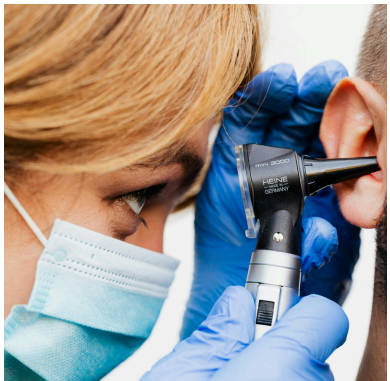
Bromley
Primary Care Networks

2024/25

Annual Report

www.bromleypcns.nhs.uk



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Foreword

As we reflect on the past year, we would like to take this opportunity to express our gratitude to everyone who has contributed to our continuing journey. Our successes in developing healthcare at scale are built on the commitment of our staff, stakeholders, and, most importantly, our practices and patients. The dedication and hard work of Bromley PCNs staff have been instrumental in helping to overcome challenges of continuing escalating demands and funding constraints faced by general practice.

PCNs are an important part of the NHS and their contribution to supporting the overall health and wellbeing of the population is immense. This annual report provides an insight into the work happening behind the scenes - recruiting more healthcare professionals, delivering innovative, at-scale models to provide more appointments for patients, improving access and collaborative clinical leadership to improve patient experience across the healthcare system. We have given a snapshot of the projects going on in the Bromley PCNs, each of which are designed to meet its own, specific population health needs.

We are particularly proud of our joint initiatives across Bromley to improve digital inclusion for all patients, and our continued collaboration with local partners to strengthen community relationships and expand our capabilities, including across the primary and secondary care interface. We take care to consistently engage with patients, practices and the ICB to provide meaningful leadership to ensure the voice of general practice is heard - an approach which is particularly important as we look ahead to meeting the national expectations to implement Integrated Neighbourhood Teams.

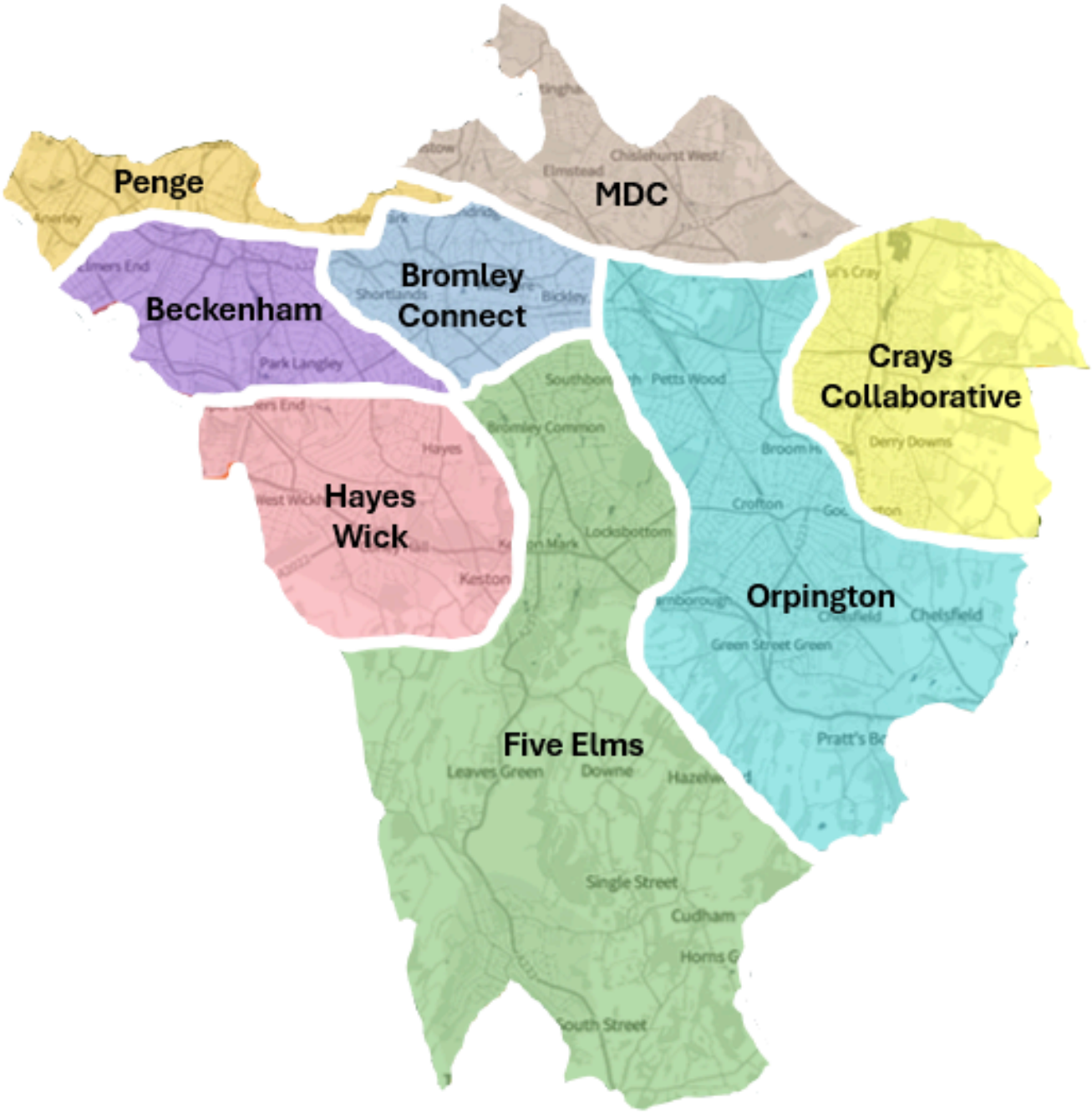
Following recent government announcements, including the abolition of NHS England and further ICB funding cuts, we expect change, but we remain fully committed as both advocates for GP practices, primary care networks and primary care, but also for population health as part of the broader vision for health in Bromley.

Bromley PCNs Clinical Directors

Dr Nirav Amin
Dr Jonathan Anthonypillai
Dr Zia Buckhoree
Dr Michael Choong
Dr Addo Djangmah
Dr Chris Fatoyinbo
Dr Natasha Hoare
Dr Chris Holdridge
Dr Bridget Hopkins
Dr Kate Jackson
Dr Claire Riley
Dr Emma Ryan
Dr Melanie Weerasuriya
Dr Bushra Yousuf

The Bromley PCNs

There are eight Primary Care Networks in Bromley PCNs, each working to develop more proactive, co-ordinated and personalised healthcare for patients that's closer to their homes. With population sizes in Bromley ranging from 35,000 to 63,000 each PCN brings economies of scale through better partnership between practices and other healthcare providers.



The Bromley PCNs

Beckenham PCN

Population: 62,253
Manor Road Surgery
Eden Park Surgery
Cornerways Surgery
Elm House Surgery
St James' Medical Centre
Cator Medical Centre

Bromley Connect PCN

Population: 40,699
South View Partnership
Dysart Surgery
London Lane Clinic

Five Elms PCN

Population: 43,549
Bromley Common Practice
Norheads Lane Surgery
Stock Hill Surgery
Summercroft Surgery
Southborough Lane Surgery

Hayes Wick PCN

Population: 40,436
Addington Road Surgery
Forge Close Surgery
Pickhurst Surgery
Station Road Surgery
Wickham Park Surgery

The Bromley PCNs

Mottingham, Downham & Chislehurst (MDC) PCN

Population: 35,574

Links Medical Practice
Chislehurst Medical Practice

Orpington PCN

Population: 62,798

Ballater Surgery
Bank House Surgery
Bromleag Care Practice
Chelsfield Surgery
Family Surgery
Green Street Green Medical Centre
Knoll Medical Practice
Tudor Way Surgery
Whitehouse Surgery

Penge PCN

Population: 36,841

Anerley Surgery
Highland Road Surgery
Oakfield Surgery
Robin Hood Surgery
Sundridge Medical Centre
The Park Surgery

The Crays Collaborative PCN

Population: 35,913

Broomwood Road Surgery
Crescent Surgery
Derry Downs Surgery
Gillmans Road Surgery
Poverest Medical Centre
St Mary Cray Practice

The leadership teams

Each of the PCNs has a small team lead by one or more Clinical Directors with support from a Network Manager and Digital Transformation Lead, and sometimes additional administrative staff.

