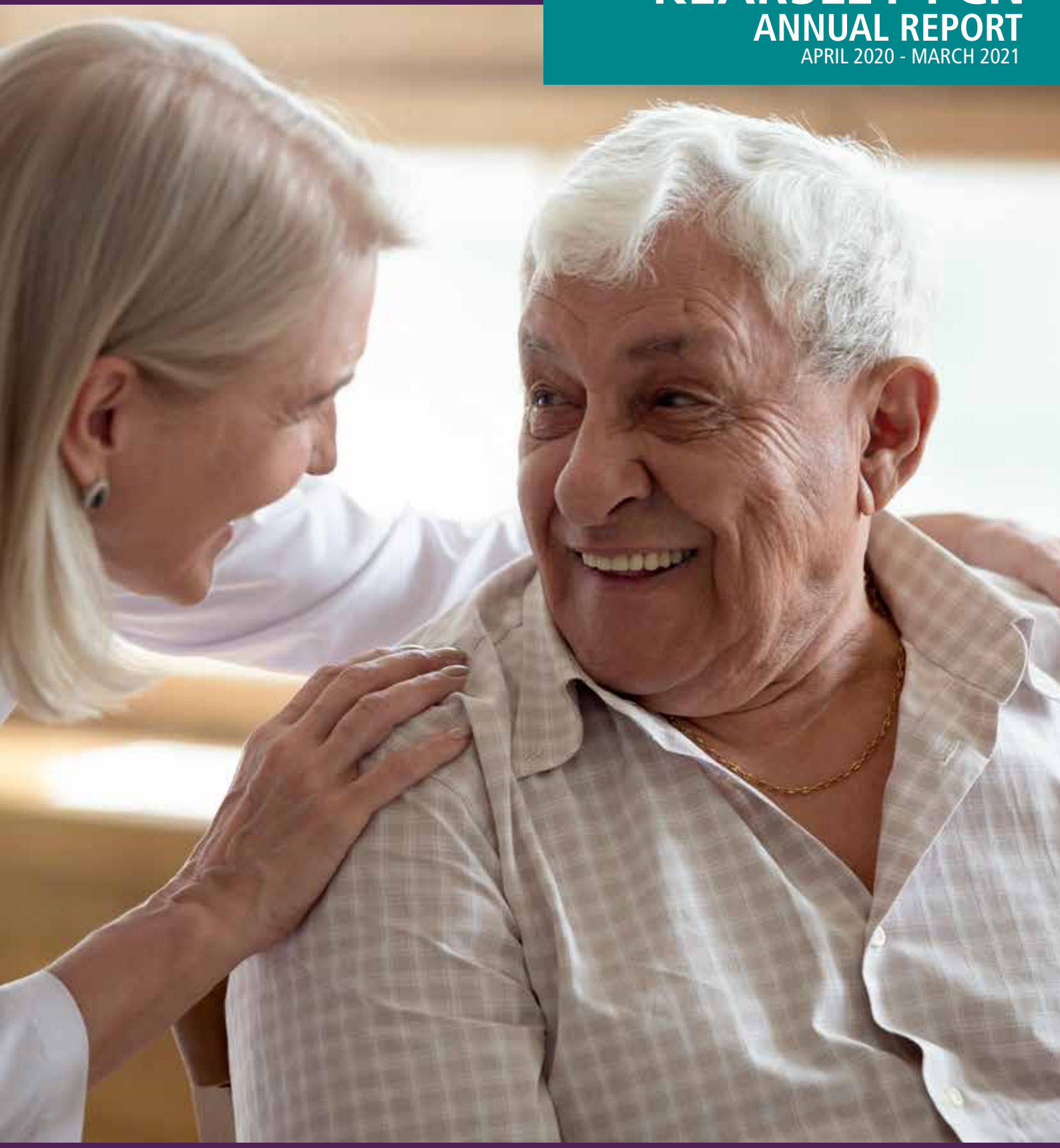
FARNWORTH AND KEARSLEY PCN
ANNUAL REPORT
APRIL 2020 - MARCH 2021



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BOLTON GPFEDERATION

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EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and financial highlights of Farnworth and Kearsley Primary Care Network (PCN) for the year April 2020 to March 2021.

