78	
Five Elms PCN	£1,757.68	
Hayes Wick PCN	£1,546.92	
MDC PCN	£1,460.70	
Orpington PCN	£2,525.79	
Penge PCN	£1,387.93	
CD representation at place level meetings and Bromley-wide interview panels		£10,641.98
CDs networking event, June 2023		£520.00
BPCNs Away Day, June 2023		£2,225.67
CDs facilitated development session, February 2024		£2,331,58
Total	**£15,878.26**	**£15,719.23**

Case Study: Beckenham PCN

Home Visiting Nurse Service

Aims:

To improve the accessibility and quality of healthcare for housebound patients. These patients often face significant barriers to accessing traditional practice-based care, leading to poorer health outcomes. The service seeks to:

- Improve the management of chronic conditions
- Provide healthy lifestyle advice
- Reduce the need for GP home visits and ultimately the need for emergency care and hospital admissions
- Enhance patient satisfaction and quality of life

How it works:

Patients are contacted by a care co-ordinator and offered a home visit by our PCN Nurse, or practices can also refer into the. The PCN Nurse reviews the patients notes prior to the appointment to ensure they offer all the relevant checks and information is recorded including blood pressure, weight, height, smoking status and alcohol intake . The checks the PCN Nurse performs includes:

- 270 home visits
- 164 Diabetic foot checks
- 19 Dementia care reviews
- 39 Asthma reviews

Staff involved:

Our care coordinators arrange the visits and any onward referrals required including referrals to our clinical pharmacists for medication reviews, our social prescriber for further input and our dietitian for specialist advice.

Outcomes for patients:

- Improved health management
- Reduced hospital admissions
- Enhanced quality of life

Outcomes for practices:

- Reduced number of acute visits required
- Improved patient relationships
- Enhanced data collection and insights into the health status of housebound patients facilitating quality improvement initiatives
- Opportunity of targeted interventions based on home visit data

Case Study: Bromley Connect PCN

eHub

Aims:

The Bromley Connect eHub provides a doctor first triage system using internal workforce ensuring continuity of care and a quality standard across the PCN.

How it works:

The PCN team undertook this transformation in close consultation with the PPG. Every PCN member was involved in the development of the pathway to ensure patients consult with the most appropriate healthcare professional in the right timeframe for their presentation. The triage is undertaken by a doctor first approach, providing reassurance to patients that their concern has been assessed by a GP. This has helped in embedding our ARRS staff in giving patients the confidence that they are seeing the most appropriate person as decided by a doctor. The eConsult smart inbox includes a red flag alert, enabling us to act on concerning symptoms quickly. We see the most appropriate patients on the same day. This has helped stop the need for patients to call 111 or utilise the local UCC or A&E.

	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
eConsults completed within 48 hours	1,242	1,389	1,171	1,597	1,380	1,269

Outcomes for patients:

The eHub provides additional morning and afternoon clinics that adds extra capacity, separate to the appointments that are already running daily in each practice, and provides increased 'on the day' access to patients. **The service provides 279 additional appointments each week for patients across the PCN - over 1,200 per month and more than 14,500 per year.**

Outcomes for practices:

- Every member of the team has a role in the pathways that work for the patient using their particular knowledge and skills.
- Improved staff well-being. The model allows the cover of situations where there are constraints because of clinical space or illness within the practices.
- We can vary clinics with a mixture of face to face, telephone and online consultations.
- The system is agile and dynamic and allows cover between the practices .We can cover any unexpected sickness or crisis as the system will continue triaging and managing the demand.
- Interventions based on home visit data

Case Study: Five Elms PCN

Health and Wellbeing Cafe

Aims:

Reduces loneliness, builds self-confidence and empowers patients to make informed decisions about their health and wellbeing by using the cafes as an extension of support to guide them to services and resources.

How it works:

There are two cafes held every month in Biggin Hill and Bromley, promoted to patients aged 65+ through the practices, invitations via Accurx or referrals. Cakes and hot drinks are offered, with activities such as love to move, art workshops, mindfulness and bingo, and talks by local community speakers. Help is on hand to guide patients on how to use the NHS App and support digital inclusion, with an opportunity for patients to have their blood pressure taken.

Five Elms PCN has worked collaboratively with Bromley Healthcare, The Met Police, London Fire brigade and Ambulance Services to deliver informative talks to promote safety at home, out and about and online, with an increasing attendance rate at their cafes. The promotion of the use of digital services is helping to drive up the number of patients able to access healthcare digitally.

Staff involved:

Our Care Co-ordinators and Social Prescribers refer patients to the cafes and manage the monthly events with support from our PPG members.

Outcomes for patients:

The café promotes mental and physical health allowing patients to try new activities and step out of their comfort zone, giving our patients a sense of belonging and information that they can use in their everyday lives. They are also able to form connections within their community.

