ANNUAL REPORT
APRIL 2021–MARCH 2022

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Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GP FEDERATION

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WELCOME FROM OUR CHAIR

The last year in the teeth of a Covid-19 pandemic, our services continued to be delivered. The Federation has shown its ability to provide primary care resilience in areas where practices or Primary Care Networks (PCNs) have been unable to provide services. This has particularly meant that there has been a uniform vaccination offer across all of Bolton.

As we move out of the pandemic and into a recovery phase, the role of the Federation will be vital in delivering services at scale, particularly in elective recovery and working with colleagues in community hubs. Our unique expertise in Bolton and understanding of the challenges that at scale working creates, puts us in a good place to work with partners to deliver on behalf of the population of Bolton.

The system around us is changing. Clinical Commissioning Groups will cease to exist, and we will be moving to working into an Integrated Care System (ICS). At present the working arrangements of the ICS and localities are unclear, and we need to make sure that primary care and the Federation has a role both in the locality and in Greater Manchester (GM). The Federation will continue to provide input both locally and in GM.

In its role to support practices and PCNs, the Federation will be a key integrator both locally and at GM. No single service will be able to deliver the ask of the health services post-pandemic.

The next three to five years are likely to see pressure in NHS and social care. The Federation now has a track record of partnership working and service delivery and will be part of a reformed NHS and social care system.

George Ogden
Chair

WELCOME FROM OUR CHIEF OFFICER

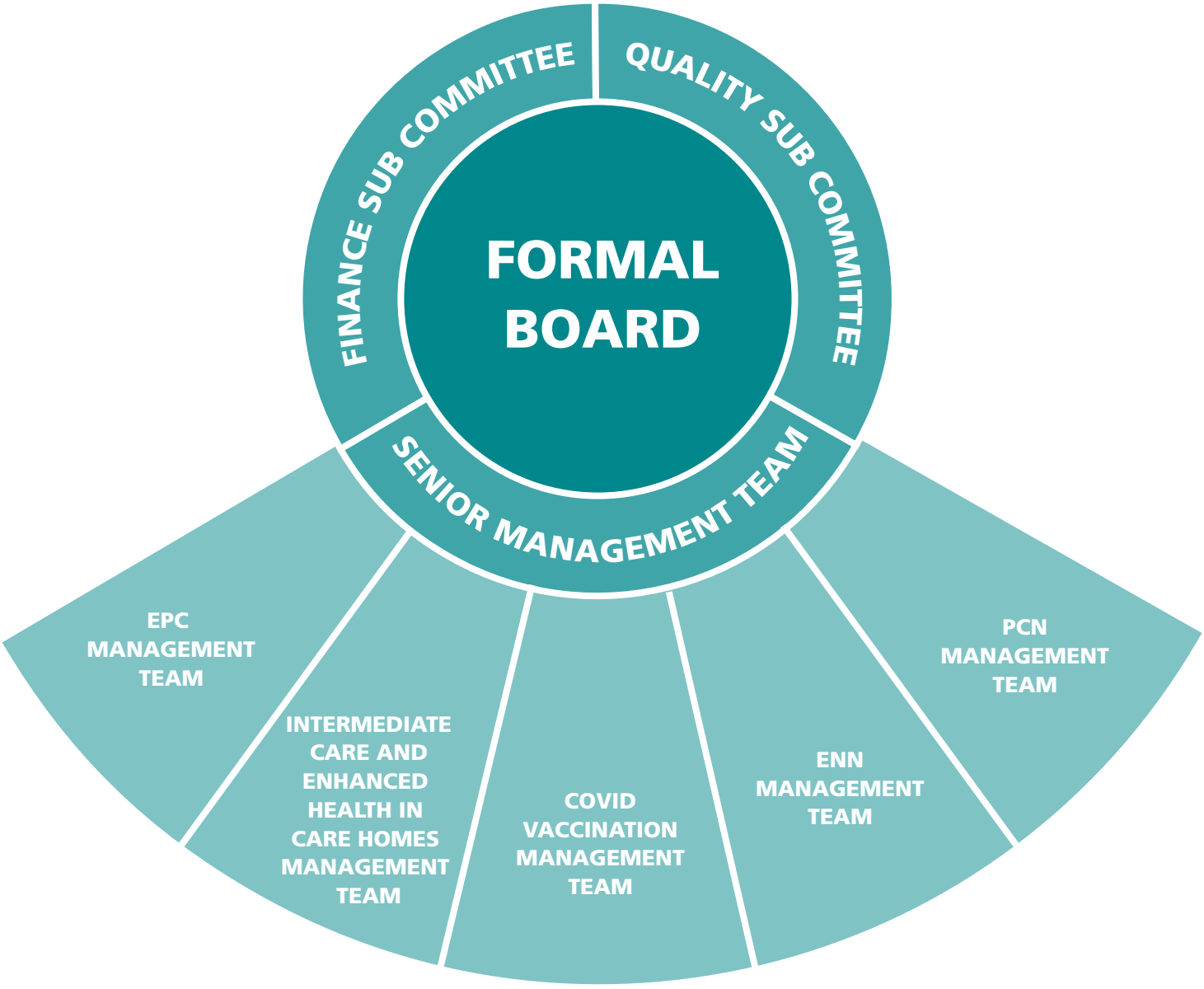
April 2021 to March 2022 was a time like no other. Whilst we and the rest of the NHS continue to recover and refocus ourselves after Covid, much of last year was taken up with the herculean effort of delivering the Covid-19 vaccine to protect the people of Bolton. I am incredibly proud of the work of the Federation team and the inspirational partnership working that enabled us to deliver almost 200,000 vaccinations in Bolton. Along with our key vaccination sites at Lever Chambers, Market Place and Avondale health centre, we also took the vaccine directly into the heart of our most under served communities. Whether that was on the 'Vaccine Bus', at drive-through sites for taxi drivers, or in workplaces and community and faith buildings, it was an honour and a privilege to be able to show how a large scale primary care provider like a Federation can be 'the difference that makes the difference', with the size to vaccinate 15,000 people in one week (at ESSA Academy) and also deliver on much smaller scales in communities across Bolton within walking distance of people's homes. Not forgetting the thousands of vulnerable older people who we vaccinated at home.

As always, much of what we delivered last year was alongside our long-standing Bolton partners. As well as our colleagues in community services and our Local Authority and housing colleagues, we continued to value shoulder to shoulder working alongside a range of valued voluntary sector partners, including Age UK Bolton, Urban Outreach, Bolton Council of Mosques and the Woodland Trust, allowing us to work in a way and reaching people we simply couldn't do on our own.

I have also been immensely proud to see our work recognised regionally and nationally, with invitations to speak at national conferences from NHS Confederation, the King's Fund and the Health Service Journal on a range of primary care issues including urgent care, Extended Access and Primary Care Networks. Our commitment to training, developing and supporting our clinical staff has also been recognised with our success as part of the GM Federation collaborative in being awarded the Greater Manchester Training Hub for Primary Care. This will allow us to support all primary care staff in Bolton with access to the training and development they need. Even more importantly, we now have the tools and resources to directly link the ongoing training of Bolton's primary care staff to the health needs of the population and the exciting opportunity to do this alongside our Integrated Care Partnership colleagues.

Michael Smith
Chief Officer

OUR GOVERNANCE STRUCTURE



OUR TEAM

Michael Smith
Chief Officer

Jenny Thomas
Business Manager

Sue Higson
Quality and Governance Lead

Mercedes Grundy
Office Manager (maternity leave)

Ellie Smith
Finance Officer

Abdullah Ashraf
Management Accountant

Dawn Lythgoe
Programme and Performance Manager

Steph Psujek
Project Manager

Kristy Barlow
Operational Manager

Barry Barlow
Service Lead

Matthew Mann
Senior Network Manager

Vicky Westwood
Network Manager

Emily Rigby
EPC Administrator

Heather Porter
Deputy Network Manager

Amy Humphries
Deputy Network Manager

Abby Edmonds
PCN Support Officer

Kath Arrowsmith
Chief Nurse

Lyndsay Bailey
Practice Nurse Lead

Mabs Rahman
Chief Finance Officer

OUR TEAM

I have worked for the Federation since August 2016. We have seen huge growth during this time and my role as Business Manager and the Company Secretary has adapted with this growth.

My role is to provide assurance to the Chief Officer and the Board that the organisation is financially sound, as well as providing excellent, quality services. In addition, I am key in procuring and developing new business.

I am vital to the strategic development and management of the organisation, and my 34+ years of working in the NHS enables me to support the whole team in the day-to-day running of the organisation.

The past year has seen pressures on the NHS like never before, and I am extremely proud to have worked with an excellent team of people who have shown resilience, strength and passion. I am dedicated to my role and always strive to improve the service we run as well as developing the organisation.

This year we started our organisation's journey to review our legal entity to be a better 'fit' in the changing shape of the NHS. As the Company Secretary I have led on the legalities of this, and we will continue this journey throughout 2022/23.

We have formed a partnership with the Greater Manchester Federations, which I am excited to be part of, and our first contract is to deliver the Greater Manchester Training Hub. Our organisation is passionate about training, we employ and support the Northwest Leadership Academy's Management Trainee Scheme. We understand the importance of training our current and future workforce and that this is vital in future workforce planning.

As we enter into our six years as an organisation, I am looking forward to growing the organisation further and working at scale with our partners.

Jenny Thomas
Business Manager

I have worked for the Federation since 2015. My current role involves overseeing the daily operations for all services and creating strategies for any new service provision. I am also a Network Manager working alongside the Clinical Director taking responsibility for implementing and monitoring contractual requirements and recruiting and managing the workforce.

The last 12 months have been very eventful. We have continued our efforts in offering Covid-19 vaccinations to the local population, we have been working with our PCNs on the planning and operational modelling for the new Enhanced Access service and in February we received the news that the GM Federations collaboration won the bid for the GM Training Hub, in which we have been identified as the lead employer.

Next year I look forward to Bolton GP Federation playing a key role in the GM Training Hub and to commence mobilisation of the Enhanced Access service for and on behalf of our Primary Care Networks.

Kristy Barlow
Head of Operations

OUR TEAM

I joined the Federation in April 2020 as the Performance and Programme Manager, and in those two short years, thanks to the can-do, supportive and autonomous culture I work in and the support and mentorship of my colleagues, I feel I have learnt, developed and delivered more than in any other part of my career.

I am responsible for leading on the Federation's strategic priorities, working with our Board and hard-working teams, including our PCNs, to deliver on our portfolios of work and contractual requirements in the best and most organised way we can. This year we have made great progress in understanding and building our organisational values and creating a clear vision that reflects us and that we are all committed to.

Communication is my passion and during my time here I am lucky to have taken on this additional responsibility. I am very excited that I get to play a lead role in developing the Federation's communication strategy with our Board, listening to and working with our shareholders, PCNs, practices, staff, partners and residents, to shape a strong, authentic and meaningful approach to how we engage with each other and how we shape what we do.

During the past year I have been extremely proud to see the growth in skills and confidence of our team. Seeing people progress, coming to work or volunteer for us on the Covid-19 vaccination programme, and moving onto new and exciting roles with us, has given me a real buzz. Our teams have gelled and with strong leadership, have continued to deliver a highly efficient vaccination programme, whilst further growing our 'business as usual'.