I am honoured and grateful to be working with you all and thank you for making my job as Clinical Director as enjoyable as it is. I'd like to thank everyone for their engagement and challenge in our PCN meetings, which I feel have been supportive and constructive.

Our network is seen as an exemplar by others. This is exampled by our piloting of the wider determinants of health Multi-Disciplinary Teams with housing and soon to be mental health input.

I'd like to thank our Network Manager, Vicky and the Federation team for stepping up and supporting us during the vaccination programme. We have piloted practice level delivery and the work that all of us have done on this I think will stand us in good stead if asked to do a booster programme with the flu vaccinations in the autumn. You are all aware that if we separate Flu and Covid vaccines in the autumn that will be a mistake and I want to try and deliver practice level boosters if that proves to be possible.

Whilst all this has been going on, Vicky and the Federation team have successfully integrated and extended our ARRS workforce and I would like to thank the practices for making them welcome.

As a network we have delivered a specialist care home service that is seen as an exemplar and other PCNs are thinking about using our model

Vicky and the Federation team have ensured that we have maximised our income with IIF and made us aware of the money we have had to spend to support our network. We have made sure that all our ARRS staff have the appropriate IT and used network funds to provide the hardware. We have also financed practice level mentoring and support which has been a problem nationally and in other networks.

Looking forward, PCNs need to think about how they work together and integrate with the locality and GM in the new NHS structures. The NHS is undergoing one of its 5 to 10 year reorganisations and we need to ensure that General Practice providers are involved in whatever new structures emerge in Bolton and GM.

We have already alluded to the IT hardware support to our ARRS staff and we have also purchased Ardens software, which allows structured data entry by all our ARRS staff which has benefits to all of our network practices.

In our network meetings we share good practice as a routine to the extent that we probably do not realise how unusual that is.

Going forward we need to think about how we support each other, use IT more effectively and try and address the perennial Farnworth & Kearsley problem of poor physical estate.

Dr George Ogden
Clinical Director
Farnworth & Kearsley Primary Care Network

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2020/21, the Network Contract DES Directions come into force on 1 April 2020 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, have applied from that date.

A number of specifications were delayed or suspended due to Covid, so for 2020/21 our focus was on:

- Providing a social prescribing service
- Carrying out structured medication reviews and meds optimisation
- Enhanced care in care homes
- Early cancer diagnosis

The pages that follow summarise the progress we have made in Farnworth and Kearsley PCN towards these requirements during 2020/21.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDS REVIEW AND MEDS OPTIMISATION from 01/10/20

- Identify and prioritise PCNs patients — ONGOING
- Offer and deliver a volume of SMRs — ONGOING
- Explain benefits of SMR to patients — ONGOING
- Only appropriately trained clinicians undertake SMRs — COMPLETE

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

by 31/07/20

- Agree aligned care homes with commissioner — COMPLETE
- Have a simple plan in place — COMPLETE
- Support residents to register with a practice in aligned PCN — COMPLETE
- Ensure lead GP in place per PCN — COMPLETE

by 30/09/20

- Deliver MDTs with partners — ONGOING
- Develop personalised care and support plan — ONGOING

by 31/03/21

- Establish protocols for info sharing, shared care planning, use of shared care records, etc — ONGOING

from 01/10/20

- Deliver a weekly home round — ONGOING
- Develop & refresh personalised care and support plans — ONGOING
- Identify/engage in shared learning — ONGOING
- Support with patient's discharge from hospital — ONGOING

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS
from 01/04/21

- Review referral practice for suspected cancers — ONGOING
- Contribute to improving local uptake of screening programmes — ONGOING
- Establish a community of practice — ONGOING

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

SOCIAL PRESCRIBING SERVICE

- Provide patients with access to a SP service — COMPLETE
- Directly employ SPLW or sub-contract provision — COMPLETE
- SPLW to comply with para3 Annex B (see appendix 1 for details of requirements and compliance) — ONGOING