PCN	Clinical Directors	Network Managers	Digital Transformation Leads
Beckenham PCN	Dr Zia Buckhoree Dr Chris Holdridge	Viv Barnett	Emily Cram
Bromley Connect PCN	Dr Emma Ryan Dr Addo Djangmah Dr Natasha Hoare	Victoria Reed Tom Whelan Nina Jenkin	Richard Ince
Five Elms PCN	Dr Bridget Hopkins	Darren Girling	Paula Swannell
Hayes Wick PCN	Dr Nirav Amin Dr Jonathan Anthonypillai	Mahmud Hassan	Lisa Sutherland
MDC PCN	Dr Michael Choong Dr Chris Fatoyinbo	Rebecca Green Vanessa Metcalf	Silvia Vazjerova
Orpington PCN	Dr Claire Riley	Gabriel Olumide	Pierre Bay
Penge PCN	Dr Melanie Weerasuriya	Sophie Michael	Shabana Kouser
The Crays Collaborative	Dr Kate Jackson Dr Bushra Yousuf	Donna Mentesh	Jessica Giwa-Osagi

Our aims

Joint leadership and strategic influence

Reduce health inequalities

Improve capacity and access

Reduce workload pressure on practices

Deliver healthcare at PCN hubs

Maximise the ARRS workforce

Develop Neighbourhood working

A strong voice for Bromley general practice

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 and provide clinical input and primary care perspective.

Strategic governance

- Primary Care Leadership Group
- Local Care Partnership Board
- One Bromley Executive
- Clinical and Professional Advisory Group
- One Bromley Primary Care Group
- Bromley General Practice Collective
- A&E Delivery Board

Long term conditions

- Bromley Cancer Working Group
- SMI Healthcheck Taskforce
- Bromley LD Healthcheck Taskforce
- One Bromley Diabetes Partnership Group
- Bromley Immunisation Board

Enablers

- Primary and Secondary Care Task & Finish Group
- One Bromley Comms & Engagement Workstream
- One Bromley Workforce Strategy Group
- Bromley Mental Health Practitioner Meeting
- 111 Procurement Taskforce

260

hours dedicated by Bromley PCN CDs representing general practice at system meetings

A strong voice for Bromley general practice

CDs attend a number of system wide meetings to put forward the best interests of general practice in Bromley.

Pooled fund

Bromley PCN CDs contributed a total of £28,000 (proportional to patient list size) to the Bromley PCNs pooled fund in 2024/25.The fund is used to reimburse CDs' attendance at an agreed list of wider system meetings, this year totalling over 260 hours.

Contributions from PCNs	Reimbursement for CD representation	Balance carried forward
£30,374	£24,589	£5,785

Development

Collaborative working

The Bromley PCN CDs meet monthly at the CDs Forum to ensure a collaborative approach to Bromley general practice leadership. The PCN Network Manager team and PCN Digital Transformation team also each hold regular Bromley-wide meetings to share best practice and facilitate peer support.

PCN clinical leadership roles

Dr Bridget Hopkins

Dr Claire Riley

In January 2025, a Bromley PCNs clinical leadership role was established to ensure PCNs and primary care are key elements in the development of local neighbourhood teams, help ensure primary care sustainability within the One Bromley programmes of work, and lead the primary and secondary care interface programme in Bromley.

The Clinical Directors appointed to the role are Dr Bridget Hopkins (CD for Five Elms PCN and GP Partner at Stock Hill Medical Centre) and Dr Claire Riley (CD for Orpington PCN and GP Partner at Green St Green Medical Centre).

Bridget and Claire work closely with the Bromley PCN CDs to represent PCNs and general practice across the local and South East London ICB.

Network, Interface and Business Project Manager

The continued drive towards more integrated working is reflected in the support provided by the Network, Interface and Business Project Manager, Sarah McCombie-Brown. As well as day-to-day coordination and delivery of strategic, business and system leadership associated with the Bromley PCN Clinical Directors responsibilities, the role co-ordinates the effective operation of cross-PCN workstreams, governance and resources to support the achievement of excellent patient outcomes and reduction in variation across PCNs.

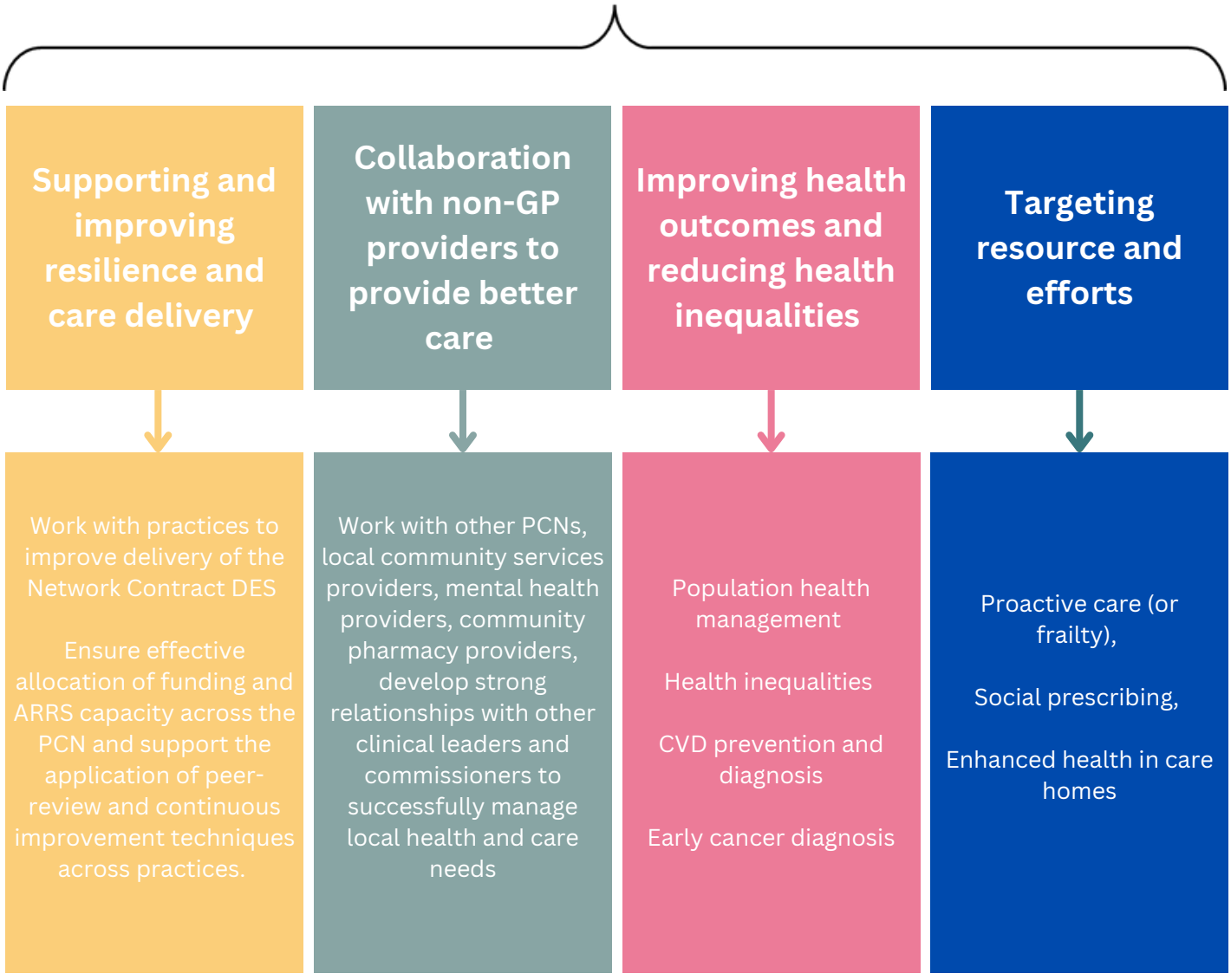
Integrated Neighbourhood Teams planning

With the national expectations for the development of a more joined-up approach to healthcare, bringing together professionals from health, social care, and public health to work collaboratively, PCNs are working hard to ensure that general practice is at the heart of neighbourhood planning in Bromley. As plans unfold for neighbourhood teams to align PCNs into four groups of two PCNs in geographical areas - North West, North East, South East and and South West - PCN CDs continue to ensure the voice of general practice is heard and patients remain at the heart of integrated working.