For this next year, I am looking forward to playing my part in our continued support to our PCNs and working with partners to tackle health inequalities and make a real difference to some of our most vulnerable residents. I am also thrilled that we get to be a part of the Greater Manchester GP Federation collaborative, working together to run the GM Training Hub, and I can't wait to see what other opportunities that brings for both my personal development and for the people of our town.

Dawn Lythgoe
Strategic Lead for Performance,
Programmes and Communications

OUR TEAM

I have worked for Bolton GP Federation for around four years now, having worked within practice as a General Practice Nurse (GPN) for two years, then joining the Head Office team in November 2020 as the Lead Nurse and becoming Chief Nurse in April 2021.

I manage a team of experienced General Practice Nurses who support Primary Care Networks (PCNs) across Bolton at times of low staffing through sickness absence, training and recruitment etc. This year the Experienced Nurse Network team has developed further and has grown to sixteen GPNs. Throughout the year the team has supported practices with all aspects of clinical support, and now includes cervical cytology mentorship and sign off assessment along with supporting other training requirements, including immunisations and vaccinations.

My role as Lead Nurse for the Greater Manchester Training Pod in Bolton supports immunisation/ vaccination training programmes and supports the Covid-19 vaccination programme.

I support with recruitment, training, mentorship, and development of staff across the PCNs. We have welcomed many new staff members over the last year, and it is wonderful that we now have our first dual trained Nurse/Paramedic, Nurse Associate and Trainee Nurse Associate working across our Primary Care Networks.

Following my participation in the CARE programme earlier this year, I have implemented a health improvement project and had the opportunity to work with local partners across the town, to increase the uptake of cervical smears in the BAME community. This Health Improvement project has created much interest across the town, and it is exciting to see it developing into a wider project. It is wonderful to hear I have been nominated for the Greater Manchester, GPN Innovator of the year award and GPN award for Improving Population Health, in recognition of this project.

During the coming year I am looking forward to becoming more involved with the roll-out of the next CARE programme to Nursing Teams and Advanced Health Practitioners, and the GP Phoenix programme to GPs across Greater Manchester.

We also have the exciting prospect of working more closely with the collaboration of GP Federations across Greater Manchester, the GM Training Hub and local Higher Education Institutions in developing education and training to GP teams and students across Greater Manchester.

Kath Arrowsmith
Chief Nurse

Following a regional project, the Bolton Training Pod will hopefully be expanding to support our PCNs with staff development across the town by providing local support and mentorship to their teams. I am currently working on the expansion of the Experienced Nurse Network to include Advanced Nurse Practitioners to continue to support practices at times of low staffing. The whole team are heavily involved in several projects to support with tackling Health Inequalities in Bolton, we are immensely proud of this work and grateful for the opportunities we have been given to continue this work throughout the coming year.

It is a privilege to work with the inspirational team at Bolton GP Federation and gives me a profound sense of pride and achievement to see the team grow, and to continue to go from strength to strength with each passing year.

OUR TEAM

I joined the Federation in 2018 as a Practice Manager, and in 2019 became more involved in Primary Care Networks, leading to becoming the Network Manager for Rumworth and HWL Primary Care Networks. In April 2021, I became the Senior PCN Manager, and continued to provide the Network Manager role to Rumworth, HWL and Central PCNs. I am also the corporate workforce lead and Federation expert on all things relating to the Additional Roles Reimbursement Scheme (ARRS).

My role is fast-paced and varied, supporting the PCNs with project management, finance management, workforce management and strategic planning for their future, alongside ensuring that our contractual obligations are met.

Last year was a very trying year indeed and saw whole PCN teams pulling together to support the Covid-19 vaccination service and our patients through the pandemic. I am extremely proud of how we worked collaboratively and supported our colleagues during this time, from team members in practice and at head office getting Covid-19, yet still providing a high-quality service to our patients.

My plans for the coming year is to embed more ARRS roles within the PCNs (space permitting!) and to support my PCNs and Clinical Directors in meeting and exceeding expectations around our contractual obligations, whilst collaboratively working with fellow providers. I also enjoy developing new and innovative projects within the PCNs and can't wait to see what 2022–23 has to bring!

Matthew Mann
Senior Network Manager

I have worked for Bolton GP Federation for two years as Primary Care Network Manager, looking after Farnworth & Kearsley and Chorley Roads PCNs. My role is to build the business and infrastructure of the primary care network alongside the Clinical Directors, all member practices and other stakeholders. Day-to-day my role is very varied; a large part of this is coordinating the recruitment and retention of the new roles, managing projects, and overseeing the contractual requirements of the network and ensuring we fulfil them all.

Since staring my role at the Federation at the very start of the Pandemic, it has been very much focused on Covid-19 and the delivery of the vaccination programme. It has also been an exciting time with the new structure of the PCNs and I have thoroughly enjoyed being part of this and focusing of the recruitment of the all the new roles.

Next year, I am most looking forward to the recruitment of our new PCN staff and working to develop their roles within the PCN. I am excited to see our plans to tackle health inequalities come into fruition and hopefully start to make a difference to patients in my PCNs.

Victoria Westwood
Primary Care Network Manager

OUR TEAM

I came to the Federation from a Financial Services background, having undertaken several senior HR roles before and taking voluntary redundancy in Dec 2020. With the luxury of time on my hands, in 2021 I initially started volunteering with the Federation, supporting the Covid-19 vaccination programme. What became immediately apparent, was the passion, dedication and determination of all our staff, to support and protect the people of Bolton through the most challenging of times.

In July 2021, I had the chance to join the Federation on a permanent basis. It is a privilege to be part of such an ambitious and growing team who put patients at the heart of everything they do, and who whose focus on Quality is unquestioned. Our growth as a Federation has continued this year, and whilst I am still on a learning curve in Primary Care, I know that what we are all doing for Bolton, and what we are doing to support Greater Manchester directly, and with our PCNs and through our services, is amazing.

Sue Higson
Quality and
Governance Lead

I have worked for the Federation for four years, starting part-time and gradually becoming full-time, taking on the role as Service Manager for our Extended Primary Care service, overseeing and ensuring the safe delivery of this service to our Primary Care Networks.

I have worked for the Federation for four years and this last year has flown by. A real highlight for me has been seeing how resolute we all are. We all took on a mammoth task with setting up Covid-19 vaccination clinics to help Bolton, which took us all out of our comfort zones. We showed great strength and determination in delivering a service that is still running to this day.

Next year I am looking forward to seeing the GP Federation growing and showing its true potential. Lots of planning is already going ahead ready for what next year has to throw at us and knowing the team I work with we are ready for anything.

Barry Barlow
Assistant Service Manager

OUR TEAM

I am currently the Finance Officer for the Federation. Within the last two years my role has developed and changed to fit around the needs of our changing and growing services. My role currently consists of dealing with the day-to-day financial transactions, processing payroll and aiding our financial advisor in the production of monthly and annual accounts and reports. I thoroughly enjoy working with the Head Office team and watching it grow immensely to tackle whatever we take on and I am excited to see what the next 12 months has in store for us all.

Ellie Smith
Finance Officer

Having worked in Primary Care since 2012, I was lucky enough to join the Federation in September 2021 as Deputy Network Manager, working directly with the Central, Chorley Roads and Farnworth & Kearsley Primary Care Networks. My job is to ensure that the Senior Network Managers, Clinical Directors, and the wider Primary Care Network teams get all the support they need to meet their contractual requirements.

I thoroughly enjoy my role within the Federation and feel very lucky to be a part of our strong Network Team.

Amy Humphries
Deputy Network Manager

I have been a part of the Federation team since February 2021, when I initially joined to support the Covid-19 vaccination programme. I am now the Deputy Network Manager for Halliwell, Rumworth and Westhoughton PCN. I mainly support the Network Managers to ensure we meet the contractual requirements on behalf of our PCNs.

Due to my previous HR experience, I also support the Senior Workforce Lead with the onboarding process and management of the staff recruited to work in the PCNs. This last year has been busy recruiting staff for our networks and ensuring they settle into their new role. It is great to see how each year our workforce continues to grow, and additional roles come to join the Federation family.

This year I am looking forward to working with our Network and PCN teams to ensure we meet and deliver the requirements of all of their contracts and meet their priorities.

Heather Porter
Deputy Network Manager

OUR TEAM

Stephanie Psujek
Project Manager

My NHS career started in 2007 as a Medical Receptionist in a town centre GP Practice where I worked for 14 years. In 2019 I started working part-time on top of this for the Federation through the Extended Primary Care Service, then in 2020 joined the Covid-19 vaccination clinic workforce, initially as admin support, then with training and support, progressing to Shift Lead position. In September 2021 I joined the Federation's Head Office team full-time as a Project Manager, where my role is to support the delivery of the Federation's projects, services and priorities.

My highlights for 2021/22 have been settling into my new role, learning new skills, and meeting my new team. I am looking forward to what next year brings and where my new role will take me and seeing the growth of myself as well as the Federation as a whole.

Mercedes Grundy
Office Manager

I have been with the Federation for almost 3 years now. I started as a bank receptionist and joined the head office team as the Office Manager in 2020.

My role is to co-ordinate, facilitate and document meetings, and provide diary management for the Chair of the Board, Chief Officer and Business Manager. I also provide administrative support to care homes and to the head office team if they need it.

During the next year, I will be on maternity leave and will be looking forward to returning in 2023 to new ventures that my colleagues have been working on during my time away.

Abby Edmonds
Primary Care Network
Administrator

I joined the GP Federation in December 2020 to help with the Covid-19 vaccination clinics at the height of the pandemic, and since December 2021, have worked in head office as the Primary Care Network Administrator, providing support to the PCN Management Team.

My role involves providing administrative assistance to management as well as HR work, supporting with the recruitment and induction processes for new PCN staff members.

I really enjoy working for the Federation - I like the fast-paced working environment and being able to see the difference our projects and services make. I am looking forward to working with the PCN team this year to help them meet their targets.

OUR BOARD

I am GP partner at Kearsley Medical Centre. I have been on the Federation board since the very first day. I am the Chair of the board, and have recently been re-elected into this position by the board members.

My role is to bring our board's diverse voices together, to develop a single view, and to make sure we action those views.

Dr George Ogden
Chair

The role of the Federation is to be an at scale provider and offer support to practice and PCNs - this way we can support to practices so they can deliver what's needed themselves and in partnership with others.

It has made me proud to see how our board has developed, how it thinks differently and how it takes every opportunity it can to work in partnership for the benefit of Bolton people. It has been excellent to see the Federation's core teams and services, working together to support the board in realising its ambitions.

Next year we will be refocusing the priorities that we've set, with a real emphasis on our approach to how we communicate with practices and PCNs, and on delivering our objectives with our partners in a new system.

I am a GP at Unsworth Practice in Westhoughton and have been a GP Federation board member since day one. I am the Vice Chair of the board and Chair of Finance Subcommittee.

I first joined the board to ensure there was real representation from GPs at the Federation, and because I had aspirations to see the Federation grow. I have seen this growth and the Federation become a strong voice that helps the rest of the system understand what primary care is really about. The Federation has also become a vehicle that helps to protect core general practice services by offering support where practices can't deliver on their own.