INVESTMENT AND IMPACT FUND

The Investment and Impact Fund (IIF) was introduced as part of the amended 2020/21 Network Contract Directed Enhanced Service (DES). The IIF ran for six months, from 1 October 2020 until 31 March 2021, helping our PCN to deliver high quality care to our patients. The IIF in 2020/21 resourced PCNs to play a leading role in the ongoing response to COVID-19, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

In Farnworth and Kearsley PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 5,887
Number of vaccinations: 4,672
% of patient population vaccinated: 80%

Patients on the LD register who received an LD health check

Patient population: 164
Number of LD checks carried out: 164
% of patients received health check: 100%

Number of patients referred to social prescriber

Target number of referrals: 287
Number of referrals: 376

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme allows PCNs to access funding to support recruitment across a range of reimbursable roles. The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage and grow the expertise in general practice. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care.

During 2020/21, Bolton GP Federation successfully accessed all of it's ARRS allocation on behalf of the six PCNs it supports.

In Farnworth & Kearsley Primary Care Network, during 2020/21, we recruited an ARRS team that included the following roles:

- Social Prescribing Link Worker
- Clinical Pharmacists
- Pharmacy Technicians
- Musculoskeletal (MSK) First Contact Physiotherapists
- Mental Health Practitioner

This team will be expanded further during 2021/22.

Further details about the progress towards the requirements of each of the individual roles is provided in Appendix 1.

Enhanced Care in Care Homes

In the Farnworth and Kearsley PCN there are 3 care homes with 178 residents.
An additional Pharmacy Technician and an additional Pharmacist has been recruited to work with these care homes. This is in addition to the Pharmacist and Technician that were recruited to deliver on the ARRS requirements.
These additional roles have enabled us to ensure the delivery of a personalised care and support plan for each care home resident within the network and complete a structured medication review.
They also:

- Attend weekly MDTs at each of the care homes.
- Support care home providers to have an effective 'care home medicines policy' that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.
- Agree what medicine the resident will take after the structured medication review and make sure they can use the medicines as prescribed.

A Paramedic has also been recruited to support with reactive care and to complete a home round weekly, also an integral part of the MDT meetings.

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

BACKGROUND

The patient is a 45 year old female with a history of chronic back problems and anxiety. She needed initial advice and support regarding her eligibility of benefits. She had previously been refused PIP and thought it may be due to her husband's wages so wasn't motivated to look into this any further. She had a history of low mood and anxiety which had been exacerbated by feeling let down by services as she had previously had counselling which stopped abruptly due to service limitations. On further discussion, she also informed me that she had been trying to enrol on a car mechanic course, but was met with gender discrimination on numerous occasions. She also tried to enrol at Bolton College but never received a response. Despite all of this, she was still interested in engaging with a course, but was less motivated and didn't feel that she was in the best place to start something like that at the time.

SUPPORT OFFERED

I allowed the patient time to describe her current situation and how it is having an effect on her current wellbeing. She explained that she had a consult with the MH practitioner who explored options of medication, but she refused as she felt she could make changes in her life. This allowed me to identify her level of motivation. From that, we worked on a plan of action and explored short term v long term goals. Short term was to receive support for benefit applications with the long term aim of gaining an apprenticeship.

SERVICES OFFERED

The 'Starts with you' project which has a service that advises and supports people by informing them what they could be entitled to and offers support with form filling and applications.

Ingues offer bespoke support for people getting into employment or places on courses. They work in partnership with the job centre.

Bolton College wellbeing classes offered free of charge to support people to understand more about their mental wellbeing.

PATIENT OUTCOME

She has received support for her PIP application and has been reassured that her husband's wages will not have an affect on reapplying. They are supporting her with the whole process so this has been a big relief as she felt this was one of the main contributors to her anxiety.

An Ingues representative has also been in touch and informed her that there are various opportunities for her to gain an apprenticeship in mechanics. She wishes to take things slowly, but is very pleased that there is support out there for her to achieve her long term goal.

She is also engaging in counselling following referral from her MH practitioner and is finding this really helpful in managing her anxiety and stress levels.

Tyler O'Neill
PCN Social Prescribing Link Worker

STAFF FEEDBACK

A survey of Primary Care Network staff was carried out in April/May 2021.
35 members of staff were invited to complete the survey.
25 people (71%) responded.