The Network DES Contract

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. The total available investment for Bromley PCNs through the 2024/25 Network Contract DES was £13,784.143.

PCN service requirements



Funding

Funding stream	Available funding 2024/25
Core funding	£2.967 per registered patient & PCN adjusted population
Enhanced Access	£7.975 per PCN adjusted population
ARRS	£22.894 per weighted population
ARRS GP	£1.303 per weighted population
Care Home Premium	£127.20 per registered bed
Impact and Investment Fund	£0.206 per registered patient
Capacity and Access Support Payment	£3.248 per PCN adjusted population
Capacity and Access Improvement Payment	£1.392 per PCN adjusted population

Local funding was also made available to PCNs for Bromley-wide projects in alignment with One Bromley priorities as follows:

- **Bromley Integrated Children's Partnership (B-CHIP)**
- **Health Inequalities Projects**
- **BP@Home Project**
- **Digital Inclusion Project**
- **PCN Learning Disabilities Champions**
- **Atrial Fibrillation Screening Project**
- **Diabetes Outcome Scheme**

Additional Roles Reimbursement Scheme (ARRS)

The Additional Roles Reimbursement Scheme creates additional workforce and capacity in general practice by providing funds for a wider scope of clinical and personalised care roles.

Bromley PCNs have utilised the ARRS funding to enable new ways of working, such as multidisciplinary working and integrated neighbourhood teams.

Two Bromley PCNs commission Bromley GP Alliance (BGPA) to employ ARRS staff. Six PCNs have incorporated and have since transferred the employment of their ARRS staff from BGPA to the PCN limited company.

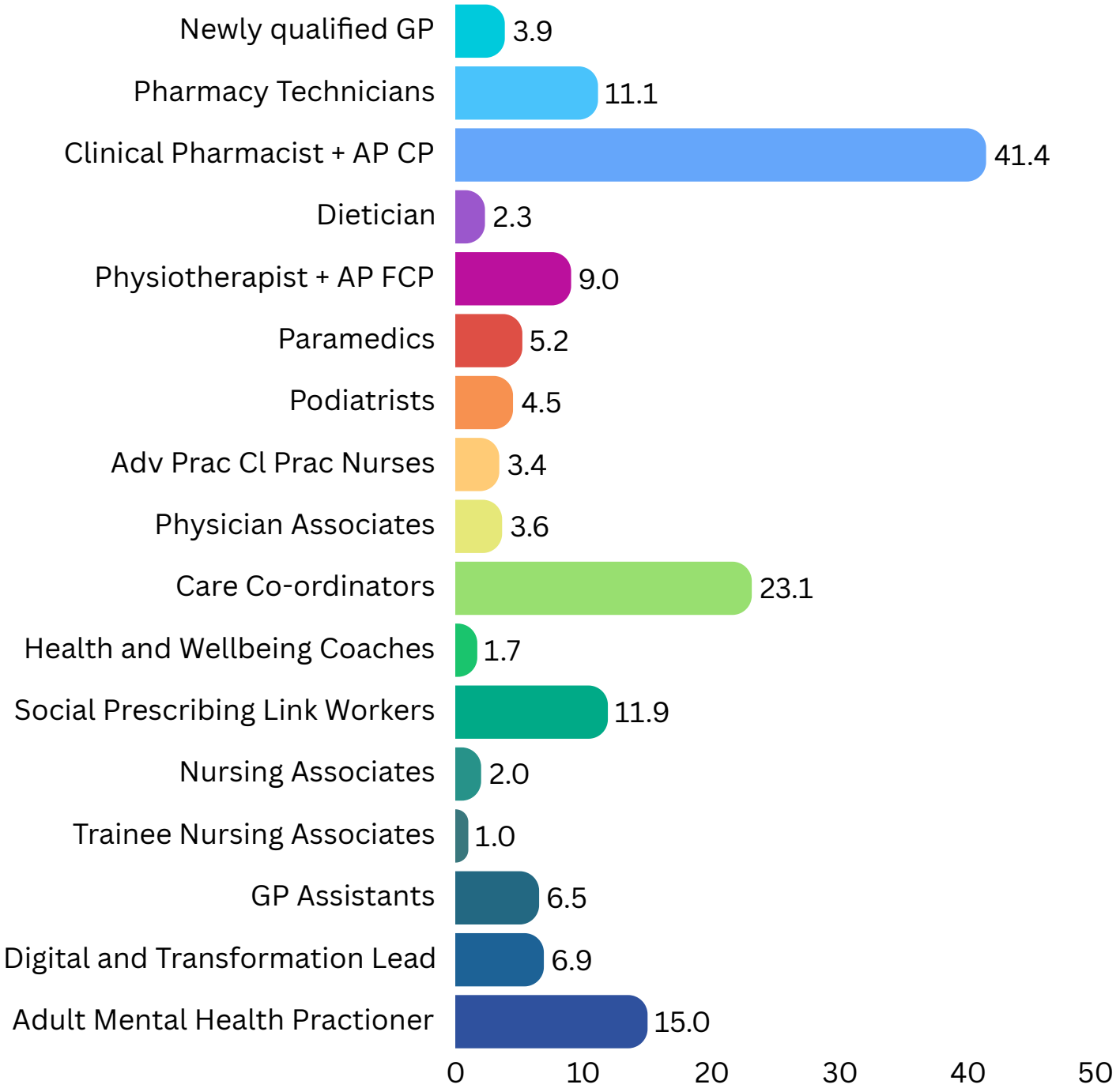
198 whole time equivalent ARRS staff deployed across Bromley.

48

Clinical Pharmacists employed by Bromley PCNs through ARRS funding

ARRS recruitment in Bromley

Bromley ARRS WTE 2024/25



Impact and Investment Fund (IIF)

The Investment and Impact Fund (IIF) is a national incentive scheme designed to encourage PCNs to support practices in the delivery of high quality clinical care to their population using priority objectives. In 2024/25, there were two indicators.

HI-03

Learning Disabilities Annual Health Check completed, action plan shared and ethnicity recorded

Rationale: People with a learning disability often have poorer physical and mental health and are around twice as likely to die of avoidable causes than the general population (LeDeR 2022). An annual health check can help to identify health concerns and emerging risk factors at an early stage. The health action plan supports individuals in any actions or follow up to support their health and wellbeing. Increasing levels of premature mortality are noted in people with a learning disability aged 18-49 from an ethnic minority. A report published by the Race Health observatory noted the median age of death of a person with a learning disability from a minority ethnic community is 34.