I am passionate about Bolton. I was born, bred and am raising my own family here, so I have a vested interest in it being a good place to be. General practice is an exciting place to work. It is generally the first port of call for patients, who I still love looking after from birth to grave.

Dr Kamran Khan
Board Member

Seeing the whole Federation team pull together through Covid-19 to deliver a fantastic, efficient and safe vaccination service made me proud. Watching the Federation's infrastructure grow and seeing how it has given us the real ability to support primary care, taking away the headaches for individual practices and PCNs has also been amazing. We still have a lot of work to do on tackling some of the health inequalities that still exist in some parts of our town. This can only be done if practices are supported to do this with the wider system across Bolton.

This year I am really looking forward to refreshing and improving how we communicate and getting better at engaging with practices, PCNs and with the wider system.

I think there's so much happening at the Federation. A lot of hard and brilliant work goes on, and we need to let people know about it.

OUR BOARD

As well as being a Federation Board member, I am a GP at Garnet Fold Practice, a GP Appraiser and Appraisal Lead for the Northwest. I am also the Clinical Director for Rumworth PCN and clinical advisor for NHSE complaints service. My role on the Board is Director for Governance, looking after safety and quality within all our services, ensuring that we provide the best and safest service for patients that we can, and that we respond to any risks in the system.

I believe that the Federation can provide an untapped, support service to practices, such as resilience and offering services at scale, that practices wouldn't otherwise be able to provide on their own. I want to ensure that the Bolton pound is being spent in the best way possible to promote and maintain a healthy Bolton population, and to tap all of those resources that are available to make sure that we can have everything that is available equally and equitably.

I think the Federation has vision for a better Bolton, working with our partners across the Council, voluntary services and secondary care and now within GM. Without the Federation, practices are at risk of decisions being made at a GM level that we are not aware of and that our voices might not be heard.

In my years in the Federation, I've found the team to be enthusiastic, hardworking, giving of their time, even outside of the normal hours to ensure that we are well represented.

Having a Federation in Bolton allows us to explore other avenues which has been recently shown with our input into the GM Training Hub, which will only maximise the potential for our Bolton family.

I'm passionate about family at all levels and everything that entails, and that includes my own family and families living in Bolton. This includes healthy relationships, being healthy in ourselves, healthy environment and living and engaging in things that our families can get involved in.

I have been in same practice for 18 years so I understand how mental and physical illness can have an effect on the whole system, and I am keen to ensure that families support each other as an untapped resource.

Food has a major role in our house, and we enjoy cooking and eating out and even our family dog, Pepper, gets involved. I'm teaching both of my children to cook so that they will be self-sufficient when they go off to university. We like walking and love the fact that we don't need to travel far to the lakes to enjoy the beautiful countryside.

My proudest moment this year was offering 3,000 vaccines in one day at Essa Academy, right in the eye of the Delta variant storm, and facing all weathers – typical Bolton weather, beautiful sunshine one minute, then rain the next. Seeing all the teams coming together to support all communities and seeing our Board step up, rolling up their sleeves to do what was needed to support the vaccine programme was wonderful.

Dr Saveena Ghaie
Board Member

Next year I am looking forward to the redesign of the Extended Primary Care service so that it offers a full and effective out of hours service that will support GP surgeries in providing appointments and resilience, whilst allowing our patients to be seen in a timely manner, at a time when GP services are so overstretched and struggling to manage demand.

Continuing to work together and sharing ideas across all our PCNs is also a priority for me, so we understand what works for others and are able to use those ideas in our own PCNs.

OUR BOARD

I am the Practice Manager at Pike View Medical Centre and have been on the Federation board since day one. Being on the board gives me the opportunity to influence primary care staying in primary care. I also sit on the Federation's Quality Board, which provides assurance on the safe and effective delivery of its services.

In all of my roles, I am passionate about giving patients the best service that we can. Outside of work I like reading, being with my grandchildren and great grandchildren, and listening to Country music (please don't say Dolly Parton there are many different modern genres!).

One of my proudest moments of being on the Federation Board, is when we set up the Extended Primary Care service and seeing practices and patients benefit from this.

I am looking forward to us moving onwards and upwards, working with different partners and getting back to 'normal' contact with practice managers.

Marie Bryan
Board Member

I am Practice Manager at Spring House Surgery and for the last 2 years, have been on the Federation's board as their Finance Director.

I sit on the board so that I can ensure Practice Manager's views and comments are shared with the Federation and to put general practice and community services first, to improve their standing in all aspects of care.

I am passionate about health equalities in Bolton – and my new fur baby Mollie, who helps to keep me sane! I believe that being kind is extremely important.

I am proud to see how the Federation and our board has developed and grown in the last couple of years and are gaining respect from colleagues and other health and social care colleagues.

During the next year I am looking forward to seeing the board represent GPs and community care organisations during the restructure of care currently underway.

Janet Scott
Board Member

OUR BOARD

I am a GP partner and trainer for Unsworth Practice in Westhoughton, and the Clinical Director for Westhoughton Primary Care Network (PCN).

As a Clinical Director I see my role as advocating for the PCN and feeding back how the Federation is supporting my PCN and keeping them informed on improvements and achievements.

As a GP I feel I'm well placed to speak about my role and how any funding decisions may help to improve patient care and primary care staff wellbeing.

I see my role on the board as ensuring that the Federation is delivering on its aims to support PCNs and practices. I'm keen for all shareholders to understand our aims and objectives and to utilise all the support available to practices (and ensuring this is communicated effectively). I'm keen to be innovative in approaching problems whilst not needing to reinvent the wheel if other areas have done things well. The Federation is there to support primary care and as such we need to understand what the challenges are and get this information from our shareholders. We then need to deliver and tell people about it.

I love training and have been a trainer for a few years and really think this keeps me on my toes in my job. Having Additional Roles Reimbursement Scheme (ARRS) staff in my PCN has been really positive. To ensure they deliver well to patients and are happy in their roles, we have invested lots of time in training and supervision and have recently set up a mentorship scheme to ensure we are listening to ideas and career aspirations.

Dr Beverley Matta
Clinical Director

I spend lots of my day job doing women's health and really enjoy this aspect of my role. At home I have 8-year-old twin girls that keep me busy! When I get a chance, I enjoy baking (so I can eat it). I also enjoy running and spinning and have a vintage clothes obsession.

I think it is refreshing to be on a board where ideas are listened to and there is a desire to ensure these come to fruition. An example would be how PCNs have vocalised the need for the DES contract to be presented in a digestible way. This has been achieved with 'plan on a page' style communication. For a board to work effectively there needs to be a level of familiarity and confidence in each other which allows challenge, and I feel this has developed well amongst our board members.

For next year, I am looking forward to seeing the ongoing work and development for PCN support, especially with the opportunities that will come with Federation hosting the Greater Manchester Training Hub.

OUR BOARD

I am working as a GP in Great Lever One, Bolton. In April 2021 I became the Clinical Director of our Central PCN. As part of this role, I was asked to join Bolton GP Federation board. This showed me that the Bolton GP Federation has endeavoured to be inclusive for oversight and scrutiny by Clinical Directors of the PCNs it supports.

I have had the opportunity to share views on behalf of my practices which have been considered carefully in the Board meetings.

I was also fascinated that after working on and securing the GM Training Hub Contract, the Federation's Chief Officer, Michael invited GPs from a different Board in Bolton to steer the strategic decisions involving the Training Hub. This again shows the commitment by Federation to work collaboratively.

It was unique for me to see the selfless commitment by Dr George Ogden and his vision to have a GP Federation which is for and on behalf of Bolton Practices and always striving for the bigger picture for residents of Bolton. A vivid example of this is the Extended Primary Care service, Covid vaccinations, supporting practices in need, engaging at GM level to maintain a Bolton voice.

Dr Adil Khan
Clinical Director

I have had the opportunity of meeting several team members in the Federation and I am cognisant of their roles and effectiveness. They are all working well and working to their bones. Their motivation is working in an excellent and supportive team which is delivering a high-quality care for Bolton residents.

In the next financial year, I can see how the Federation has engaged with PCNs conducting workshops for Extended Hours will help the practices by bringing those services closer to our patients and providing a bespoke model for each network.

The way I see the GP Federation can be summed up as follows:

We demand – they deliver. As Bolton Central PCN Clinical Director, I see the GP Federation as a supporting tool that skilfully manages the finer details of contracts. It is not just having a manager from the Federation but having a lean, effective team that manages HR, KPIs, accountancy and services.

I am a locum GP and the Bolton CCG Clinical Lead for prescribing. I am also the Clinical Lead for the Halliwell Primary Care Network (PCN) and have been on the Federation board for a few years now. I enjoy being on the board to be involved in discussions about how we're engaging with practices, PCNs the rest of Bolton and Greater Manchester.

Dr Alison Lyon
Clinical Director

Our board is very approachable, and I find being involved helps me keep up to date on developments of the new system arrangements.

My passion is improving diabetes and understanding how deprivation has an impact on alcohol addiction. I have been in the very fortunate position of being able to see the impressive work the Federation team has done on delivering the vaccination programme.

For the next year I am looking forward to seeing how we can improve communication with our partners and building new relationships in the new system, including finding ways for primary care and secondary care to communicate and work better together.

OUR BOARD

By day I am a GP Partner and Trainer at Heaton Medical Centre. I am also the Clinical Director for Chorley Roads PCN and an out of hours GP.

My role on the Federation Board is as a non-executive member.

I have been a Board member for a few years now, and I see my role there as being to help provide scrutiny and direction for the GP Federation in providing for networks and General Practice, by using knowledge and experience of working in multiple areas of general practice. I also use my role to encourage better relations with system partners to help with the integration agenda.

My passions are ensuring our patients in care homes get the best possible care from us, elderly care, excess opiate neuropathic prescribing, cricket, golf, and fishing – they all keep me motivated and busy.

My proudest moment this year was establishing the Covid vaccination for the network with the Federation. Next year I am looking forward to working on anticipatory care with our partners and being involved in the GM Training Hub.

Dr Dharmesh Mistry
Clinical Director

OUR SERVICES

During 2021–22 we continued to run a number of services. This included:

Extended Primary Care has been running since 2015/16 in partnership with BARDOC offering evening and weekend appointments for general practice.

Intermediate Care has been running since 2017, providing clinical leadership and GP support to deliver enhanced care in care homes.

Experienced Nurse Network was a new pilot service developed in July 2020 in response to requests from GP practices to support them with their nursing needs.

In December 2019 we began the delivery of the **Covid vaccination programme** on behalf of four of Bolton's PCNs. In 2021–2022 we continued this service on behalf of five PCNs (Halliwell joined in September 2021).

The Training Hub – we set this up in January 2021 at the request of Greater Manchester Health and Social Care Partnership to upskill workforce quickly in response to Covid vaccination programme.