Outcomes for practices:

Promoting and services or online tools such as the NHS app or Pharmacy First can help relieve pressure for practices as patients are better informed about different ways to access healthcare. Offering blood pressure monitoring also keeps patient records up to date with initial readings to support targets and identifies those patients who need to be seen by their GP.

Case Study: Hayes Wick PCN

Diabetes Hub

Aims:

After analysing data and engaging with member practices and clinicians, the PCN identified the need to increase the clinical capacity for managing care for patients with diabetes. Hayes Wick PCN developed a PCN Diabetes Hub to help with hitting the 8 care processes and the titration of medication.

How it works:

The Diabetes Hub clinic runs every Tuesday at a member practice where a GP completes a 4 hour diabetes clinic. Our dedicated PCN care coordinator fills the clinic appointment book with patients from all five member practices.

Staff involved:

GPs and PCN Care Coordinators.

Outcomes for patients:

Patients have their full diabetes review completed by the Hub GP. We receive positive feedback from patients, reflecting their satisfaction with the Hub service.

Outcomes for practices:

Since the Hub was launched, there has been a reduction of pressure on practices, with more capacity created for their diabetic patients. We have received positive feedback from the Practice Managers during our monthly PCN meetings.

Case Study: MDC PCN

Digital Inclusion

Aims:

This funded project aims to capture and digitally include patients who are currently feel digitally excluded for any number of reasons such as not having home internet access or experiencing health issues preventing use of digital software. A project evaluation process in autumn 2024 will summarise how the interventions impacted patient access and learnings gained.

How it works:

A site at was secured at Mottingham Children and Family Centre every first Friday of the month. There is a projector and picture slides for NHS App and training video for eConsult and we take our time to explain step-by-step process to patients and answer any questions they might have.

Staff involved:

PCN DTL, PCN Admin, PCN Care coordinator, PPG members, Community Champion.

Outcomes for patients:

Patients are confident when using the NHS App on their device; knowing how to complete eConsult and better understanding of digital technology .

Outcomes for practices:

More patients with NHS App, less patients on the phone and more patients completing eConsults.

Case Study: Orpington PCN

Wellbeing Cafe

Aims:

To tackle social isolation and health inequalities and improve wellbeing by providing a welcoming environment that offers social interaction, professional healthcare support from a team of care co-ordinators, clinical pharmacists, podiatrists and social prescribers, and a range of activities focused on mental and physical health.

How it works:

Aimed at local people aged 70+, the Café opens fortnightly at the Orpington Methodist Church to help build friendships to address social isolation and loneliness. On offer are activity classes and bingo along with a free cup of tea/coffee and cake, as well as talks given by clinicians and representatives from local services.

Outcomes for patients:

The Café has attracted over 300 unique visitors. Significant strides have been made in supporting patients experiencing loneliness – for example, a 78-year-old retiree was referred to the Wellbeing Café by his GP after showing signs of depression and social withdrawal following his wife's passing. Initially hesitant, John attended a coffee morning and was warmly welcomed by staff and fellow participants. Through regular visits, John began to form new friendships and found solace in the supportive environment.

Outcomes for practices:

Pharmacists' interventions have led to better medication adherence, management of LTCs and understanding among patients.

- Care coordinators helped streamline patient care plans, reducing missed appointments and improving health management.
- Podiatry clinics resulted in fewer foot-related health issues, enhancing patient mobility.
- Social prescribers have connected patients with various community resources bringing a more integrated approach to health and wellbeing.

The Café offers a variety of services to enhance overall wellbeing through integrated working. Delivered by the PCN's ARRS staff, the Café collaborates with other Health and Social Care teams. Key partnerships with other organisations further strengthen this integrated approach.

Measurable outcomes include improved emotional wellbeing and resilience, enhanced social interaction and connectivity, increased physical activity and better health management, and higher utilisation of community resources.

Case Study: Penge PCN

Remote Monitoring and BP @ Home

This successful initiative is being rolled out across all Bromley PCNs.

Aims:

Personalised clinical support is delivered remotely to help patients to better manage their health and care with a view to:

- Reducing inequalities in healthcare CVD events due to uncontrolled hypertension
- Providing more convenient, high quality and timely alternatives to face-to-face care where clinically appropriate and right for the patient
- Providing a sustainable approach at PCN level to the management of long-term conditions

How it works:

Patients are identified from the PCN hypertension register and contacted for consent for BP @home. Care Co-ordinators onboard patients via AccuRx or phone and if needed an initial face to face appointment is booked. The best method of sending in results is agreed with the patient and patients are trained to use the BP monitor. Patients are on the scheme for 6 – 12 weeks until there is an improvement in their BP readings. When the patient is discharged, they are given links for further support and, if necessary, there is a follow up 3 -6 months later.