CAN-02

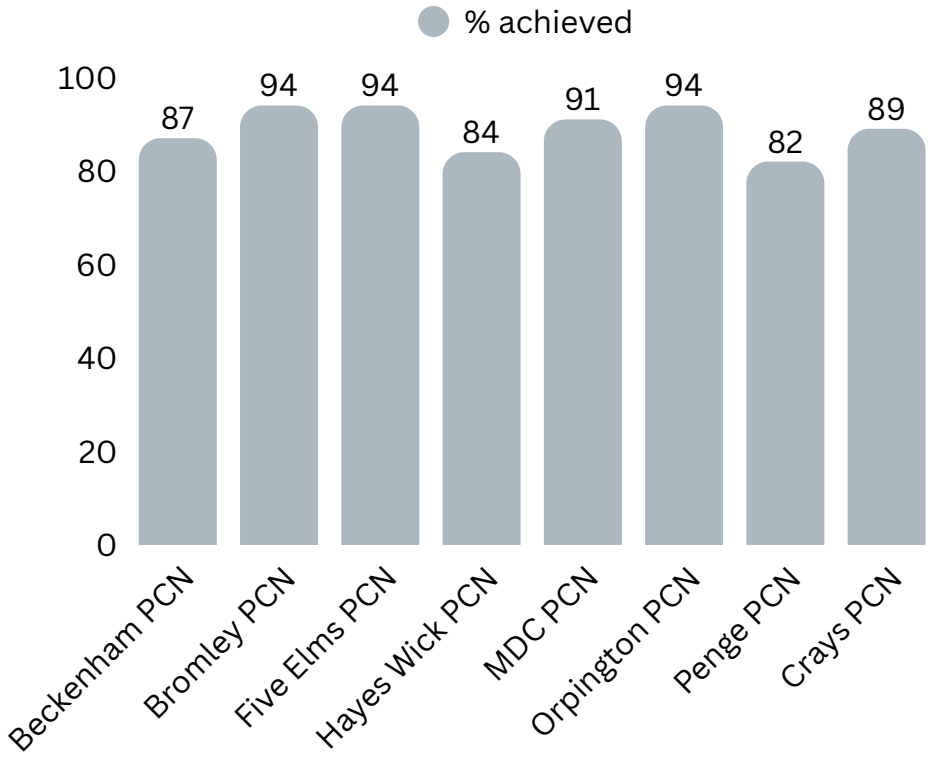
Cancer suspected gastrointestinal referral accompanied with Faecal Immunochemical Test (FIT) with result recorded within 21 days

Comprehensive use of FIT is critical to improving bowel cancer survival, ensuring patients on the lower GI pathway can be diagnosed promptly. The risk of colorectal cancer in those with a negative result, a normal examination and full blood count is <0.1%.

IIF achievement

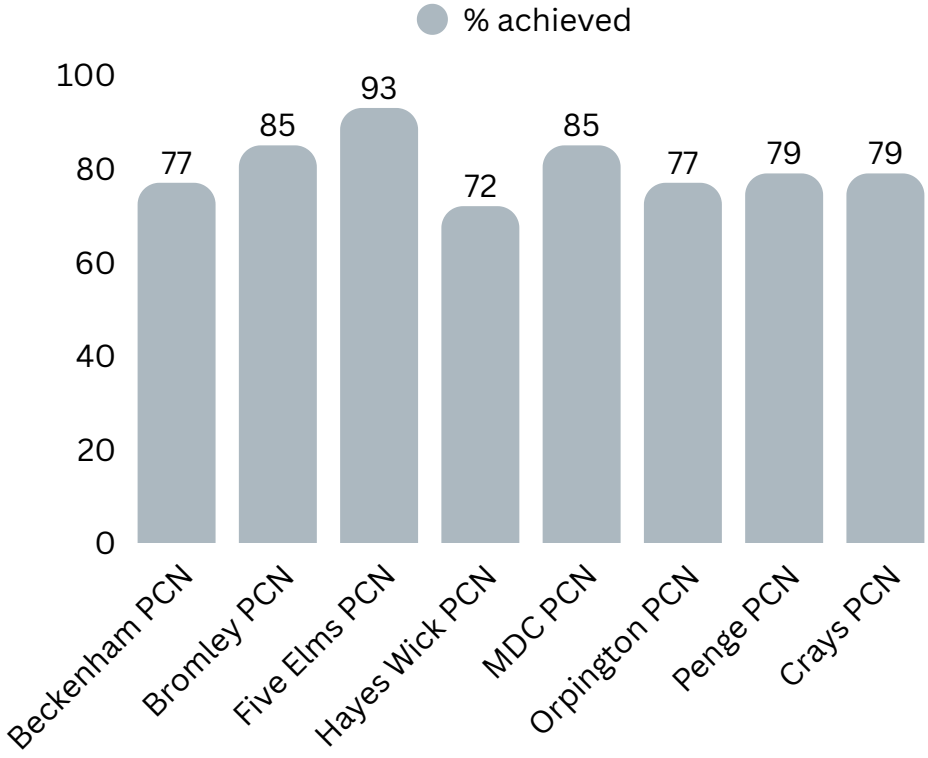
Learning Disabiilites annual health checks + action plan + ethnicity

Upper target 80%
Lower target 60%



Lower GI 2WW referral 2024-25 with FIT 21 days before referral

Upper target 80%
Lower target 65%



Figures according to Ardens searches

Improving capacity and access

Following the expectations set out in NHSE's 'Delivery of Recovering Access to Primary Care' published in May 2023, Bromley PCNs continued their improvement plans to 'tackle the 8am rush' and make it easier for patients to get the help they need at their GP practice. Incentives to support this work under the national Capacity and Access Improvement scheme was split into two parts:

1. Capacity and Access Support Funding
Utilised to improve access to general practice for patients by:

- implementing Modern General Practice, including enhancing care navigation processes and redesign of workflow (supported by the use of common digital tools across a PCN)
- enabling PCN and practice teams to participate in the Support Level Framework (SLF) and national programmes to help identify priorities for improvement and development of a personalised improvement action plan, for example to backfill staff time for participation
- supporting and optimising available staff and capacity, such as backfill for ARRS staff, eg improving delivery of care to people living in care homes
- supporting the delivery and coordination of care continuity by and benchmarking for service improvement purposes

£1.1m

support Funding utilised by PCNs to improve patient access in 2024/25

2. Capacity and Access Improvement Funding

PCNs focussed on implementing in every practice the three domains of the Modern General Practice Access model:

- Better digital telephony
- Simpler online requests
- Faster care navigation, assessment and response

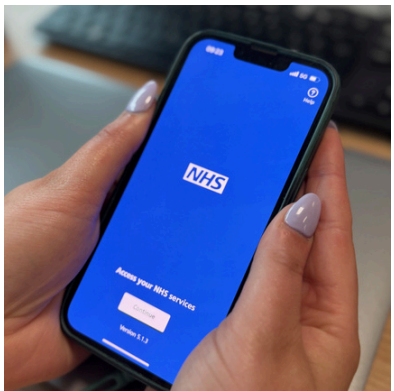
Better digital telephony
Digital telephony was implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England. Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.

Simpler online requests
PCNs worked hard to find solutions to enable online consultation to be made available for patients to make administrative and clinical requests during core hours.

Faster care navigation, assessment and response
Practices improved their processes to ensure a consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests.

68%

NHS App uptake in Bromley in February 2025, compared to 64% in April 2024.



The number of NHS App users with push notifications enabled in February 2025 - a 33% increase since April 2024.

129,415

Promoting digital inclusion

Bromley PCNs developed digital investment initiatives to improve uptake of digital healthcare tools, reduce the disparity of uptake and improve access to primary care through digital routes.

There was a partnership focus on supporting digital literacy amongst older people, those with disabilities and from areas of high deprivation. Interventions included patient events, drop-in workshops, staff training, printed educational resources, and a dedicated telephone line for patient queries.

Several PCNs ran digital hubs to build patient confidence, improve digital literacy and provide hands-on support. PCNs also partnered with Clear Community Web and the Good Things Foundation to hold joint information events with Bromley Libraries to expand community engagement and encourage digital access.

Impact

- The NHS App uptake in Bromley rose from 64% in April 2024 to 68% in February 2025.
- The number of users with push notifications enabled increased by nearly 32,681 over the same period, helping to ensure SMS messages are being read via the NHS App, contributing to a reducing in SMS costs across the borough.
- Patients reported greater confidence in using digital tools , with interventions helping more vulnerable cohorts to access GP services digitally.
- Bromley's work on digital inclusion was shared as best practice across London primary care.