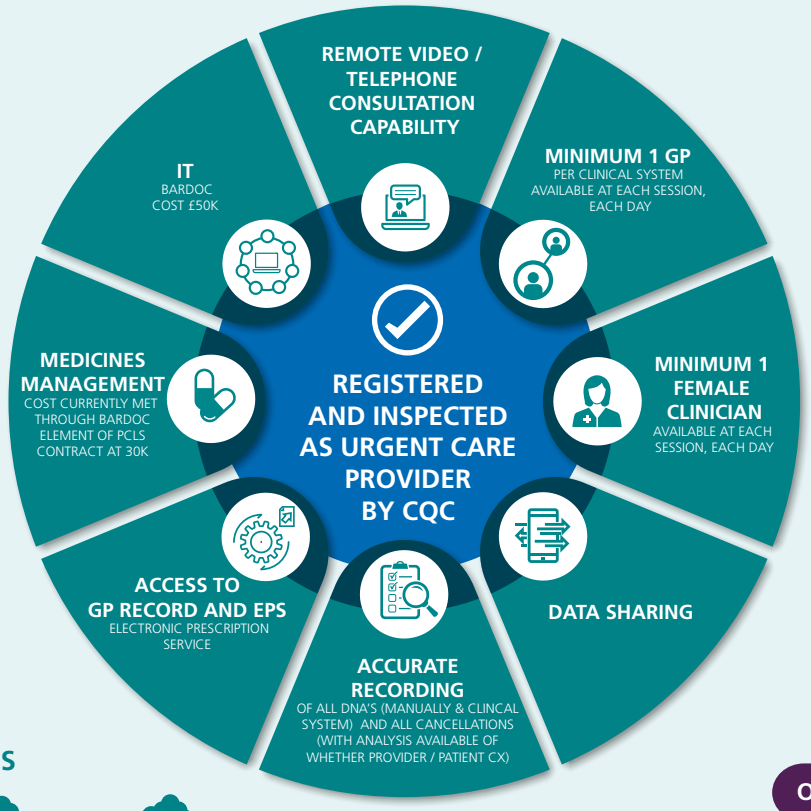
EXTENDED PRIMARY CARE (EPC) OVERVIEW

CURRENT PROVISION AND CONTRACTUAL REQUIREMENTS | FUTURE POSSIBILITIES

CURRENT CLINICAL SERVICE PER 1,000 PEOPLE

Start consultation within 15 mins of agreed appointment time

365 days/year
7 days/week
6.30–9.30pm Mon-Fri
9am–1pm/
10am–2pm weekends



ESTATES

COST CURRENTLY MET THROUGH BARDOC ELEMENT OF PCLS CONTRACT AT £120K

OOH?

URGENT CARE?

GP CO-OP MODEL OF DELIVERY?

EXTENDED PRIMARY CARE (EPC)
BOLTON GP FEDERATION STAFFING

The EPC service is currently running from Waters Meeting Health Centre, Royal Bolton Hospital and Winifred Kettle.

25GPs

8ANPs

22NURSES

6HCAs

15ADMIN

3MSKs

3MHP

APPOINTMENT USAGE 2021–22

Appointments offered: 19,439

Appointments used: 18,194 (94%)

DNAs 829 (4%)

Appointments unused: 416 (2%)

Face-to-face appointments: 937 (5%)

EXTENDED PRIMARY CARE (EPC) REQUIREMENTS IN DETAIL

CQC REQUIREMENTS

- **Registered as Urgent Care Provider**
- **Inspection**

SAFE

- Comprehensive quality assurance
- Site risk assessments
- Safety assessments
- Safety policies
- Safeguarding
- Communications/ lessons learned
- Responding to and meeting people's needs

EFFECTIVE

- Audit and service improvements
- Effective staffing
- Staff supervision/ appraisal
- Consent to care

RESPONSIVE

- Understanding needs of the population (skill mix)
- Timely access to services
- Concerns and complaints

CARING

- Patient feedback
- Interpretation services

WELL LEAD

- Clinical and organisational governance

PERFORMANCE MONITORING

Key performance information monthly:

- Full data set
- Planned care appointments usage split by GP practice
- Quality Data submission
- Staffing and skill mix six-monthly report
- Consultation audits
- Cancer audits
- PCLS monthly report
  - Friends and Family
  - % of available appointments booked
  - DNA rate
  - Incidents
  - Duty of candour

EXTENDED PRIMARY CARE (EPC) REQUIREMENTS IN DETAIL

GOVERNANCE

- Clinical governance framework
- System patient experience
- Formal and process complaints
- Audit
- Business continuity plans
- Incidents/SUIs
- Risk register/management
- Feedback and lessons learned
- IG/toolkit level 2
- Caldecott guardian
- Clinical effectiveness
- Equality and diversity
- Clinical leadership

HR

- Rota
- Staffing
- Appraisal
- Professional development
- Contracts
- Induction
- Registration
- Training
- Mentorship
- Staff survey/ meetings
- DBS checks

IT

- Access to patient records for all practices using the service
- Shared access to multiple system licences across all sites (Federation costs)
- IT support OOH (BARDOC cost)
- IT equipment (BARDOC cost)
- Telephony

EXTENDED PRIMARY CARE (EPC)
EARLY CANCER DIAGNOSIS

Early cancer diagnosis: safety netting

Safety netting has many elements and is an important way to ensure that patients are followed up in a timely fashion. Safety netting has been defined as ensuring:

- **Attendance at appointment following urgent referral for suspected cancer**
- **The results of investigations are received and acted upon promptly**
- **That people with a symptom that is associated with an increased risk of cancer but who do not meet the criteria for referral or investigation are reviewed appropriately**

AIM:

To ensure that patients referred under 2 week wait (2ww) are given the information about the importance of attending appointments and systems are in place to check they have attended the appointment.

CRITERION:

All patients referred under 2ww should have the information about the importance of attending the appointment and systems are in place to check they have attended the appointment.

STANDARD:

100%

DATA GATHERING

A search was done on our 2ww referrals between April and July 2021. The clinical lead went through the patient records and collected information regarding safety netting and attendance.

RESULTS

Total number of patients referred under 2ww: 15

Evidence of safety netting: 1/15

DNAs: 0

DISCUSSION

This audit shows we need to improve our safety netting. Fortunately, on this occasion all patients attended their appointment. The audit findings were discussed at the EPC meeting.

ACTIONS

1. All patients referred under 2ww will be sent a leaflet explaining the importance of attending appointment. This will be carried out by the admin team at the GP Federation.
2. We will make the 2ww referral template available to all GPs so we have a standard template which checks the patient's availability for a 2ww appointment.
3. Re-audit in a year.

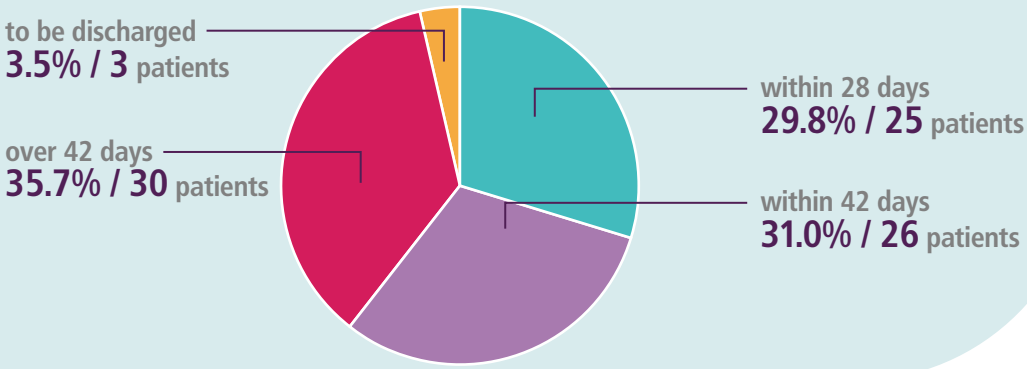
INTERMEDIATE CARE

Since 2017 the Federation has provided clinical leadership and GP support to deliver enhanced care in care homes.

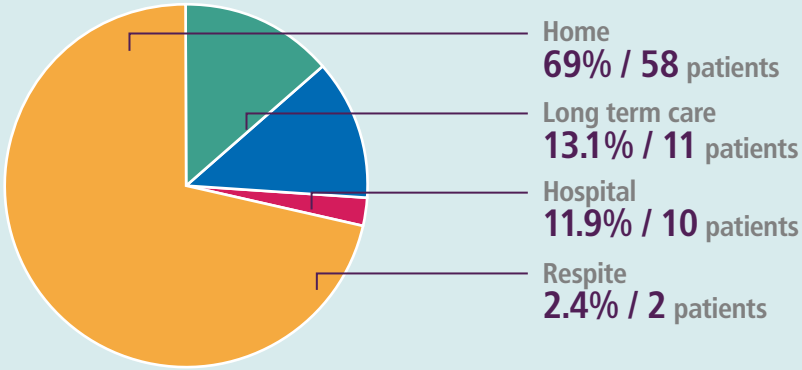
In 2021–22, we provided this support to 12 beds in Wilfred Geere House. During this time:

- 84 patients were admitted
- We carried out patient-centred geriatric assessments upon admission
- We followed a multidisciplinary approach that enable joined-up care for patients, meaning:
  - 69% of patients were able to return home
  - Medication reviews enabled prescribing cost reductions
- We partnered with the Age UK (Bolton) Home from Hospital Team to follow patients who were discharged to their homes.
- Our access to the GP record enabled better continued care, reviewing previous baselines, diagnosis and treatments.

PATIENTS DISCHARGED



DESTINATION ON DISCHARGE



Experienced Nurse Network

EXPERIENCED NURSE NETWORK (ENN)

Our Experienced Nurse Network (ENN) was a pilot service developed in 2020 in response to requests from GP practices to support them with their nursing needs. Due to its success and growing popularity, this became a mainstream service during 2021.

As of March 2022, we had **16 nurses** in our Experienced Nurse Network – a growth of 78% since the same time last year, when we had 9 nurses in the network.

During this year, our experienced nurses supported **17 practices** from across Bolton. This is more than double the previous year, where we supported 8 practices.

Our nurses provided over **1,000 hours** of supporting practices with recruitment gaps and covering for holidays, sick leave, and whilst staff are on training programmes. The nurses have provided:

- General Practice Nurse cover
- Cervical smears
- Child immunisations
- Flu vaccinations
- Covid-19 vaccinations

Month	Number of hours
April	107
May	92
June	59.5
July	78
August	69
September	92
October	127.5
November	117
December	40
January	62.5
February	61.5
March	118.5
TOTAL	**1,024.5**

EXPERIENCED NURSE NETWORK (ENN)

ENN Cervical Cytology Mentorship

This year we introduced cervical cytology mentorship as part of our ENN service. This involved three of our very experienced nurses, who are Cervical Cytology Mentors, being allocated to new cervical cytology trainees. Previously, practices had been unable to secure mentors themselves and were keen to utilise this service provided by the ENN team as it gave them and the trainees the flexibility needed to access mentors during hours that were convenient.

During 2021–22 we:

- supported two practices with the cytology service
- provided two smear mentors to practices
- signed off one mentor who completed their final assessment.

COVID-19 vaccinations programme

COVID-19 VACCINATIONS PROGRAMME

2020-21 was a very busy and also rewarding year for our teams and our partners working on the Covid-19 vaccination service.

At Bolton GP Federation we delivered the Covid vaccination programme on behalf of five of Bolton's Primary Care Networks: **Central**; **Chorley Roads**; **Farnworth & Kearsley**; **Halliwell**; and **Rumworth**.

In April 2021, we launched the Covid Vaccination Bus – one of the first in England to hit the road.