- The majority of staff strongly agreed or agreed that the last year working in a primary care network for Bolton GP Federation had been professionally satisfying.
- 96% of people would recommend the GP Federation to their colleagues and peers.
- Most people strongly agreed or agreed that they felt well integrated into their network.
- 80% of people felt supported by management and know who to come to with any issues.
- 92% of people strongly agreed or agreed that they felt their skills and background were valued in the practices and networks they served, and within the Federation.
- The majority of people felt challenged and supported to grow and develop into their role.

Comments from staff included:

"Loved working for the Federation so far. Matt has been very supportive and available at any time to answer any of my questions."

"Fantastic experience so far in my first few months working for the Federation. Great support and guidance at all times."

"I feel part of the team and know if there is a problem I will be supported. Hope you have more face to face meetings with the rest of the team soon."

"Would be appreciated to have regular / monthly reviews."

YOU SAID, WE DID

You wanted regular monthly reviews

All members of staff are offered regular catch ups

You wanted more face to face training /meetings

We provided a large meeting room (COVID SAFE) to hold the meetings

You said you wanted further training on Mental Health

We provided training with the Mental Health Practitioner team and additional Mental Health Training

You said you needed devices to allow working from home

We ordered a number of laptops (although awaiting delivery of these!)

You said you wanted to know more information around elements of the DES

We have structured presentations for the team

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Fanrworth and Kearsley PCN began in mid-December 2020 following a collaboration agreement to run the clinic through a designated site at Lever Chamber Health Centre.

In the 14-week period through to 31 March 2021, the Rumworth, Central and Farnworth & Kearsley collaboration delivered:

50 first dose clinics held at Lever Chambers

26,027 first dose vaccinations given at Lever Chambers

7 pop-up/mobile clinics at Farnworth Health Centre, BRASS, Pikes Lane, Memory Lane and Great Lever and Harvey Children's Centres.

1,702 first dose vaccinations given at pop-up/mobile clinics

644 housebound residents were vaccinated in their homes

26 care homes visited

1595 staff and residents received 1st dose and **1530** received 2nd dose

That's over **800** hours of vaccinating!

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during COVID-19, on 25 January 2021 Bolton's NHS Foundation Trust established a 14-day oximetry pathway for patients who had received a positive COVID-19 test result. This included providing the patient with an oximetry machine at home to monitor their oxygen levels, with regular calls from a health professional and clinical decisions on admission to hospital for further observations/treatment should the levels drop.

The service offered by the trust included all initial patient and discharge discussions carried out by an Advanced Care Practitioner and training for the patients on how to use the machine and what to do if symptoms worsened.

Feedback has found that whilst some were apprehensive in the first instance, patients largely had a positive experience throughout the pathway, feeling supported by remote staff, reassured by the information available to them and thankful to avoid hospital visits/admission.

COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

> I found it a good experience mainly because you have no idea what your oxygen levels are. You can feel fine even if they are low and you would be unaware until there was a problem.

> Really good experience to do this at home rather than unnecessary hospital trips as going to hospital is very scary and can make you feel worse.

BETWEEN 25 JANUARY AND 31 MARCH 2021

285 people were supported through the pathway.

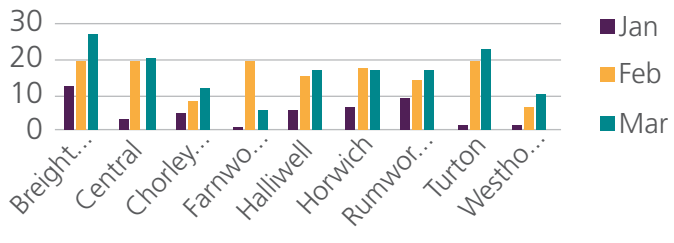
28 people (**9.8%**) were sent to hospital with **96.4%** of these being admitted for treatment.

13 referrals were received from primary care, one from North West Ambulance Service the remainder directly from the COVID-19 test result list.

A total of 26 patients from the Farnworth and Kearsley PCN area received support through this pathway.