Promoted NHS App for repeat prescriptions, records access, and appointments

Supported access to online consultations

Improved practice websites to access services through self referral

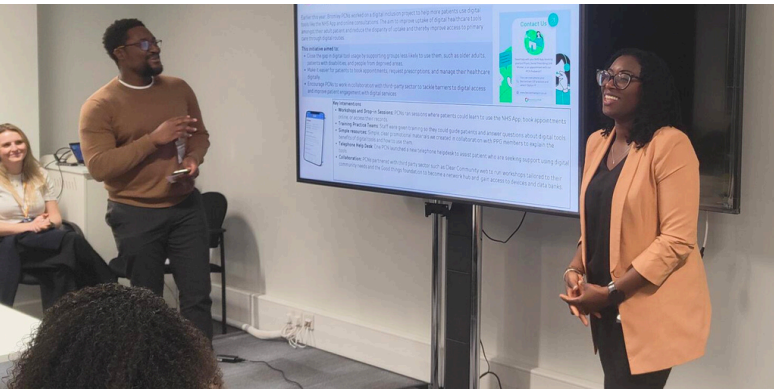
Automated registrations and updating personal details

Remote care including BP@Home and ACR testing

Developed digital drop in sessions to offer training and support

Partnered with Bromley Libraries for the national health literacy campaign

Bromley PCN Digital Transformation Leads share best practice at a London DTL networking event



Bromley

has the highest use of the NHS App in SE London.

Hub services

Each PCN develops hub services according to the specific health and wellbeing needs of its local population.

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

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
- eHub
- Health and Wellbeing Hub
- Menopause Group Consultations
- Carers Café
- Anticipatory Care Team
- Healthcare Assistant Hub

Penge PCN

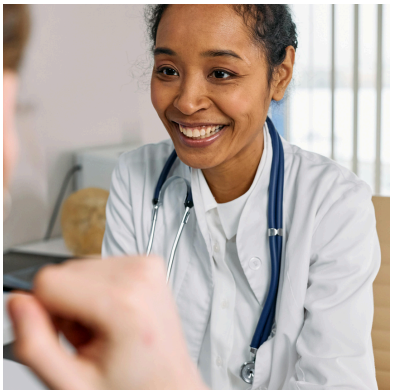
- Enhanced Access
- Health and Wellbeing Hub
- Renal Cardiometabolic Hub
- Diabetes Hub
- B_CHIP
- Remote BP Monitoring
- eHub
- Health webinars

The Crays Collaborative PCN

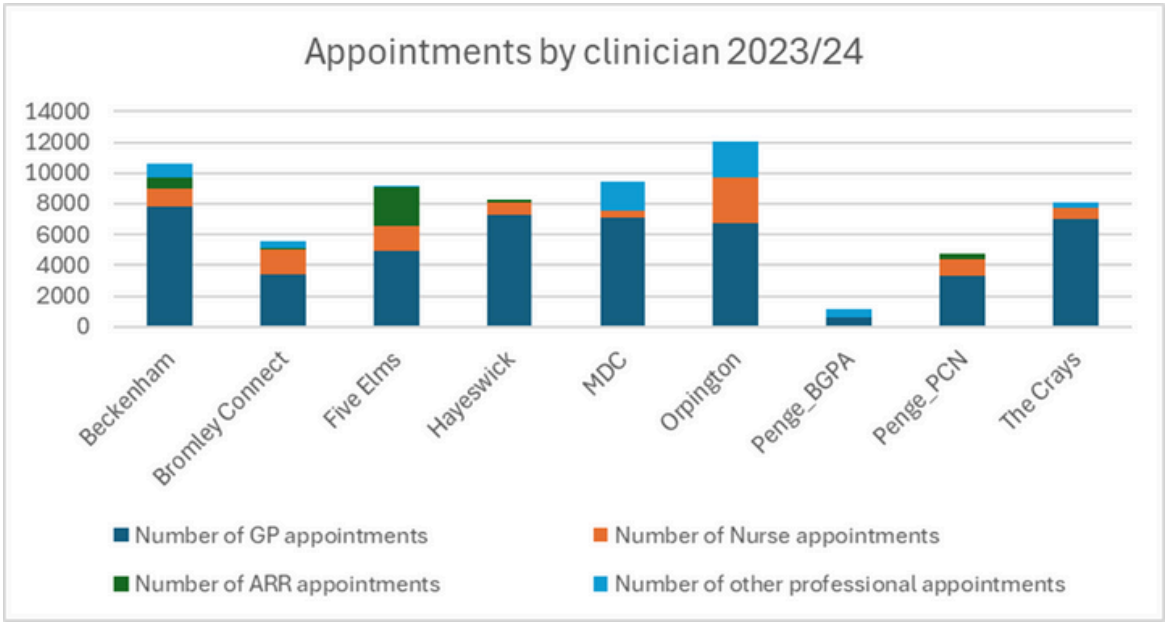
- Enhanced Access
- Health and Wellbeing Hub
- B-CHIP
- Wellbeing Cafe (over 65s)
- BP@Home
- Anticipatory Care Team

436,919

extra appointments delivered by Bromley PCNs in 2024/25



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 develop their Enhanced Access services to best suit local population health needs, offering a range of appointment types (63% in person, 28% telephone and 8% online consultations) for patients from all member practices to see a GP, nurse or ARRS healthcare professional such as a clinical pharmacist or social prescriber.

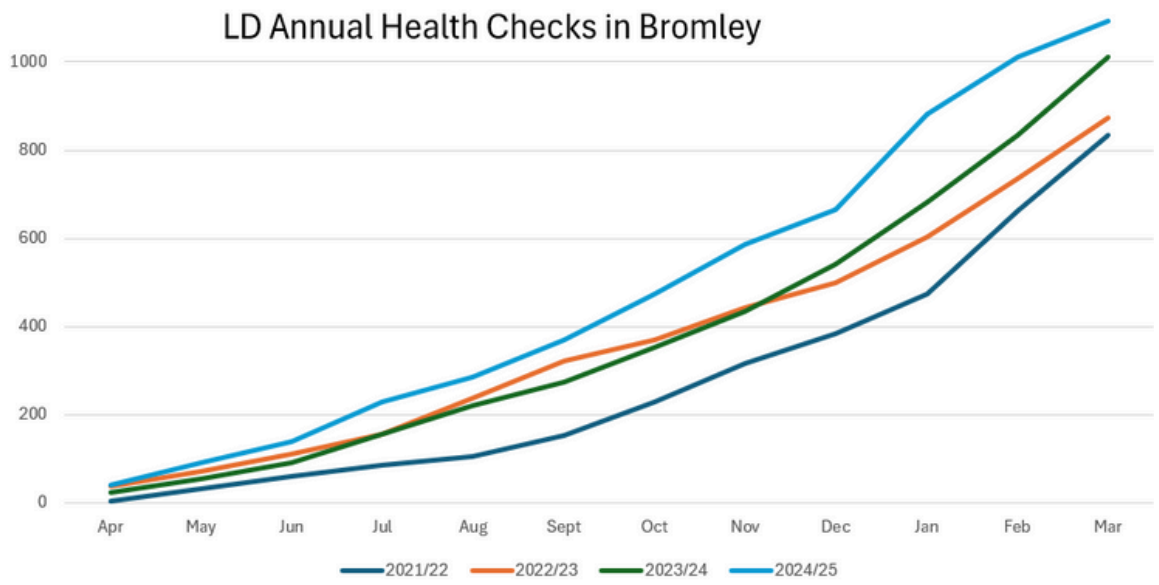
79,195

extra appointments offered by Bromley PCNs at Enhanced Access clinics.

Improving health outcomes for patients with learning disabilities

Bromley PCNs Learning Disabilities Champions

This year saw the development of the PCN LD Champion role using funding invested into PCNs by the ICB. Each PCN LD Champion worked with their practices to improve the take up of Learning Disability annual health checks to improve the health and wellbeing of this vulnerable cohort of patients. **At 87% annual health checks completed in 2024/25, Bromley was the highest achieving borough in SE London.**



Activity

LD Champions ensured member practices booked in a consistent number of health checks throughout the year and delivered a high quality of health checks.

Regular contact with patients on the Learning Disabilities register to book appointments and give reminders, taking the time to offer reassurance and arrange reasonable adjustments.