During this year, we continually offered first, second and booster vaccines to all priority groups identified by NHSE through our local vaccination sites, whilst also tackling new variants and the need to step up urgent surge vaccine activity in the epicentre of the outbreak.

In particular, working with our practices, PCNs and partners, we were able to respond to the Delta variant, which was first detected in the BL3 area of Bolton in mid-May 2021. More recently, we have used our innovation and learning from Delta, to help respond to the Omicron variant and share learning with other areas of the country affected by outbreaks.

Our Delta variant response included:

- Delivering a record-breaking number of vaccines in one weekend on the Covid vaccination bus in the heart of the BL3 area (Essa Academy), making the national news.
- Working with the military to open up and run pop-up clinics in non-clinical, community settings.
- Operating one of the country's first drive-through Pfizer clinics to taxi drivers.

COVID-19 VACCINATIONS PROGRAMME

During this time, we developed a range of innovation and targeting techniques which were shared nationally as best practice. These included:

- Large-scale surge vaccination
- Probation services
- Co-delivery with health checks
- Co-location with testing activity
- Whole families
- Targeting geographical areas with low uptake
- Refugee and asylum seekers
- International new arrivals
- People who were unregistered/undocumented
- Women only
- Sex workers
- Pregnant women

More details on our approach can be found on our website: www.boltongpfed.co.uk/case-studies

Alongside running our local vaccination centres at Market Place Shopping Centre and Avondale Health Centre, we also vaccinated at our mobile clinics in non-clinical and community settings, including:

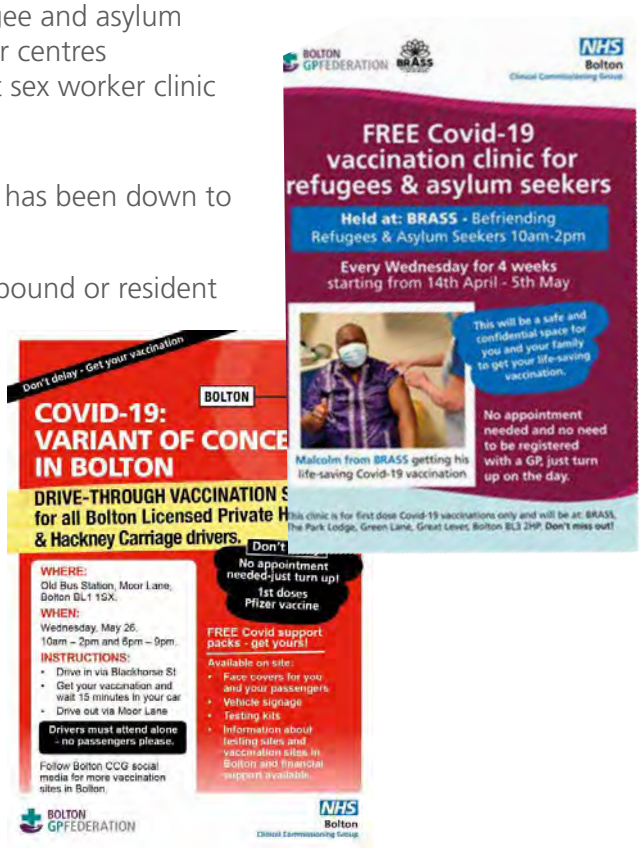
- Taxi-driver drive-through
- Workplaces
- Parks and open spaces
- Town Hall square
- Garage forecourts
- Schools, universities and colleges
- Places of worship
- Shopping centres and retail parks
- Health centres
- Children's centres
- Wedding venues
- Community centres
- Refugee and asylum seeker centres
- Street sex worker clinic

The successful delivery of our Covid vaccination programme has been down to the fantastic partnerships we have developed.

We delivered Covid vaccinations to people who were housebound or resident in a care home thanks to the support from practices and Bolton Council, and through our partnership with Bolton NHS FT we delivered vaccines to Bolton school children.

With support from the Learning Disability Team, we provided special, quiet vaccine clinics for people with learning disabilities at Lever Chambers and Market Place clinics. With additional help from the Health Improvement Practitioners, we also took the vaccine out to people living in supported living accommodation. More information can be found here:

www.boltongpfed.co.uk/boosting-health-for-people-with-learning-disabilities



COVID-19 VACCINATIONS PROGRAMME

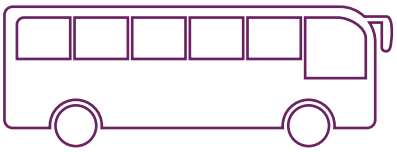
Here are the numbers...

From April 2021 to March 2022 we gave

156,629

Covid vaccinations

We delivered **251** vaccination clinics at Lever Chambers, Market Place and Avondale Health Centre



We ran **174** mobile and pop-up clinics in the community

Working in partnership with Bolton NHS FT, we delivered almost

5,000

first and second dose vaccines to Bolton school children in school settings

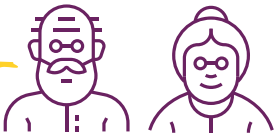
We gave

1,577

vaccinations to housebound patients in their homes

Working in partnership with Bolton Council, we delivered

1,739



vaccinations to care home residents

COVID-19 VACCINATIONS PROGRAMME

Staff survey

During June 2021 we surveyed the clinical and non-clinical staff working for us in the Covid vaccination clinics.

100% of respondents said they are happy with communications.

100% said they enjoy working at the vaccination clinics and feel they are valued members of the team.

When asked if there was anything else they would like to raise, they said:

> I would like to continue working for the GP Fed doing vaccines.

> The service is efficient, well organised, friendly, lots of up-to-date information, and excellent support from all levels of the teams.

> Good service which supported the staff and high morale.

> Excellent service provided for the people of Bolton. I felt the service went above and beyond to roll out the vaccinations.

> I am completely happy with the service.

> GP Federation provided an excellent service during Covid and also extended services.

> Every single member of the team has worked amazingly and it has been an absolute pleasure.

COVID-19 VACCINATION TRAINING HUB

The Covid Vaccination Training Hub was set up by the Federation in January 2021 at the request of Greater Manchester Health and Social Care Partnership to upskill workforce quickly to support the Covid vaccination programme.

From 1 April 2021 to 31 March 2022, **64 people** were referred into the hub and trained from across Greater Manchester.

The hub also trained an additional **150 people** who came through Bolton GP practices, Bolton Hospital, Army personnel, St John Ambulance and NHS Professionals.

Each person trained followed a Vaccinators Competency Assessment. Once this was completed and their training had been observed, it was signed off as competent. Following this, their GM Covid-19 Training Passports were approved. This passport could be used at Covid vaccination sites across the whole of Greater Manchester.

Types of roles that have become vaccinators:

- Opticians
- Pharmacists
- Pharmacy Technicians
- Health Care Support Workers
- Critical Care Nurse
- Learning Disability Nurses
- GPs
- Retired GPs
- Army Personnel
- Health & Social Care Students
- Dentists
- Dental Technicians
- Dental Hygienists
- Orthodontists
- Orthodontal Technicians
- Orthodontal Hygienists
- Registered Nurses Adult
- Registered Nurses Paediatric
- Public Health Nurses

We have welcomed people from the surrounding areas:

I was really happy with the training provided by Kath Arrowsmith...she taught me everything step-by-step and she really helped build my confidence in vaccinating.

Kathryn was very organised, clear, and patient. First class trainer.

Although I am nurse who has given injections, I have never done immunisations before, so this detailed training was more useful than I had expected it to be... I found the opportunity to do some vaccinations under supervision quite refreshing and useful in knowing that I was following the correct technique.

I found the session really helpful and I did value the process pathway from start to finish. Kath was really easy to talk with and answered all my questions. I felt at ease and definitely would recommend the morning to anyone who needs an update on theory and practical support!

2022

For 2022 the Training Hub will be part of the GM Nurse pathway and will support GM localities with general practice nursing services such as cervical cytology, immunisations and vaccinations and mentorship and support.

OUR PRIMARY CARE NETWORKS

The Federation supported six of Bolton's nine Primary Care Networks.

- **Central**
- **Chorley Roads**
- **Farnworth & Kearsley**
- **Halliwell (HWL) Waters Meeting and Lever Chambers**
- **Rumworth**
- **Westhoughton**

The Federation has employed a dedicated team to support PCNs, which includes PCN Network Managers, Deputy Network Managers and an administrator, who assist the Clinical Directors with the organisation and project management of the contractual specifications, which this year included implementing and monitoring targets around the Investment and Impact Fund (IIF).

The Federation also acted as the host employer for the PCNs, employing from the roles available under the Additional Roles Reimbursement Scheme (ARRS), including:

- **Social Prescribing Link Workers**
- **Pharmacists**
- **Pharmacy Technicians**
- **Musculoskeletal (MSK) First Contact Practitioner**
- **Physician Associates**
- **Mental Health Practitioners**
- **Paramedics**

Training and development at the Federation is a high priority, and a number of opportunities which would further support PCNs were provided during 2021–22, including:

- **Network Managers completed Level 7 Diploma in Advanced Primary Care Management**
- **Enrolling Pharmacists and Pharmacy Technicians onto the CPPE pathway and GP Ready scheme**
- **MSK Practitioner commenced Level 7 MSc Advanced Clinical Practice**
- **Pharmacist commenced Level 7 MSc advanced clinical practice and Paramedic commenced Level 7 MSc advanced clinical practice**
- **PCN Administrator commenced Level 3 Team Leader / Supervisor Apprenticeship**
- **Social Prescribers attended Level 2 qualification in Gambling Related Harm**
- **Support to the Cervical Cytology mentorship and sign off process**
- **Promotion of the GP Assistant programme and the Care Programme via the networks**

Each of our PCNs have a detailed annual report, setting out in detail the progress they made during 2021–22 and the priorities they face for 2022–23 (See Appendix 1).

OUR VISION AND VALUES

During 2021/22 we reviewed our Bolton GP Federation vision, mission and values.

Through engagement and consultation with our Board, staff and partners (including practices, PCNs and colleagues from other organisations such as Bolton CCG, Bolton Council and Bolton CVS), we co-created a set of values that reflect our most current priorities and culture.

A statement of our vision (how we want to be perceived):

To be the leader in primary care collaboration.

Our mission statement (what we do):

Our mission is to improve health and care. We meet everyday health and care needs for people by connecting and shaping primary care systems and using creative thinking to develop, improve and support great local services.

Shared purpose (a set of experiences that our audiences will have when they engage with us):

We support primary care through the development of joined up solutions using creativity and forward thinking to deliver at scale, in a responsive, achievable, practical and sustainable way.

We deliver great experiences through seamless solutions with our partners that meet the needs of local populations. Together we can deliver more.