	JAN	FEB	MAR
Breightmet & Little Lever	13	19	27
Central	3	19	20
Chorley Roads	5	8	12
Farnworth & Kearsley	1	19	6
Halliwell	6	15	17
Horwich	7	18	17
NULL	7	7	1
Rumworth	9	14	17
Turton	2	19	23
Westhoughton	2	7	10
All Bolton	**55**	**145**	**150**

PULSE OXIMETRY PATIENTS SUPPORTED



FINANCE

TYPE	TRANSACTION	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
ARRS Fund	ARRS - Staff	277,291	-277,291	0
CD	CD Payments	25,863	-25,863	0
Core	Fee by GPFed (1.25p/p)	53,732	-53,732	0
Ext Hours	Ext Hours Payment	51,940	-51,940	0
I&I Fund	Invoice to CCG	27,071	-4,539	22,532
Care Home Fund	Invoice to CCG	10,680	-10,680	0
Dev Fund 19/20	Development Costs	11,138	-7,523	3,615
Dev Fund 20/21	Development Costs	10,195	0	10,195
CD Extra Q4	CD Payments	19,415	-6,472	12,943
GRAND TOTAL		**487,325**	**-438,040**	**49,285**

PRIORITIES AND TARGETS FOR 2021/2

As the Network Manager for Farnworth and Kearsley PCN, my main priorities for 2021-22 will be:

- to continue monitoring and achieving our IIF targets, including appointment mapping.
- the recruitment of further ARRS staff to complement the current workforce and ensure staff are able to support the continuing work of enhanced care in care homes.
- reviewing our Cancer Quality Improvement work and ensuring we are consistent in delivering a high quality of care throughout the network.
- continuing to deliver a high level of structured medication reviews supported by the pharmacy team
- to continue to develop our relationship with the ICP.

Victoria Westwood
Farnworth and Kearsley Network Manager
Bolton GP Federation

APPENDIX 1
ADDITIONAL ROLES REIMBURSEMENT SCHEME (ROLE REQUIREMENTS)

Complete Ongoing

CLINICAL PHARMACISTS	
Ensure that the CP is enrolled in, or has qualified from, an approved 18-month training pathway or equivalent that equips the CP to:	
Be able to practice and prescribe safely and effectively in a Primary Care setting	
Deliver the key responsibilities outlined in section B1.2	
Ensure that each CP has the following responsibilities:	
Work as part of an MDT to clinically assess/treat patients using their expert knowledge of meds for specific disease areas	
Be a prescriber, or completing training to become prescribers, and work with and alongside the general practice team.	
Be responsible for the care management of patients with chronic diseases and undertake med reviews to proactively manage polypharmacy (through STOMP).	
Provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients and to help tackle inequalities	
Provide leadership on person-centres meds optimisation (including conserving antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst contributing to the quality and outcomes framework and enhanced services	
Through SMRs, support patients to take their meds to get the best from them, reduce waste and promote self care	
Have a leadership role in integration of general practice with the wider teams to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload	
Develop relationships and work closely with other pharmacy professionals across PCNs and the wider health and social care system	
Take a role in the shared care protocols, research with medicines, liaison with specialist and community pharmacists and anticoagulation.	
Have access to appropriate clinical supervision	
Each CP must receive a minimum of one supervision session per month by a senior CP	
The senior CP must receive a minimum of one supervision session every three months by a GP supervisor	
Each CP will have access to an assigned GP supervisor for support and development	
A ratio of one senior CP to no more than five junior CPs with appropriate peer support and supervision	