Working with Oxleas for support with contacting LD patients who have become uncontactable.

Monthly peer support meetings to facilitate shared learning and share LD AHC data to identify potential issues.

Impact

- A record total of 1,092 LD annual health checks were completed in Bromley, helping to reduce morbidity and preventable deaths, improve health and wellbeing and improve quality of care.
- Reduced avoidable admissions to inpatient settings.
- Reduced workload on practice staff.
- All PCNs achieved the upper payment target for LD health checks in the Impact and Investment Fund scheme
- The successful development of a team of LD specialists across Bromley to enable expansion of support to patients with learning disabilities, raising awareness for those eligible on vaccinations, cancer screenings and weight management referrals.

Cutting bureaucracy at the primary and secondary care interface

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.

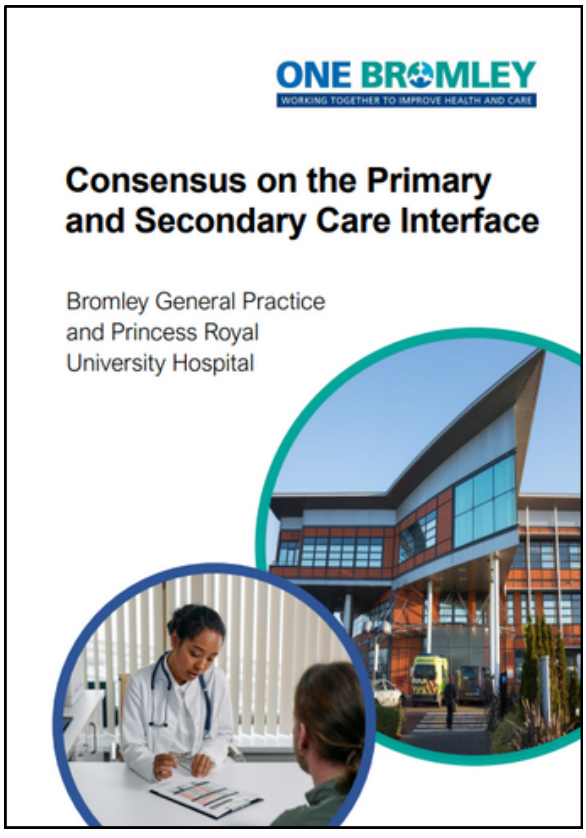
Onward referrals	Complete care	Call and recall	Clear points of contact

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

- Monthly PCSC Interface Task & Finish meetings
- Regular evening Round Table events
- GP/Consultant Exchange scheme
- Interface meetings with One Bromley partners
- Engagement with wider system leaders across SE London and Bromley

Consensus

The Bromley Primary and Secondary Care Interface Consensus document was published in March 2024.



Primary and Secondary Care Interface Task and Finish Group

Established in February 2024 and chaired by Bromley PCN Leads

Onward referrals

Progress highlights

- Epic referrals functionality has been shared extensively for cancer; EPIC functionality for onward referrals routinely used.
- Secondary care can view information from Referral Optimisation Protocol to support their triage process, eg whether patient can speak English/able to conduct a telephone consultation.
- Referrals survey circulated to GPs and consultants and outcomes reported.

Complete Care

Progress highlights

- Secondary care confirmed fit notes are possible in Epic system; no fit notes requests should be requested to GPs.
- Maternity department confirmed will no longer request GPs to prescribe
- Discharge Letters (Docman) Workload Impact Review conducted and presented.
- GPs discharge summary learning sessions held at PRUH.

Call and recall

Progress highlights

- Secondary Care confirmed that Epic has functionality to enable patient recalls without impacting the Trust's discharge performance measures, thus should no longer request GPs to undertake this work.

Clear points of contact

Progress highlights

- GP practice bypass numbers shared with PRUH.
- Primary Care Liaison Officer being recruited by PRUH.

Work continues to ensure a smoother interface for a better patient experience, with particular focus on improving discharge summaries from secondary to primary care, enabling electronic prescribing from Epic thus removing the need for requests to go to GPs and the sharing of direct contact details to facilitate better communcation.

Round Table events

Key healthcare leaders from Bromley general practice and PRUH come together at the Round Table events to work on finding solutions to interface issues.

Communication and Engagement

As practices continue the 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 expanded online services and front desk care navigation.

PCN websites and social media

Our new website www.bromleypcns.nhs.uk was funded by the ICB to develop an online presence for Bromley PCNs in line with our One Bromley partners. It provides a central portal to communicate our mission, engage with patients and other stakeholders, provide an overview of the eight Bromley PCNs and direct links to more information, the leadership team, services, workforce and recruitment, access, healthcare guidance and ongoing developments in neighbourhood working. Each PCN continues to share information on their individual websites and social media pages to raise awareness of PCN services.

Bromley PCNs newsletters

A Bromley PCNs quarterly newsletter is shared with all Bromley practice staff to share information and news on the latest developments in ARRS staff roles and achievements across their at scale activities. Many PCNs also circulate their own newsletters highlighting PCN services such as health and wellbeing cafes and enhanced access.

Patient surveys

PCNs work to promote the Friends and Family Test, other surveys, workshops and focus groups. PCNs have delivered presentations at a patient events to provide the opportunity for patients to ask questions. Discussions have included new developments and improvements, such as the introduction of Accurx Patient Triage, the new patient online consultation system and the online patient services available on the NHS App.

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.

Communication and Engagement

Patient Participation Groups

Patient Participation Groups (PPGs) continue to bring together volunteer patients, carers, and GP practice staff to discuss and the services offered by their GP practice. PCNs actively invite patients to join their local PPGs to encourage the patient voice in improving healthcare services in their communities.

PCN shared learning

Bromley PCNs recognise the value of shared learning amongst clinical and non-clinical staff to continually improve the quality of healthcare provision. Bromley Digital Transformation Leads attended a London-wide event in February 2025 to exchange best practices, strengthen relationships, and explore new ways to support patients in accessing digital healthcare tools as well as learn about what is being delivered and achieved across other London PCNs

Collaboration with Bromley libraries

A national Health Information Week in January saw Bromley PCNs focus on the promotion of winter health, mental health, wellbeing, health literacy and misinformation and digital literacy to patients and the public. The initiative in Bromley was a great success, with pop up stalls hosted at local libraries where residents learned how to stay well in winter and explored the benefits of the NHS App. One Bromley, Bromley Libraries, Bromley Council and Bromley PCNs worked together to provide support and advice on vaccinations, health services and community activities.

Showcase: Beckenham PCN

HPV Project

Aims:

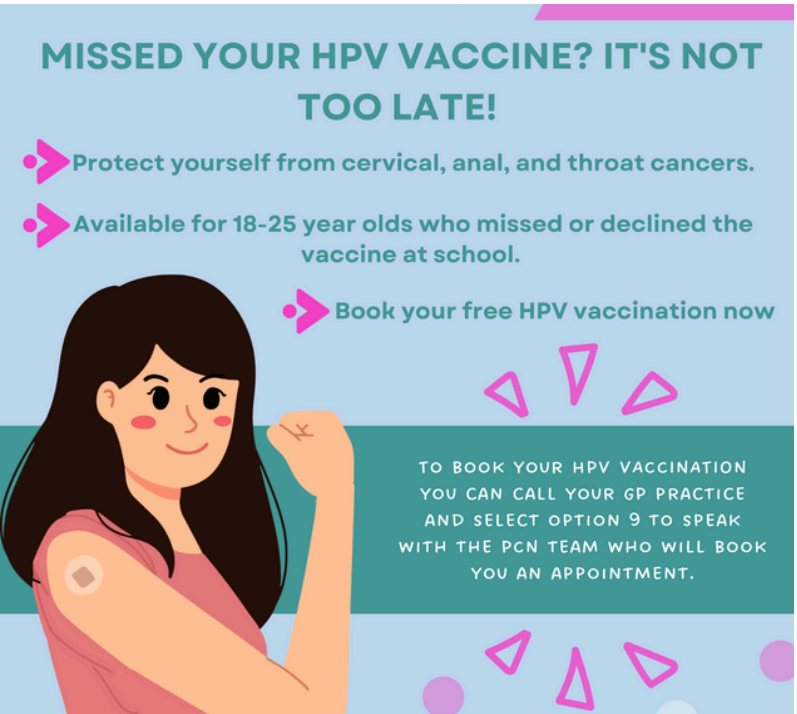
To implement a PCN HPV (human papillomavirus) vaccination catch-up programme for eligible 18–25-year-olds who missed or declined HPV vaccination through the school-based programme, with the aim to reduce the risk of cervical, anal, and pharyngeal cancers.