Values (that represent 'how we do business'):

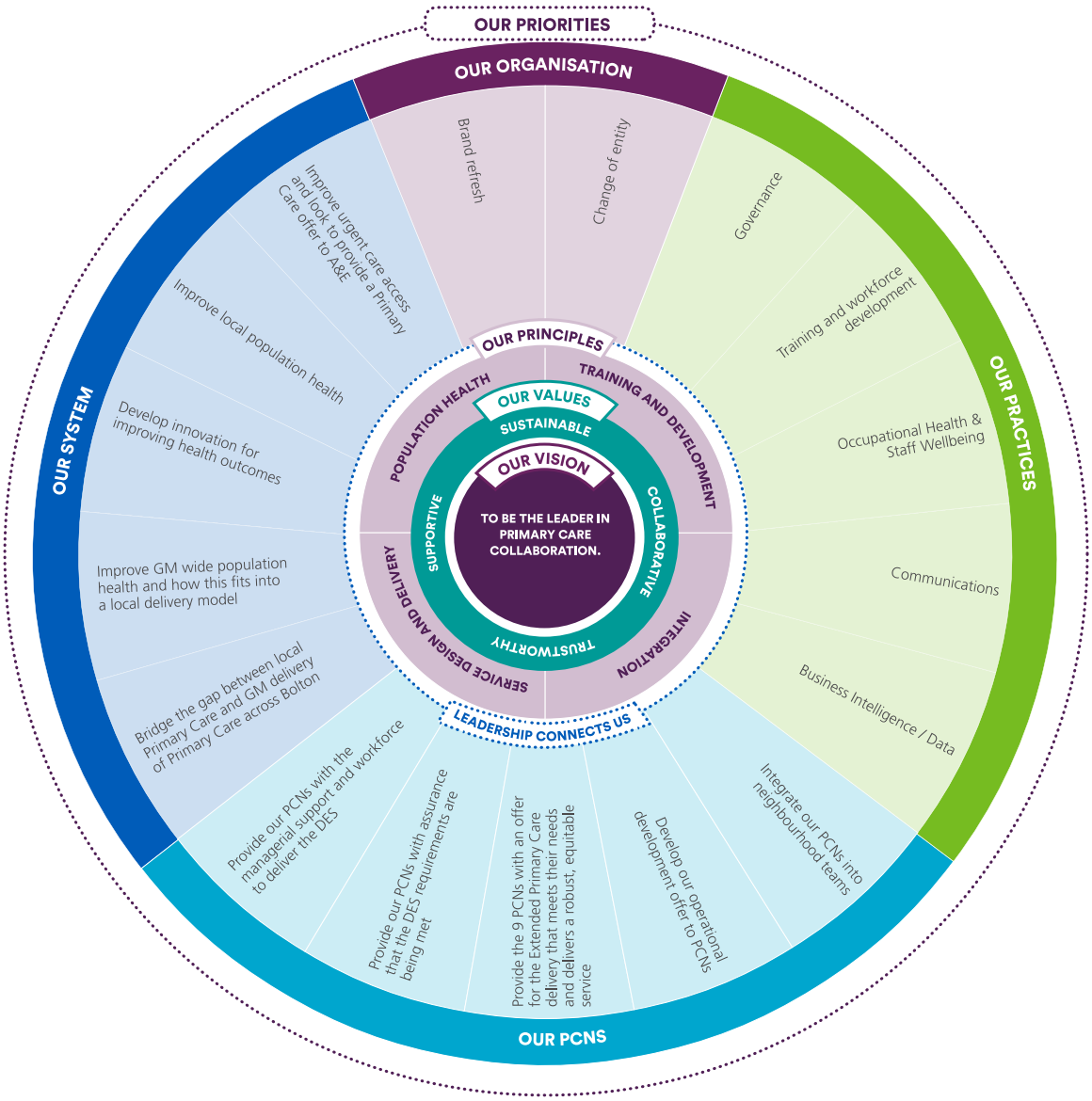
- **Trustworthy**
- **Collaborative**
- **Supportive**
- **Sustainable**

VISION AND VALUES NEXT STEPS

For 2022–23, our priority will be to bring our vision and values to life in a meaningful way for our stakeholders. To help do this we will work with our Board, Senior Management Team and our external brand and strategic communication partners to:

- **Develop a communication strategy that is insight driven and brings our vision and values to life**
- **Engage our workforce to integrate and improve communication**
- **Review our brand strategy and presence**
- **Review and consult on our legal entity**

OUR PRIORITIES FOR 2022/2023



OUR ORGANISATION

- Carry out primary research and engagement of stakeholders and workforce
- Develop, launch and embed new vision and values
- Define our priorities and principles
- Review our brand name and identity (logo)
- Develop communications strategy that is insight driven
- Explore options of different entities
- Stakeholder engagement and voting
- Work with legal team to convert
- Staff, partners, public engagement

OUR PRIORITIES FOR 2022/2023

OUR PRACTICES

- Explore options around sharing 1 x DPO for all practices
- Develop and provide a suite of resources for CQC requirements
- Provide a central repositary for easy access and updates to policies and templates
- Explore options to introduce a nurse/HCA training element to the Experienced Nurse Network service
- Develop and facilitate introductions to primary/secondary care both ways for new staff inductions
- Develop work experience/student placements with local education providers
- Create 'Fedworks' to facilitate rota/bank system with view to enabling practice access
- Explore GM offer and opportunities to create pathway/signposting for practices to access
- Support practices to create social media presence
- Provide guides and policies re: comms and social media etc
- Provide regular comms to practices with a 'you said, we did' approach
- Understand the current offer/position via CCG new arrangements
- Engage practices and PCNs to review BI and data requirements

OUR PCNs

- Recruitment and development of workforce
- Invest in and roll out the use of Ardens Manager including training
- Provide regular performance monitoring information including monthly highlight reports, quarterly performance and annual reports
- Commence stakeholder engagement; understand needs
- Transition arrangements from notice period
- Develop the delivery model (operational and financial), including estates and digital offer
- Seek agreement in principal
- Implement new services
- Refresh PCN offer to reflect new contractual requirements, e.g. DES, IIF, vaccine service
- Carry out joint estates opportunties and co-location (community hubs)
- Creating pathways and sign-posting across services to enable navigation
- Bridge the gap between community and primary care by connecting with key operational management delivery teams

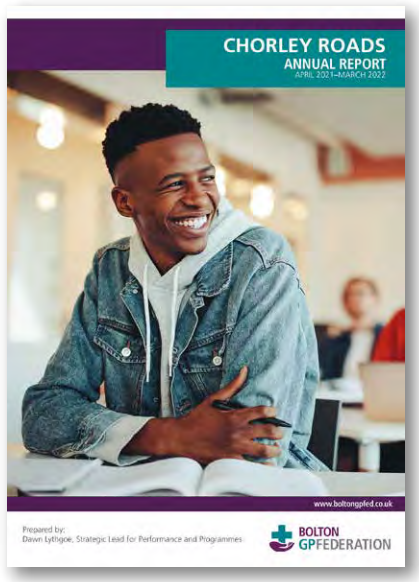
OUR SYSTEM

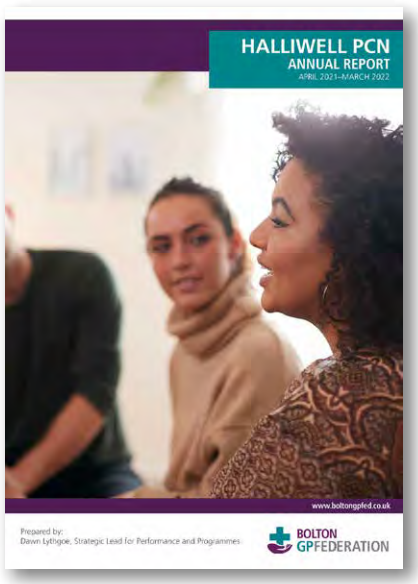
- Have representation on Urgent Care Board
- Faciliate cross-sector/PCN workshop to reflect and plan on neighbourhood health inequalities at practice, PCN and service level
- Pilot community-based cancer screening and share learning/scale up
- Have representation on Bolton GP Board

ANNUAL ACCOUNTS

PROFIT & LOSS £000s	2021/22	2020/21
Commissioned Income	7,457	4,459
Cost of Service	-6,938	-3,952
Gross Profit	519	507
Admin Expenses	-502	-443
Interest Payable	0	-7
Corporation Tax	-3	-12
NET PROFIT	**14**	**45**

APPENDIX 1 - PCN ANNUAL REPORTS





CENTRAL PCN
ANNUAL REPORT
APRIL 2021–MARCH 2022

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and highlights of Central Primary Care Network (PCN) for the year April 2021 to March 2022

It is indeed an honourable responsibility to represent and support the 13 GP practices looking after over 44,000 patients in the heart of Bolton. Each year poses its opportunities and challenges. I take pride in sharing that our practices are working collaboratively with each other as well as local health service providers, including Bolton GP Federation.

We have been responsive in pro-actively supporting the Covid vaccination campaign as the practice staff have spent a lot of time and effort in inviting and booking the patients. Our network worked on and implemented a hub and spoke model – the vast majority of vaccines were delivered by the hub (Bolton GP Federation) and several practices acted as spoke sites to administer the vaccine with bookings open on the national booking system, as well as having the ability to cope with any walk-in patients.

Although some of the requirements for quality achievements were relaxed by NHS England, in view of added workload for the Covid vaccination campaign, our network planned and supported the looking after of vulnerable patients by ensuring that a high number of those with learning disabilities and severe mental impairment, were seen and reviewed face to face, ensuring that their health and wellbeing was looked after.

We take pride in our network team members who have joined us through the Additional Roles Reimbursement Scheme (ARRS), including our Pharmacists, Paramedics, Pharmacy Technicians, Physiotherapists, Social Prescribers, and Mental Health Practitioners. Working across several practices with different computer systems is indeed a challenge which many have overcome diligently, showing resilience and flexibility. Here I would particularly like to thank our Network Manager, Matthew Mann, for planning and managing the workforce.

It has been very stimulating to see some of our team members working diligently and taking their level of ownership for an allocated piece of work to the next level and championing a cause. Our networks' first paramedic, Sharron Robertson-Taylor, championed the cause of looking after vulnerable patients with learning disabilities and undertook reviews across all 13 practices, working on three separate computer systems for the vast majority of these patients, either at the GP practices or in their homes. Similarly, our new paramedic, Tania McManus, worked with patients having mental health conditions. The way Hafeeza Bhaiyat has undertaken her role as the Senior Pharmacist shows her diligence, hard work and awareness of primary care. She has started

work on standardising some of the processes and procedures for practice pharmacists and provides them guidance and support.

The challenges in the upcoming year are to ensure that our performance is measurable along the national standards, and that we achieve the targets set in variety of enhanced services. Therefore, work is underway to map the requirements and ensure there are adequate staff numbers to handle the volume of work and to support the member practices in our network. A key focus for the year ahead, in addition, will be the work to start tackling health inequalities. Another aspiration is to work with system partners and bringing the extended hours appointments to an easily accessible building. We shall endeavour to ensure we surpass the seasonal influenza targets as well by identifying additional resources and admin time to support practices where necessary.

Finally, I would like to take this opportunity and express my gratitude to all our member practices and team members for their support and teamwork.

Dr Adil Khan
Clinical Director
Central 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 2021/22, the Network Contract DES Directions came into force on 1 April 2021 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.