Complete Ongoing

PHARMACY TECHNICIANS	
Ensure the PT is registered with the GPhC	Complete
Meets the qualification and training requirements as specified by the GPhC to register as a PT	Complete
Enrolled in an approved training pathway such as the PCPEP or MOCH	Complete
Working under appropriate clinical supervision to ensure safe, effective and efficient use of medicines	Complete
Undertake patient facing and supporting roles to ensure effective meds use through shared-decision making conversations	Ongoing
Carry out meds optimisation tasks inclusing meds administration, supporting meds reviews, and meds reconciliation. Where required, utilise consultation skills to work in partnership with patients to ensure safe meds use	Ongoing
Support meds reviews and reconciliation for new care home patients and synchronising meds for patient transfers between care settings and linking with local community pharmacists	Ongoing
Provide specialist expertise to address both the public health and social needs of patients including lifestyle advice, service information and help in tackling health inequalities	Ongoing
Take a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients	Ongoing
Support initiatives for antimicrobial stewardship to reduce innapropriate antibiotic prescribing	Ongoing
Assist in the delivery of medicines optimisation and management incentive schemes and patient safety audits	Ongoing
Support the implementation of prescribing policies and guidance within Primary Care settings through clinical audits, supporting quality improvement measures and contributing to the Quality and Outcomes Framework and enhanced services	Ongoing
Work with the PCN MDT to ensure efficient meds optimisation, including implementing efficient ordering and return processes, and reducing wastage	Complete
Supervise practice reception teams in sorting and streaming prescription requests to allow CPs and GPs to review the complex requests	Ongoing
Provide leadership for meds optimisation systems	Ongoing
Provide training and support on the legal, safe and secure handling of meds, including implementation of EPS	Ongoing
Develop relationships with other PTs, pharmacists and members of the MDT to support integrtion of the pharmacy team across health and social care	Ongoing

Complete Ongoing

MUSCULOSKELETAL (MSK) FIRST CONTACT PRACTITIONER	
Has completed an undergraduate degree in physiotherapy	
Is registered with the Health and Care Professional Council	
Holds the relevant public liability insurance	
Has a Masters Level qualification or the equivalent specialist knowledge, skills and experience	
Can demonstrate working at Level 7 capability in MSK related areas of practice or equivalent (such as advanced assessment diagnosis and treatment)	
Can demonstrate ability to operate at an advanced level of practice	
Work independently, without day to day supervision, to assess, diagnose, triage, and manage patients, taking responsibility for prioritising and managing a caseload of the PCN's Registered Patients	
Receive patients who self-refer (where systems permit) or from a clinical professional within the PCN, and where required refer to other health professionals within the PCN	
Work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of movement and function issues, to create stronger links for wider services through clinical leadership, teaching and evaluation	
Develop integrated and tailored care programmes in partnership with patients, providing a range of first line treatment options including self-management, referral to rehabilitation focussed services and social prescribing	
Make use of their full scope of practice, developing skills relating to independent prescribing, injection therapy and investigation to make professional judgements and decisions in unpredictable situations, including when provided with incomplete or contradictory information. They will take responsibility for making and justifying these decisions	
Manage complex interactions, including working with patients with psychosocial and mental health needs, referring onwards as required and including social prescribing when appropriate	
Communicate effectively with patients, and their carers where applicable, complex and sensitive information regarding diagnoses, pathology, prognosis and treatment choices supporting personalised care	
Implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training	

Complete Ongoing

MSK FIRST CONTACT PRACTITIONER (CONTINUED)	
Develop integrated and tailored care programmes in partnership with patients through:	
Effective shared decision-making with a range of first line management options (appropriate for a patient's level of activation);	
Assessing levels of patient activation to support a patient's own level of knowledge, skills and confidence to self-manage their conditions, ensuring they are able to evaluate and improve the effectiveness of self-management interventions, particularly for those at low levels of activation;	
Agreeing with patient's appropriate support for self-management through referral to rehabilitation focussed services and wider social prescribing as appropriate; and	
Designing and implementing plans that facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence, and reduce the need for pharmacological interventions	
Request and progress investigations (such as x-rays and blood tests) and referrals to facilitate the diagnosis and choice of treatment regime including, considering the limitations of these investigations, interpret and act on results and feedback to aid patients' diagnoses and management plans	
Be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice	
Work across the multi-disciplinary team to create and evaluate effective and streamlined clinical pathways and services	
Provide leadership and support on MSK clinical and service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care	
Develop relationships and a collaborative working approach across the PCN, supporting the integration of pathways in primary care	
Encourage collaborative working across the wider health economy and be a key contributor to supporting the development of physiotherapy clinical services across the PCN	
Liaising with secondary and community care services, and secondary and community MSK services where required, using local social and community interventions as required to support the management of patients within the PCN	
Support regional and national research and audit programmes to evaluate and improve the effectiveness of the First Contact Practitioner (FCP) programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development	