How it works:

Targeted searches were run to identify eligible patients, confirm vaccination status, and improve the coding of historical school-based HPV vaccinations. The programme was rolled out in phases:

- Q1: Patients aged 23–24
- Q2: Patients aged 21–22
- Q3: Patients aged 19–20
- Q4: Patients aged 18

Vaccinations are delivered via dedicated PCN clinics with flexible scheduling, including Saturday sessions to accommodate work and study commitments.



Staff Involved

- PCN Cancer Care Coordinator
- PCN Nurse:
- Weekend Receptionists
- Clinical Leads:

Outcomes for Patients

- Increased access to HPV vaccination for 18–25-year-olds
- Clear, consistent invitation process and convenient clinic availability
- Reduced future incidence of HPV-related cancers

Outcomes for Practices

- Improved accuracy of HPV vaccination records
- Streamlined processes for coding and recall
- Enhanced collaboration across PCN
- Opportunity for increased vaccination-related income via correct coding and monthly claim checks
- Sustainable model to invite future cohorts at school-leaving age (18–19 years)

Our next steps:

- **Host an evening webinar to highlight HPV vaccine benefits.**
- **Follow up with patients by phone or second text if no response.**
- **Gather vaccination details from responders and update records accordingly.**
- **Promote clinics via social media**
- **Continue offering unused HPV slots to member practices for cervical smear bookings.**

Showcase: Bromley Connect PCN

Proactive Care and Health Promotion for Housebound Patients

Aims:

We aim to tackle the widening access issues and gaps in care for older people, and to address the inequalities across the PCN relating to hypertension. We would like to see our housebound patients receive a planned proactive care review.

How it works:

To arrange home visits for our housebound cohort and address the “Vital 5”, diabetic checks and assistance with signposting and referrals to other community services, through MDTs. Any abnormal results are flagged with a GP for further treatment, as well as any other unmet clinical needs. There was also bi-monthly PCN MDT meetings.

Staff involved:

Care Co-Ordinators, Social Prescribers, GPs, Admin facilitators, Mental Health Nurses, Community Nursing Team (BHC)

Outcomes for patients:

- Patient feedback via a phone call survey is positive with 85% stating that they were “Satisfied” or “Very Satisfied” with the care received.
- Patients and their relatives are appreciative of the contact.
- The MDT meetings enable the PCN District Nursing Team to resolve difficult situations and receive advice.

Outcomes for practices:

This project highlighted some of the challenges regarding housebound patients, such as ensuring accurate coding records which result in less time wasted for the patient and staff, and learning to work around staff timetables to avoid lone visiting for the safety of our staff and patients. We have strengthened relationships and communication channels with the District Nursing team and Care Co-ordinators, as well as improving the trust between housebound patients, their families and the practices within our PCN.

This project has successfully reduced the health inequalities gap for our housebound patients, improved access to healthcare and provides a pro-active care plan for this vulnerable group by offering at home services for basic health checks and MDT meetings for complex issues.

Showcase: Five Elms PCN

Enhanced Access

Launched in April 2023 for all patients within the PCN, the PCN Enhanced Access clinics were based at The Crown Medical Centre, with further clinics every second Saturday of the month at Stock Hill Medical Centre.

Extended appointment hours

We offer more flexible hours for GP and other primary care services, including weekday evenings from 18:30 to 20:00 and weekends Saturdays from 09:00 to 17:00. This helps those who may not be able to attend appointments during regular hours due to work or family commitments. A range of appointments, booked by the patients' registered GP practice, are offered including face to face, telephone and online consultations. Telephone and online consultations make it easier for patients to receive care without having to visit the surgery, particularly helpful for patients who have mobility issues, live in rural areas, have difficulty getting time off from work/school or need advice on minor medical concerns.

Enhanced Access integrates services across various disciplines such as GPs, Nurse and Nurse Associates, Clinical Pharmacists and Advanced Care Physiotherapists. With streamlined processes and more appointments, patients can often see specialists more quickly, reducing waiting times for consultations and treatment.

Outcomes

- Patients have reduced waiting times and more flexible scheduling.
- The integration of different services in the Enhanced Access clinics has allowed patients to receive continuous care without needing to navigate multiple healthcare systems - especially beneficial for individuals with chronic conditions who require ongoing support from various healthcare providers.
- Reduced pressure on Emergency Services by offering more accessible and timely primary care. Patients are less likely to seek emergency care for non-urgent issues, knowing they have an alternative option available.

By improving coordination between primary care specialists, Enhanced Access fosters stronger healthcare networks that benefit the entire community. A well-coordinated health system is more resilient and capable of responding to emerging health needs.

Showcase: Hayes Wick PCN

Pathology Hub

Aims:

Developed in response to a growing number of test results generated by the increased appointment capacity across GP practices., the pathology hub supports the sustainability of practices by centrally managing follow-up of test results and maintaining continuity of care.

How it works:

- The Hub GP agrees on clinical management pathways and preferred communication methods with each member practice.
- The Hub GP reviews all results generated through PCN Hub services each day.
- Patients are contacted based on clinical need: via SMS, through appointment bookings, or directly by phone if urgent action is required.

Staff involved:

- A regular team of GPs staff the Hub, ensuring consistent coverage.
- The GPs work closely with practices to establish and follow agreed protocols.
- Practice admin teams assist with appointment booking and patient communication.

Outcomes for patients

- Improved continuity of care, especially where the same GP is involved in both the initial consultation and follow-up through the Hub.
- Timely communication of results and appropriate clinical follow-up based on established practice pathways.

Outcomes for practices

- Reduction in day-to-day test result workload for practice GPs.
- A more sustainable and resilient model for managing the ever-growing volume of investigations.

The Hayes Wick PCN Pathology Hub supports GP resilience by managing the growing number of test results centrally. With agreed pathways, dedicated triage by HUB GPs, and support from admin teams, the service reduces GP workload while maintaining continuity and timely patient follow-up.

Showcase: MDC PCN

Multi-Morbidity Project

Aims:

Reduce the need for patients to attend hospital, urgent care or A&E by providing comprehensive, continuous care within the community setting. The model focuses on slowing the progression of chronic kidney disease (CKD) by equipping patients with the knowledge, tools, and support to manage their condition effectively at home.

How It Works:

Patients with a CKD 3 or 4 diagnosis, under the age of 75, and who have at least one additional comorbidity such as cardiovascular disease (CVD), diabetes, mental health conditions, or others are identified and booked into the multidisciplinary team (MDT) clinic. The patient receives information on managing kidney health, relevant services and resources to improve their overall well-being and manage their comorbidities effectively.

Staff involved:

GPs, ANPs, PAs and PCN Clinical Pharmacists, ANP, care coordinator, social prescriber and Digital Transformation Lead.

Outcomes for patients:

Improvements in patients' understanding of their CKD diagnosis, medications prescribed, and practical steps to manage their health, with ongoing suppport providing continuity of care.

Outcomes for practices:

Significant time savings for clinicians by allowing the PCN to take the lead in managing patients with long-term conditions. With the support of a wider MDT, including secondary care specialists, practices are able to address complex patient needs more efficiently. Practices are able to focus their time and resources on other pressing patient needs, ultimately enhancing the overall efficiency and effectiveness of primary care delivery.

This initiative highlights the importance of bringing healthcare closer to patients' homes, ensuring that care is accessible, convenient, and tailored to individual needs. It brings out the benefits of personalised care, fostering a more patient-centred approach to long-term health management.