The requirements for 2021/22 were themed around:

- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

The pages that follow summarise the progress we have made in Central PCN towards these requirements during 2021/22.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

- In place in care homes *and/or*
- For those with complex and problematic polypharmacy, specifically those on 10 or more medications
- Offer and deliver a volume of SMRs determined and limited by the PCNs clinical pharmacist capacity, *and*
- The PCN must demonstrate reasonable ongoing efforts to maximise capacity
- Ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from, SMRs
- Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs
- PCN must ensure that professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills
- Clearly record all SMRs within GP IT systems

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

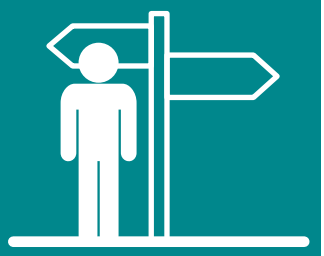
- Agree aligned care homes with commissioner
- Have a plan in place with local partners
- Support residents to register with a practice in aligned PCN
- Ensure lead GP in place per PCN
- Deliver MDTs with partners
- Develop personalised care and support plan
- Establish protocols for info sharing, shared care planning, use of shared care records, etc
- Deliver a weekly home round
- Develop & refresh personalised care and support plans
- Identify/engage in shared learning
- Accurately record care home coding on continuous basis

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

- Review referral practice for suspected and recurrent cancers and work to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas
- Work with local system partners to agree contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations.
- Requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
- Use of teledermatology to support skin cancer referrals where available and appropriate
- Develop and implement plan to increase proactive and opportunistic assessment of patients for potential prostate cancer diagnosis in population cohorts where referral rates have not recovered to pre-pandemic baseline.
- Review use of non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

- [x] Implement new process to enable college referrals
- [x] Implement new process to enable NWAS referrals
- [x] Remind PCNs to refer at monthly PCN meetings
- [x] Ensure coding tallies across Ardens and Elemental
- [x] Monitor uptake using Ardens and Elemental

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 in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

In Central PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 2,775
Number of vaccinations: 2,022
% of patient population vaccinated: 73%

Patients on the LD register who received an LD health check

Patient population: 197
Number of LD checks carried out: 163
% of patients received health check: 83%

Number of patients referred to social prescriber

Threshold: 0.8–1.2%
Target number of referrals for lower threshold: 322
Number of referrals: 209 = 0.52%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme (ARRS) allows Primary Care Networks (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 2021–22, Bolton GP Federation successfully accessed all of its ARRS allocation on behalf of the six PCNs it supports. In Central Primary Care Network, during 2021–22, we recruited additional ARRS team members which included:

- Clinical Pharmacists
- Pharmacy Technicians
- Musculoskeletal (MSK) First Contact Physiotherapists
- Mental Health Practitioners
- Social Prescribing Link Workers
- Paramedics

The PCN team will be expanded further during 2022–23. Further details about the progress towards the requirements of each of the individual roles is provided in Appendix 1.

The Central Primary Care Network ARRS team:

CLINICAL PHARMACISTS

Habiba Ahmad
Hafeeza Bhaiyat
Muhammed Shafique
Talib Talib
Iqra Yasin
Karen Lee
Abeer Hashmi

PHARMACY TECHNICIAN

Kay Ross

MSK

Rituraj Patwardhan
Joseph Obese-Amaning
David Campbell

MHP

Biju Anthony

SPLW

Faye Halliwell
Arvind Adma

PARAMEDICS

Sharron Robertson-Taylor
Tania McManus

CASE STUDY

STRUCTURED MEDICATIONS REVIEW

Patient had stopped taking all of his medication after he had a heart attack.

Before conducting a medication review, I noticed the patient had not ordered his medication for a few months. I rang the patient to see how he was getting on with his medication, giving him the opportunity to be able to tell me in detail and share any concerns without any judgement. He felt comfortable to share with me that he had not been taking it. He told me that after his heart attack two years ago, he had started taking a lot of medication, and he couldn't see how it was helping. His view was that he had already had a heart attack, so what was the point in taking them. I understood his point of view – when a patient has a heart attack they are started on many lifelong preventative medications.

I went through each medication with the patient and explained the benefits of taking them in detail. I helped him understand why he should continue taking them. I also informed him of the risks of his decision – this was important to enable him to make an informed decision.

After speaking to the patient, he was very grateful as he said nobody had actually told him why he needed these tablets and what they were for. He felt he was just given a bag of medication after his heart attack without an explanation. He felt motivated and happy to take all of his prescribed medication after speaking to me.

I believe it is imperative that patients understand why they are taking their medication as this is an important factor in aiding compliance. Due to this, I always ask every patient when conducting medication reviews if they are aware of the indication. A lot of patients admit to not knowing why they are taking certain medication and I ensure I spend some time explaining the condition they are prescribed for and how the medication works for them.

Iqra Yasin
Clinical Pharmacist

CASE STUDY

STRUCTURED MEDICATIONS REVIEW

Trying alternative measures for a dementia care home resident before considering covert administration.

I also manage the medication for a dementia nursing home, where I complete covert administration forms for residents who are deemed to not having capacity after being assessed with a best interest meeting and mental capacity act.

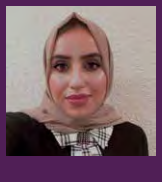
I have authorised covert administration requests for 4 residents after assessing all factors, since starting my post in November.

This is done after a request from the care home as patients due to their dementia/poor health are unable to answer simple questions from care home staff and have been refusing medication without any justification. This is a process whereby I act in the best interests of the patient and authorise the care home staff giving medication hidden in food/drink and provide instructions for each medication for this to be done safely, as not taking their medication could be serious for their health.

I received a covert administration request from the care home for a 69-year-old patient. I always speak to the nurse looking after the patient first to gain more of an insight on the situation despite a completed mental capacity act form and best interest meeting being held. After a detailed conversation regarding the patient's habits with her medication, I found she refuses medication in the morning but has been taking the night-time ones without a problem. I advised to change the timing of administration from morning to afternoon and trial that first, as covert administration should only be considered as a last resort. The nurse was aware to call back if there were any issues after changing timing.

The staff had not called back since and patient has been taking all her medication.

It is very important to find out details before authorising this as covert administration is taking away the rights of the patient to consent. This is done after exhausting all measures and therefore, I made the right decision acting in the best interest of this patient by declining the request for covert administration at that moment in time.



Iqra Yasin
Clinical Pharmacist

STAFF FEEDBACK

Staff feedback is important to us. This year the staff working remotely and on location within our Primary Care Networks said...

Our staff tell us they ***"Feel supported by management"***

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

The Mental Health Practitioners collected feedback during the last quarter of 2021/22 using a variety of different formats.

Since the team was established in 2018, practitioners have been collecting feedback via paper patient satisfaction questionnaires. However, response rates have been low. Coupled with this, Covid and estate challenges moved many appointments to telephone, meaning paper questionnaires were not appropriate.

With this in mind, the MHPs have been collating feedback using verbal qualitative feedback, online surveys, collating case studies and most recently have developed questionnaires set up through MS teams which can be e-mailed to patients via the GP Accurx system, which will become the main approach taken by the team going forwards.

Overall feedback

Between January and March 2022 in total 72 patient, carer and staff experiences were captured.

Satisfaction questionnaires

44 satisfaction questionnaires were collected. All responses were positive in the following areas:

- ***Do you feel your appointment was helpful today?***
- ***Do you feel the practitioner understood your current difficulties?***
- ***Do you feel you were given enough information and support for your current needs?***
- ***Would you want to see the mental health practitioner again if you had another mental health problem in the future?***

Common themes

Common themes emerging from all of the feedback collected were:

- **The expertise in mental health in a GP surgery was important**
- **Receiving help and support at a time when it was really needed**
- **Receiving psychoeducation was invaluable**
- **The knowledge of other services and signposting to the right service**
- **Patients feel listened to, heard, and understood by MHPs**
- **Having medication reviews is helpful**
- **Having more than 10 minutes**
- **Speaking to a mental health professional in a GP surgery is reassuring**

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

"She is a highly skilled practitioner who has integrated well into the practice. I frequently receive positive feedback from patients." (GP feedback)

"I can't speak highly enough of him." (patient feedback)

"Excellent health professional who listened to me compassionately." (patient feedback)

"Very understanding and allowed me to speak as much as I wanted." (patient feedback)

"The most helpful person I have spoken to in the last 10 years." (patient feedback)

"She was amazing." (patient feedback)

"Brilliant in the support that he has offered and the discussions we have had." (patient feedback)

"I have been told top notch things about you and I agree... I give you a gold star for helping me!" (patient feedback)

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Central PCN began in mid-December 2020 following a collaboration agreement to run the clinic through a designated site at Lever Chamber Health Centre, which then moved to the Market Place in July 2021.

In the period between 1 April 2021 and 31 March 2022 the Central, Farnworth & Kearsley, Halliwell and Rumworth collaboration delivered:

139,717 vaccinations

198 clinics held between Lever Chambers & Market Place

174 bus/pop up clinics including Essa Acadamy, Victoria Square, Asda (Burnden Park and Farnworth), Bolton College/University and Moses Gate

1,577 housebound residents were vaccinated in their homes

14 care homes visited with **1,535** staff and residents vaccinated

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during Covid-19, 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.

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

175 people (**4.8%**) were sent to hospital with **115** (**65.7%**) of these being admitted for treatment.

A total of **311** patients from the Central PCN area received support through this pathway.

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

The team have been very supportive and kept in touch with me on a regular basis. I appreciate their help and care.

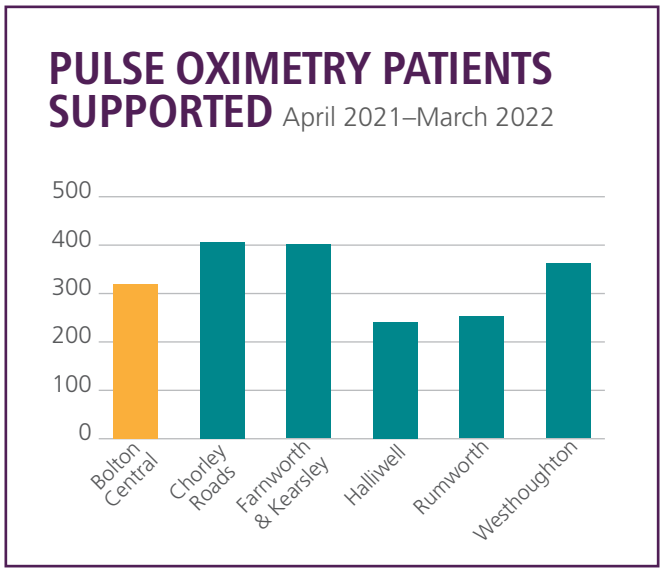
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

Everything was explained in detail and gone over again until I was happy with how to use it. When contacted by phone again everyone was polite and thorough.

I think that it's a brilliant service. The team offers support and reassurance at a scary time. Thank you.

It took away the stress for me so that I could keep an eye on my oxygen levels.

PCN	No. patients
Breightmet & Little Lever	484
Bolton Central	**311**
Chorley Roads	408
Farnworth & Kearsley	399
Halliwell	241
Horwich	432
Rumworth	255
Turton	653
Westhoughton	378
OOA	56
All Bolton	**3,617**



FINANCE

TYPE	B/F	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
Core	23,188	71,536	-59,614	35,110
Ext Hours	0	68,675	-68,675	0
CD Funds	0	35,100	-35,100	0
Care Home	4,545	35,880	-35,880	4,545
Dev Fund	25,067	11,844	-26,891	10,021
I&I Fund	4,433	51,436	4,532	60,401
ARRS Fund	0	539,385	-539,385	0
Leadership Funds	0	36,840	-1,410	35,430
Extra CD Funds	25,523	99,306	-98,539	26,291
GRAND TOTAL	**82,756**	**950,003**	**-860,960**	**171,799**

REFLECTIONS AND PRIORITIES FOR 2022/23

It has been a busy year for our Central PCN, whilst practices are still recovering from the effects the pandemic has had on them and their patients.