Complete Ongoing

MENTAL HEALTH PRACTITIONER	
Provide a combined consultation, advice, triage and liaison function, supported by the local community mental health provider	
Work with patients to support shared decision-making about self-management	
Work with patients to facilitate onward access to treatment services	
Work with patients to provide brief psychological interventions, where qualified to do so and where appropriate	
Work closely with other PCN-based roles to help address the potential range of biopsychosocial needs of patients with mental health problems. This will include the PCN's MDT, including, for example, PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support	
May operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and the mechanism of booking between the PCN and the provider	
A PCN must ensure that the post holder is supported through the local community mental health services provider by robust clinical governance structures to maintain quality and safety, including supervision where appropriate	

Complete Ongoing

SOCIAL PRESCRIBING LINK WORKER

A PCN must provide to the PCNs patients access to a social prescribing service. To comply with this, a PCN may:	
Directly employ Social Prescribing Link Workers, or	Complete
Where a PCN employs or engages a SPLW under the ARRS, the PCN must ensure that the SPLW:	
Has completed the NHS England and NHS Improvement online learning programme	Complete
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	Complete
Attends the peer support networks run by NHS England and NHS Improvement at ICS and/or STP level; in order to deliver the key responsibilities outlined below.	Complete
Where a PCN employs or engages one or more SPLW under the ARRS or sub-contracts provision of the SP service to another provider, the PCN must ensure that each SPLW providing the service has the following key responsibilities in delivering services to patients:	
As members of the PCN's team of health professionals, take referrals from the PCN's Core Network Practices and from a wide range of agencies* to support the health and wellbeing of patients	Complete
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	Complete
Co-produce simple personalised care and support plan to address the patient's health and wellbeing needs by introducing or reconnecting people to community groups and statutory services, including weight management support and signposting where appropriate and it matters to the person	Complete
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	Ongoing
Provide personalised support to patients, their families and carers to take control of their health and wellbeing, live independently, improve their health outcomes and maintain a healthy lifestyle	Ongoing
Develop trusting relationships by giving people time and focus on 'what matters to them'	Ongoing
Take a holistic approach, based on the patient's priorities and the wider determinants of health	Ongoing
Explore and support access to a personal health budget where appropriate	Ongoing
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	Complete
Where required and as appropriate, refer patients back to other health professionals within the PCN	Complete

* agencies include but are not limited to: the PCN's members, pharmacies, MDTs, hospital discharge teams, allied health professionals, fire service, police, job centres, social care organisations, housing associations, VCSE organisations

Complete Ongoing

SOCIAL PRESCRIBING LINK WORKER (CONTINUED)	
Identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the SPLWs. This could be provided by one or more named individuals within the PCN.	
Ensure the SPLWs can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.	
Ensure referrals to the SPLW are recorded within the GP clinical systems using the new national SNOMED codes in section 6.4.1 and 10	
Where a PCN employs or engages one or more SPLWs under the SRRS or sub-contracts provision of the service to another provider, the PCN must ensure that each SPLW has the following key wider responsibilities:	
Draw on and increase the strength and capacity of local communities, enabling local VCSE organisations and community groups to receive SP referrals from the SPLW	
Work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities	
Have a role in educating non-clinical and clinical staff within the PCN through verbal or written advice or guidance on what other services are available within the community and how and when patients can access them.	
A PCN must be satisfied that organisations and groups to who the SPLW directs patients:	
Have basic safeguarding processes in place for vulnerable individuals	
Provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence	
Ensure that all staff working in practices that are members of the PCN are aware of the identity of the SPLW and the process for referrals.	
Work in partnership with commissioners, social prescribing schemes, local authorities and voluntary sector leaders to create a shared plan for social prescribing which must include how the organisations will build on existing schemes and work collaboratively to recruit additional SPLWs to embed one in every PCN and direct referrals to the voluntary sector.	