HALLIWELL PCN
ANNUAL REPORT
APRIL 2020 - MARCH 2021

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Prepared by:
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BOLTON GPFEDERATION

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EXECUTIVE SUMMARY AND INTRODUCTION

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

This year our PCN experienced a huge challenge by our network to deliver the vaccination programme with Bolton Community Practice from the site at Waters Meeting. This went well with the hard work and involvement of the team and practices.

All of our practices have coped well with more remote working, which was implemented overnight due to the pandemic and we are now starting to see more patients in the surgery.

There were a few issues with getting the Mental Health Practitioner (MHP) in place and we have been disappointed not to have had one in Lever Chambers all year. However, we have now managed to align our PCN MHP to cover all practices, therefore providing more universal cover across the network.

A couple of members of the Pharmacy team have started their maternity leave, for which we were prepared for by recruiting additional Pharmacists to support the ongoing projects within the network.

Our Paramedic has started recently and has been well received. We expect to reduce the workload further as we planned to recruit an additional Paramedic for the network.

The MSK Practitioners have embedded well into the network and have been very well received by practices and patients alike.

There has been some teething problems with the Multi-Disciplinary Team meetings and we will continue to try to improve this process by working closely with Community services.
All submissions for the PCN have been submitted in a timely manner and we look forward to the upcoming projects within the network.

Alison Lyon
Clinical Director
Halliwell 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 Halliwell 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 Halliwell PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 5,631
Number of vaccinations: 5,349
% of patient population vaccinated: 95%

Patients on the LD register who received an LD health check

Patient population: 226
Number of LD checks carried out: 175
% of patients received health check: 77%

Number of patients referred to social prescriber

Target number of referrals: 242
Number of referrals: 244
% of target reached: 101%

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 Halliwell Primary Care Network, during 2020/21, we recruited an ARRS team that included the following roles:

- Social Prescribing Link Worker
- Clinical Pharmacists
- Pharmacy Technician
- Musculoskeletal (MSK) First Contact Physiotherapists

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.

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

CASE STUDY

Female patient, 58 years old with a health background including breast cancer, type 2 diabetes, degeneration of intervertebral disc, osteoarthritis of the knee and depression.

The patient had been sleeping downstairs for two years as she could not get upstairs.

I referred her to the Independent Living Service to be assessed in her home and also for the adapted housing register.

At the patient's wishes, I gave advice to her on how her daughter could register her for housing on the Bolton Council website.

I followed this up and as her daughter had not been able to register her, I contacted housing options for additional support with this.

A home visit and assessment was carried out by the Independent Living Service. They were very supportive and helped to get the patient registered correctly.

The patient was very thankful and happy with the help she was offered and for my involvement in ensuring the right people were involved.

CASE STUDY

Male patient, 75 years old who was referred in for support with a housing issue. The patient was using an outstanding repair as a justification to drink alcohol daily.

Patient wanted a repair to his bathroom floor. Bolton at Home agreed to sort the repair and I agreed to call in two weeks time to check something happened. The patient declined support from the Achieve service and said he would cut back drinking by himself.

When I followed this up with him 2 weeks later, work had started on the repair. Patient was back to drinking alcohol only at weekends (2 vodkas on a Saturday).

I later rang the patient who was very distressed. The repair work had started but had not been finished and the bathroom floor was up. I emailed Bolton at Home and emailed them and the contractor over the next few days.

I followed up with the patient again and the repairs had been carried out. However, a few days later the patient became upset as the person laying his lino had to self-isolate. I sent a further email to get the job completed for him.

Eventually, all repairs were completed. The patient thanked me for listening and for sending the e-mails and reported that because of this he was still only drinking at weekends.

Jayne Spotswood
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

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.