Showcase: Orpington PCN

Cancer Screening Project

The aims:

To improve the uptake of bowel, breast and cervical cancer screenings for patients with learning disabilities (LD) and severe mental illness (SMI), as well as their carers by providing targeted support and education.

The model:

- Working with the practices to identify and engage with LD/SMI patients who are eligible for cancer screening but have not participated.
- Conducting education sessions with patients, carers, and care home staff, providing easy-read materials, visual aids, and translated resources; and providing training on how to support patients through screening.
- Booking appointments, arranging transport, reasonable adjustments and desensitisation sessions where necessary
- Monitoring patient uptake and outcomes

Staff involved:

- Cancer Care Coordinators Vienna Griffiths & Naomi Mead, GP practices, care home staff & carers, screening services & public health teams.

Patient outcomes:

- Increased cancer screening rates, contributing to improved public health outcomes.
- Reduced health inequalities by addressing disparities in screening access.
- Enhanced collaboration between primary care, screening services, and social care providers.
- Reduced administrative burden on practice by having dedicated Cancer Care Coordinators manage patient engagement and support.
- Strengthened relationships with care homes and carers, improving overall patient care coordination.

By targeting LD/SMI patients and their carers with tailored education, support, and access facilitation, the project has made significant strides in reducing barriers to screening. The insights gained from this initiative provide a model for further expanding cancer screening efforts across Orpington PCN and beyond.

Showcase: Penge PCN

Children's Health Integrated Partnership (BCHIP)

Aims:

To provide a fast, efficient way for GPs to access expert paediatric care for new patients aged 0-16 through a weekly, multi-disciplinary triage clinic, streamlining the healthcare journey for children and reducing delays in care. The clinic allows for quicker assessment and tailored recommendations for further care, including investigations, treatment trials, or referrals to other relevant services. This helps to significantly reduce the typical 6-8 month wait time for referrals to secondary care.

How it works:

GPs can refer new patients to the weekly PCN triage clinic where the case will be discussed by team consisting of a specialist paediatric nurse, paediatric consultant, and GP lead. A monthly face-to-face clinic is held at a practice for patients who require in-person consultations. Appointments are arranged by the GP Assistants, following requests from the GP Lead and Paediatric Consultant after reviewing the cases in the PCN triage clinic.

Staff involved:

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

Outcomes for patients:

Early intervention with a quicker and significantly enhanced service for young patients who might otherwise face long waiting times to be referred and seen by a hospital paediatrician. The triage enables patients to avoid being referred to secondary care only and are also seen in local child health clinics, ensuring care is provided closer to home.

Outcomes for practices:

A reduction in the number of GP appointments required and GPs have benefitted from further training, advise and guidance.

The BCHIP service was successfully implemented in all Bromley PCNs in 2024/25.

The utilisation of the BCHIP service has consistently exceeded 90%. This high level of engagement demonstrates the value and effectiveness of the service.

Showcase: The Crays Collaborative PCN

Healthier Living Hub

The aim:

To support practices to proactively identify patients living with obesity and support them to make healthier lifestyle choices to improve their health outcomes.

The data:

National data shows there has been a significant increase in obesity in the most deprived communities in England, translating to worse health outcomes. Rates of obesity-related hospital admissions in the most deprived areas of England are 2.4 times greater than in the least deprived areas.

The model:

There were 6 hub sessions, a session every 6 weeks plus a monthly wellbeing cafe where patients over 18 years old with BMI of over 27.5 could visit for updated weight measurements and lifestyle advice.

Patients were given access to a dietician, Social prescriber, Health & well-being coach, clinical pharmacist, physiotherapist, as well as information on community support and dietary lifestyle changes, and patients could also take part in exercise and meditation at the cafe.

The 6 session plan was:

- Introduction: what is BMI
- Focus on diet, exercise and meal planning
- Use of digital tools to assist with exercise and shopping healthier on a budget
- Medication and their side effects. Focus on hypertension and cholesterol.
- Pain management
- Recap - group discussion and reflection

The initial target for patients was a decrease in weight by 5%, however, patients felt the pressure to lose weight would discourage them from attending so we focused on motivation, social interaction and changes to diet and daily routine to improve health.

Patients reported they felt more positive about their health and felt that small steps would help them realise their long-term goals. We received 88% positive feedback. Through their interactions with one another, a patient walking group has been created and led by a Super PPG member to keep patients active.

Review of 2024/25 priorities

2024/25 Priorities	Outcomes
1. Build more collaboration across PCNs	• The funding and deployment of Bromley PCN LD Champions successfully improved the number of annual health checks completed for patients on the learning disabilities register. • CDs, Network Managers and DTL teams met regularly to ensure a collaborative approach across Bromley.
2. Forge a unified voice and empower leadership in Bromley	• Bromley PCNs and the ICB worked together to agree the funding and creation of a Bromley PCNs clinical leadership role with effect from November 2024.
3. Foster an effective relationship with Bromley GP Alliance	• A working group was developed comprising of PCN CDs and BGPA CDs to build an improved relationship based on transparency and trust. The group continues to meet on a regular basis.
4. Achieve an improved Primary and Secondary Care Interface	• PCNs CDs established and chaired a Primary and Secondary Care Task and Finish Group to bring together key clinical leaders from Bromley primary care and the PRIH to address the key areas of interface issues.
5. Develop a cultural transformation towards further innovation and improvement	• PCNs continue to deliver at scale models of working to relieve workload on practices and increase appointment availability. • PCNs have deployed their Digital Transformation Leads to take a data-driven approach to develop tailor-made services to reduce health inequalities, improve access via cloud telephony and online consultations and increase local take up of the NHS App.
6. Create capacity for neighbourhood working in line with One Bromley strategic priorities	• PCNs worked with the ICB and One Bromley partners to ensure that general practice sustainability was at the heart of early stages of planning for neighbourhood working.

Bromley PCNs priorities for 2025/26

2025/26 Priorities	Delivery plan
1. Provide a strong and united voice for Bromley general practice	• Actively and consistently engage with practices to ensure PCNs are wholly representative at strategic and decision-making system forums. • Influence and actively partake in the development of future models in general practice, ensuring sustainability is prioritised. • Share insights on delivery of primary care across clinical care and patient outcomes at practice and PCN level.
2. Provide a central role in the development and mobilisation of INTs	• Ensure that PCNs have a pivotal role in neighbourhood team planning, helping to develop joined up ways of working in a way that prioritises patient care and primary care sustainability. • Regularly engage with One Bromley partners using a solution-based approach aimed at improving the patient journey at the heart of every interaction. • Provide clarity on the requirements of Bromley PCNs and practices to support the shift to working to neighbourhood footprints, eg estates, IT, finance, workforce, data, access to diagnostics and wider primary and secondary care services. • Work with One Bromley partners to begin the operational establishment of INT services, staffing and structures.
3. Improve patient access and support practice workload through at-scale working	• Develop and expand primary care at scale to increase access to primary care and optimise care for patients, for example hub services such as Health and Wellbeing Cafes, phlebotomy hubs, housebound visit service and diabetes clinics. • Remain committed to engaging with patients via Patient Participation Groups and organisations such as Healthwatch and Bromley Well to ensure that the patient voice is heard and acted upon.
4. Contribute towards achieving the One Bromley strategic priorities	• Proactively plan PCN activities that ensure a Bromley-wide approach towards meeting clinical priorities, with particular focus on identifying those patients most at risk to target interventions, supporting patients with learning disabilities and mental health needs and improving healthcare for children and young people. • Continue to identify health inequalities across PCN populations to develop projects designed to support patients' health and psychosocial needs.
5. Build on the developing role of Bromley PCNs as a key One Bromley partner	• Establish a dedicated work stream focused on fostering collaboration among PCNs. • Prioritise joint initiatives and projects that address neighbourhood-level needs. • Cultivate trust, transparency, and effective communication among PCNs to facilitate joint decision-making and action. • Bromley PCNs to mature as a One Bromley partner by developing its organisational infrastructure.

Contact us

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