Annex A – Primary Care Networks – Plans for 2021/22 and 2022/23 - New PCN service requirements

CVD Prevention and Diagnosis

2021/22

From 1 October 2021, a PCN must:

a. Improve diagnosis of patients with hypertension, in line with NICE guideline NG136, by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up.

b. Undertake activity to improve coverage of blood pressure checks, by:

   i. Increasing opportunistic blood pressure testing where patients do not have a recently recorded reading
   ii. Undertaking blood pressure testing at suitable outreach venues, agreeing the approach with local partners and targeting need as informed by local data on health inequalities and potentially at-risk groups
   iii. Working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the NHS community pharmacy hypertension case finding service

2022/23

In addition to the requirements above, which continue into 2022/23, from 1 April 2022, a PCN must:

a. Improve the identification of those at risk of atrial fibrillation, in line with NICE guideline CG180, through opportunistic pulse checks alongside blood pressure checks undertaken in a clinical setting.

b. Undertake network development and quality improvement activity to support CVD prevention including:

   i. Reviewing outputs from CVD intelligence tools (including CVDPREVENT, when available) and sharing key learning amongst PCN staff
   ii. Supporting the development of system pathways for people at risk of CVD through liaison with wider system partners
   iii. Collaboration with commissioners to improve levels of diagnostic capacity for ‘ABC’ testing, including availability of ambulatory blood pressure monitors (ABPMs) and electrocardiogram (ECG) monitors
   iv. Ensuring processes are in place to support the exchange of information with community pharmacies, including a process for accepting and documenting

referrals between pharmacies and GP practices, for when the NHS community pharmacy hypertension case finding service is formally launched

c. Identify patients at high risk of Familial Hypercholesterolaemia (as defined in NICE guideline CG71, section 1.1), and make referrals to secondary care for further assessment where clinically indicated. This should include systematic searches of primary care records to identify those aged 30+ with Chol > 9mmol/L or with Chol > 7.5mmol/L aged less than 30.

d. Offer statin treatment to patients with a QRISK2&3 score >= 10%, where clinically appropriate, and in line with NICE guideline CG181.

e. Support the earlier identification of heart failure (HF), through building awareness among PCN staff around the appropriate HF diagnostic pathway, and early identification processes for HF including the timely use of N-terminal pro B-type natriuretic peptide (NTProBNP) testing.

Tackling Neighbourhood Health Inequalities

2021/22

a. From October 2021, a PCN must[1]:

   i. Identify and include all patients with a learning disability on the learning disability register, and make all reasonable efforts to deliver an annual learning disability health check and health action plan for at least 75% of these patients who are aged over 14
   ii. Identify and include all patients with a severe mental illness on the severe mental illness register, and make all reasonable efforts to deliver comprehensive physical health checks for at least 60% of these patients
   iii. Have recorded the ethnicity of all patients registered with the PCN (or have recorded that the patient has chosen not to provide their ethnicity)
   iv. Appoint a lead for tackling health inequalities within the PCN

b. By 31 December 2021, a PCN and commissioner must jointly:

   i. Utilise available data on health inequalities, to identify a population within the PCN experiencing inequality in health provision and/or outcomes, working in partnership with their Integrated Care System, including local medical/pharmaceutical committees, and local authority commissioners
   ii. Have held discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement
   iii. Begin engagement with the selected population to understand the gaps in, and barriers to their care

[1] As a part of their health and care system, to support delivery of the five key priorities to address health inequalities outlined in NHS England's 2021/22 operational planning guidance, p.11

iv. Have defined an approach for identifying and addressing the unmet needs of this population

c. By 28 February 2022, a PCN must have finalised its plan to tackle the unmet needs of the selected population, which should include:
   i. Locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities
   ii. Delivery of relevant interventions or referrals to services that provide these interventions for the selected population
   iii. Ongoing engagement with the selected population

and must proceed to deliver the plan from 1 March 2022.

2022/23

We expect the locally defined elements of the service to remain in place as described throughout 2022/23. We will review the delivery of the service alongside a review of the nationally defined priorities to establish what, if any, changes should be considered for implementation of the service from 2023/24.

Anticipatory Care

2022/23

ICSs have lead responsibility for coordination of Anticipatory Care for their system, of which the following PCN requirements form a part:

a. By 30 September 2022, a PCN must agree a plan with their ICS and local partners (including acute, community and care providers), with whom the Anticipatory Care service will be delivered jointly.

b. This plan must be in line with forthcoming national model and guidance on delivering anticipatory care and should include detail of:

   i. How to identify the population cohort which will benefit most from proactive care in the community. This is likely to be predominantly but not necessarily exclusively older people living with frailty, may also include those living with multi-morbidity or those who are frequent users of health and care provision. The cohort will exclude those who are care home residents, who are supported through the Enhanced Health in Care Homes arrangements.

   ii. How partners will ensure the necessary data sharing agreements are in place to both identify the anticipatory care cohort and to provide coordinated care across organisational and professional boundaries of health and care.

   iii. The minimum number of patients to be offered anticipatory care.

iv. How assessment of patient need, and care planning will be carried out and updated when needed; how interventions will be decided upon and how anticipatory care will be coordinated.

v. The agreed protocol for engagement of an individual followed by addition and then removal to the cohort list.

vi. How the activity, experience and impact of anticipatory care will be tracked, and quality of the service improved.

By 1 October 2022, a PCN must have, in partnership with relevant local providers, commenced the operation of the service in line with the agreed plan.

Personalised Care

Proactive Social Prescribing – community development

2022/23

a. By 30 September 2022, as part of a broader social prescribing service, a PCN and commissioner must jointly work with stakeholders including local authority commissioners, VCSE partners and local clinical leaders, to design, agree and put in place a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs. This plan must take into account views of people with lived experience.

b. From 1 October 2022, commence delivery of the proactive social prescribing service for the identified cohort.

c. By 31 March 2023 review cohort definition and extend the offer of proactive social prescribing based on an assessment of the population needs and PCN capacity.

Digitising Personalised Care and Support Planning

2022/23

a. By 31 March 2023, a PCN must work with other PCNs, their commissioner and local partners, to implement digitally enabled personalised care and support planning for care home residents.

Shared Decision Making (SDM)

2022/23

a. By 30 September 2022, a PCN must ensure all clinical staff complete the Personalised Care Institute's 30-min e-learning refresher training for Shared Decision Making (SDM) conversations, available here.

b. By 31 March 2023, a PCN must audit a sample of their patients' current experiences of shared decision making through use of a validated tool and must document their consideration and implementation of any improvements to SDM conversations made as a result.