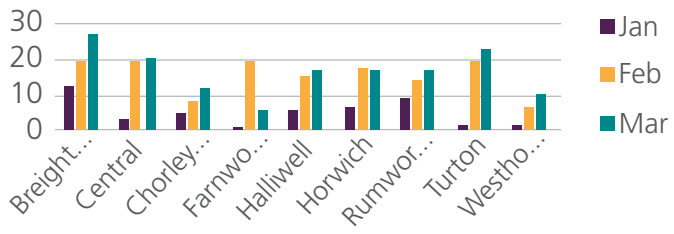
28 people (**9.8%**) were sent to hospital with **96.4%** of these being admitted for treatment.

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 38 patients from the Halliwell 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	198,402	-198,402	0
CD	CD Payments	18,628	-18,628	0
Core	Fee by GPFed (1.25p/p)	45,428	-37,856	7,571
Ext Hours	Ext Hours Payment	43,913	-43,913	0
I&I Fund	Invoice to CCG	18,437	-10,850	7,587
Care Home Fund	Invoice to CCG	1,800	-6,360	-4,560
Dev Fund 19/20	Development Costs	10,222	-8,983	1,239
Dev Fund 20/21	Development Costs	7,343	0	7,343
CD Extra Q4	CD Payments	13,984	0	13,984
GRAND TOTAL		**358,157**	**-324,993**	**33,164**

REFLECTIONS AND PRIORITIES FOR 2021/2

The past year has been a huge challenge for our PCNs, with the pandemic on top of our usual working days. However, I have found it to be a hugely rewarding year.

Relationships with our member practices have grown, our success with recruitment and expanding the workforce and our success with meeting and exceeding targets within the PCN targets has been successful. There are a few obstacles still cropping up (such as rooms for the team!) but we are slowly working through.

I thoroughly enjoy working closely with my Clinical Directors, their knowledge and clinical expertise is vital for me to be successful in supporting the PCN and during recruitment for the Additional Roles.

I would like to thank my Clinical Director Dr Alison Lyon and the member practices for their support throughout the past year, I am looking forward to continuing to welcome new members of the PCN workforce and I am looking forward to planning our workstreams for the upcoming year. Keep up the good work all!

Matthew Mann
Halliwell 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	
Meets the qualification and training requirements as specified by the GPhC to register as a PT	
Enrolled in an approved training pathway such as the PCPEP or MOCH	
Working under appropriate clinical supervision to ensure safe, effective and efficient use of medicines	
Undertake patient facing and supporting roles to ensure effective meds use through shared-decision making conversations	
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	
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	
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	
Take a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients	
Support initiatives for antimicrobial stewardship to reduce innapropriate antibiotic prescribing	
Assist in the delivery of medicines optimisation and management incentive schemes and patient safety audits	
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	
Work with the PCN MDT to ensure efficient meds optimisation, including implementing efficient ordering and return processes, and reducing wastage	
Supervise practice reception teams in sorting and streaming prescription requests to allow CPs and GPs to review the complex requests	
Provide leadership for meds optimisation systems	
Provide training and support on the legal, safe and secure handling of meds, including implementation of EPS	
Develop relationships with other PTs, pharmacists and members of the MDT to support integrtion of the pharmacy team across health and social care	

Complete Ongoing

MUSCULOSKELETAL (MSK) FIRST CONTACT PRACTITIONER	
Has completed an undergraduate degree in physiotherapy	Ongoing
Is registered with the Health and Care Professional Council	Complete
Holds the relevant public liability insurance	Ongoing
Has a Masters Level qualification or the equivalent specialist knowledge, skills and experience	Ongoing
Can demonstrate working at Level 7 capability in MSK related areas of practice or equivalent (such as advanced assessment diagnosis and treatment)	Ongoing
Can demonstrate ability to operate at an advanced level of practice	Ongoing
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	Complete
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	Complete
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	Complete
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	Ongoing
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	Complete
Manage complex interactions, including working with patients with psychosocial and mental health needs, referring onwards as required and including social prescribing when appropriate	Ongoing
Communicate effectively with patients, and their carers where applicable, complex and sensitive information regarding diagnoses, pathology, prognosis and treatment choices supporting personalised care	Ongoing
Implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training	Complete

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

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.	