Staff involved:

Admin and Care Co-ordinators carry out searches and onboard patients. The GP Lead, Clinical Pharmacist and Nursing Assistant are also involved in the project

Outcomes for patients:

- Improved health outcomes
- Greater understanding of blood pressure (BP) and the importance of maintaining a healthy blood pressure
- Ability to implement lifestyle changes

Outcomes for practices:

- The project provides a consistent, evidence-based approach across the borough
- Establishes a PCN level shared Hub approach that is sustainable
- Ensures flexibility for practices to use clinical and non-clinical staff
- Encourages and empowers patients to take responsibility for their own health
- Provides an opportunity for healthy lifestyle promotion to reduce CVD risk

Case Study: The Crays Collaborative PCN

Bromley Children's Health Integrated Partnership

This successful initiative is being rolled out across all Bromley PCNs.

Aims:

The service offers a PCN paediatric triage clinic for 0-16 years olds, enabling cases to be reviewed much faster than the patient waiting for an appointment with the paediatrician in the hospital. This can reduce a 6-8month wait if referred to secondary care.

How it works:

GPs can refer their paediatric patients to the weekly PCN triage clinic where the case will be discussed with a multi-disciplinary team. This service is for new patients only, and recommendations regarding the care of the child will be passed back to the GP, ie, recommendation for specific investigation, trials of treatment or referral to community services. For those patients deemed to need a face-to-face appointment, a monthly face to face clinic will take place in a practice. This is booked exclusively by the GP Lead or GP Assistants at the request of the GP Lead and Paediatric Consultant, following case reviews in the triage clinic.

Staff involved:

The MDT consists of a specialist paediatric nurse, paediatric consultant, and a GP.

Outcomes for patients:

A faster and much improved service for young patients who may otherwise have had to wait a much longer time to be referred and seen by a hospital paediatrician. A significant proportion of triaged patients avoid referral to secondary care, instead being seen within local child health clinics, resulting in care being provided closer to home.

Outcomes for practices:

Positive outcomes has included a reduction in the number of GP appointments needed, and GPs have benefitted from further training and guidance.

Next steps for 2024/25

PCN Delivery Plan

The 2024/25 PCN Network DES Contract provides a clear definition of PCN functions:

Organisational/operational

Co-ordinate, organise and **deploy shared resources to support and improve resilience and care delivery** at PCN and practice level.

Collaborate with non-GP providers to provide better care, as part of an integrated neighbourhood team

Clinical

Improve health outcomes for its patients through **effective population health management and reducing health inequalities.**

Target resource and efforts in the most effective way to meet patient need, which includes delivering proactive care

Throughout the next financial year, PCNs in Bromley will continue to deliver the PCN contract specifications by supporting member practices in the provision of health care to patients in a way that meets patient needs and is pro-active, sustainable, collaborative, data-driven and innovative.

2024/25 will see PCNs across Bromley continue to focus on strategies and services that help to ease pressures and improve patient care, through numerous workstreams such as:

- **Enhanced Access**
- **Capacity and Access improvement**
- **Programmes for digital inclusion**
- **Population health management using data-driven approach**
- **At scale hubs**
- **Remote monitoring**
- **ARRS recruitment**
- **Primary and Secondary Care interface**
- **Integrated neighbourhood teams development**

Bromley Primary Care Networks

Next steps for 2024/25

Developing collaboration across Bromley PCNs

The Bromley PCN Clinical Directors have developed a set of ambitious plans to enable more effective delivery of healthcare in line with recommendations set out in the Fuller Stocktake Report. Bromley PCNs have built a business case for funding to help achieve the following aims:

Build more collaboration across PCNs

to enable effective prioritisation of joint initiatives that address neighbourhood level needs and cultivates trust and transparency to facilitate joint strategy and action.

Forge a unified voice and empower leadership in Bromley

to establish a clear and united articulation of the needs of general practice and patients.

Foster an effective relationship with Bromley GP Alliance

to leverage the strengths and resources of both BPCNs and BGPA to drive improvements across neighbourhood teams.

Achieve an improved primary and secondary care interface

to provide a better experience for patients more efficiency for staff working in hospitals and general practice, working closely with our secondary care colleagues.

Develop a cultural transformation towards further innovation and improvement

by at-scale delivery, close integrated working, a data-driven approach and responsive decision-making.

Create capacity for neighbour-hood working in line with One Bromley strategic priorities

to ensure long term sustainability to share learning and deliver at scale.

Contact Us

Contact us

Queries:

Sarah McCombie-Brown
Bromley PCNs Co-ordinator
sarah.mccombie-brown@nhs.net