This year we have welcomed to the PCN:

Dr Adil Khan – Clinical Director
Sharron – Paramedic
Tayyeba - Pharmacist
Iqra - Pharmacist
Joseph - MSK Practitioner
Kay – Pharmacy Technician
Tania – Paramedic
Arvind – Social Prescribing Link Worker
Abeer - Pharmacist
Karen - Pharmacist
David - MSK Practitioner

We have been successful in meeting a high number of our targets and have carried out some new and exciting projects with new members of the Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) team, which haven't been trialled in the PCN before. This includes our two new Paramedics taking a lead on Learning Disabilities and Severe Mental Illness patients, which resulted in massive improvements on the care plans and physical health reviews for the patients.

We have been working on the implementation of a number of new specifications such as Cardiovascular Disease, Extended Access and Tackling Neighbourhood Health Inequalities. I look forward to continuing the partnership working across all sectors to improve the health of our population, whilst continuing to work on the original specifications.

We will also be focusing on the ARRS roles and looking at how we can recruit and embed more clinicians into the PCN to support our member practices.

I would like to thank each member practice for their continued support during 2021-2022 and I look forward to the coming year!

Matthew Mann
Central 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 including 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 inappropriate 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 integration of the pharmacy team across health and social care	

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

PARAMEDIC	
Is educated to degree/diploma level in Paramedicine or equivalent experience	
Is registered with the Health and Care Professions Council (HCPC)	
Has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic"	
Has a further three years' experience as a band 6 (or equivalent) paramedic	
Is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework	
If the Paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.	
Work as part of a MDT within the PCN	
Assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team	
Advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services	
Be able to perform specialist health checks and reviews within their scope of practice and in line with local and national guidance	
Perform and interpret ECGs	
Perform investigatory procedures as required	
Undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance	
Support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)	
Provide an alternative model to urgent and same day GP home visit for the network and clinical audits	
Communicate at all levels across organisations ensuring that an effective, person-centred service is delivered	
Communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required	
Maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice	
Communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices	

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	
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	
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	
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.	
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	
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	
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	
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	
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	
Develop trusting relationships by giving people time and focus on 'what matters to them'	
Take a holistic approach, based on the patient's priorities and the wider determinants of health	
Explore and support access to a personal health budget where appropriate	
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	
Where required and as appropriate, refer patients back to other health professionals within the PCN	

* 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.	

CHORLEY ROADS
ANNUAL REPORT
APRIL 2021–MARCH 2022

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and highlights of Chorley Roads Primary Care Network (PCN) for the year April 2021 to March 2022

Another year of Covid navigated. I congratulate everyone on sticking together and surviving and continuing to contribute to a functioning Primary Care Network (PCN). I hope our practices do feel the difference with the Additional Roles Reimbursement Scheme (ARRS) staff and are finding them increasingly helpful and integrating them into our team. The roles have expanded this year and will continue to do so. It does require practices to change how they work but hopefully for the better.

Although Covid will still play a part, there will hopefully be less staff absence in the coming year. What is clear is that we will have to work together to achieve our Impact and Investment Fund requirements. The ethos will continue to be that we will achieve these by introducing good practice, which helps practices deliver good care and not just tick boxes and utilise the ARRS staff to reduce the burden on GPs so they can concentrate on the more complex patients with whom they are most effective.

Tackling health inequalities is a big priority, and we are committed to engaging with our local partners to help improve health care access for our mental health patients of all severity.

Finally, this next year will see PCN's providing extended access which will hopefully help with access and capacity for patients in our Network.

A big thank you to Vicky and her team in the background keeping us on track and updated.

Dr Dharmesh Mistry,
Clinical Director, Chorley Roads
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 2021/22, the Network Contract DES Directions came into force on 1 April 2021 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.

The requirements for 2021/22 were themed around:

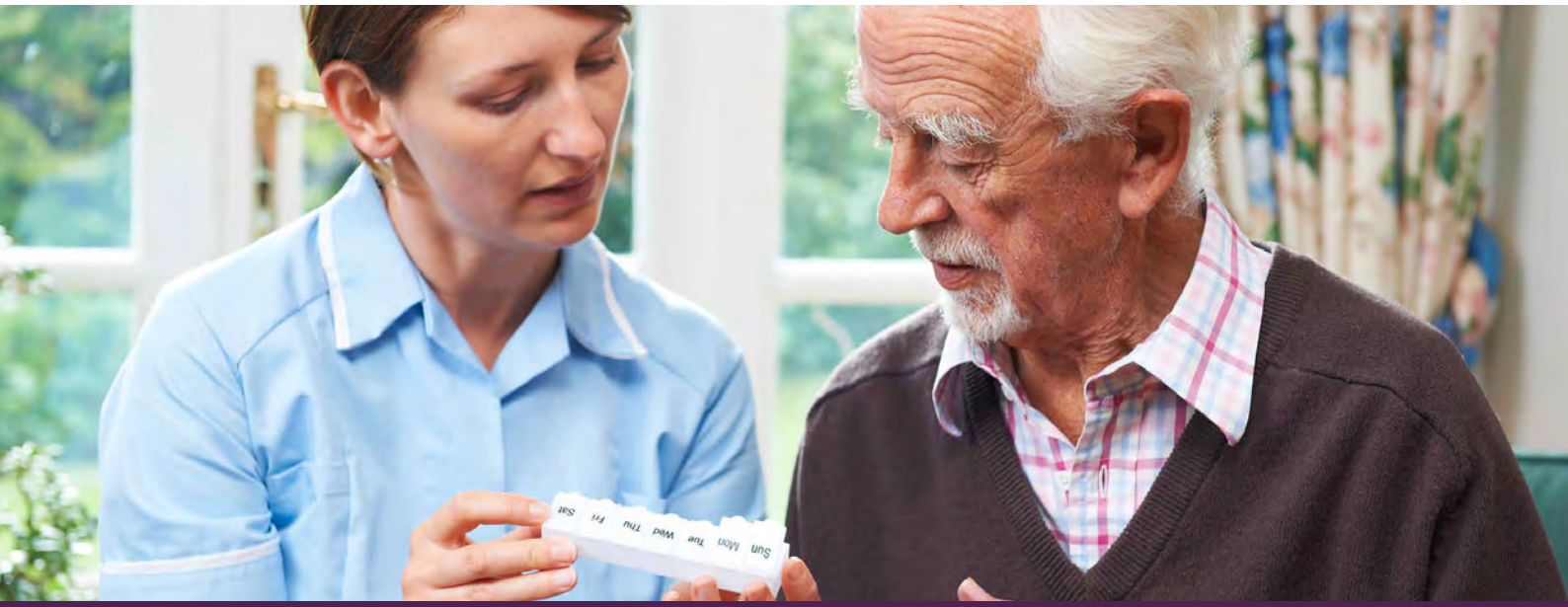
- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

The pages that follow summarise the progress we have made in Chorley Roads PCN towards these requirements during 2021/22.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

- In place in care homes *and/or*
- For those with complex and problematic polypharmacy, specifically those on 10 or more medications
- Offer and deliver a volume of SMRs determined and limited by the PCNs clinical pharmacist capacity, *and*
- The PCN must demonstrate reasonable ongoing efforts to maximise capacity
- Ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from, SMRs
- Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs
- PCN must ensure that professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills
- Clearly record all SMRs within GP IT systems



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

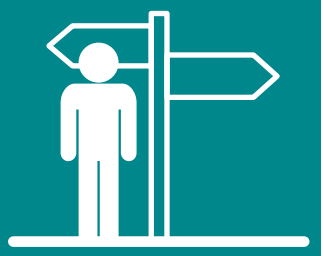
- Agree aligned care homes with commissioner
- Have a plan in place with local partners
- Support residents to register with a practice in aligned PCN
- Ensure lead GP in place per PCN
- Deliver MDTs with partners
- Develop personalised care and support plan
- Establish protocols for info sharing, shared care planning, use of shared care records, etc
- Deliver a weekly home round
- Develop & refresh personalised care and support plans
- Identify/engage in shared learning
- Accurately record care home coding on continuous basis

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

- Review referral practice for suspected and recurrent cancers and work to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas
- Work with local system partners to agree contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations.
- Requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
- Use of teledermatology to support skin cancer referrals where available and appropriate
- Develop and implement plan to increase proactive and opportunistic assessment of patients for potential prostate cancer diagnosis in population cohorts where referral rates have not recovered to pre-pandemic baseline.
- Review use of non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

- ☑ Implement new process to enable college referrals
- ☑ Implement new process to enable NWAS referrals
- ☑ Remind PCNs to refer at monthly PCN meetings
- ☑ Ensure coding tallies across Ardens and Elemental
- ☑ Monitor uptake using Ardens and Elemental

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 in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

In Chorley Roads PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 5,537
Number of vaccinations: 4,911
% of patient population vaccinated: 89%

Patients on the LD register who received an LD health check

Patient population: 123
Number of LD checks carried out: 90
% of patients received health check: 73%

Number of patients referred to social prescriber

Threshold: 0.8–1.2%
Target number of referrals for lower threshold: 270
Number of referrals: 195 = 0.58%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme (ARRS) allows Primary Care Networks (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 2021–22, Bolton GP Federation successfully accessed all of its ARRS allocation on behalf of the six PCNs it supports. In Chorley Roads Primary Care Network, during 2021–22, we recruited additional ARRS team members which included:

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

The PCN team will be expanded further during 2022–23.

Details about the progress towards the requirements of each of the individual roles is provided in the appendix.

The Chorley Roads Primary Care Network ARRS Team:

CLINICAL PHARMACISTS
Kiran Altaf
Raisa Patel
Maryam Rehman

PHARMACY TECHNICIAN
Graziele Amado
Kirsty Broadbent

FIRST CONTACT (MSK) PRACTITIONERS
Paul Edney
Stuart Baker

MENTAL HEALTH PRACTITIONERS
Jacqueline Pickup

SOCIAL PRESCRIBING LINK WORKERS
Patricia Goodwin
Chloe Jackson

PARAMEDICS
Bartlomiej Gadulski
Laura Savage

PHYSICIAN ASSOCIATE
Naeem Wadiwala

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

Enhanced Care in Care Homes

In the Chorley Roads PCN there are 11 care homes with 225 residents. In addition to the Pharmacist recruited to deliver the ARRS requirements, another Pharmacist has been recruited to work with these care homes. Having the additional Pharmacist has enabled us to ensure the delivery of a personalised care and support plan for each care home resident and complete a structured medication review. During 2021–22, this pharmacist has also:

- Attended weekly multi-disciplinary team (MDT) meetings at each of the care homes.
- Supported care home providers to have an effective 'care home medicines policy' that aimed to avoid unnecessary harm, reduced medication errors, optimised the choice and use of medicines, and reduced medication waste.
- Agreed what medicine the resident would take after the structured medication review and made sure they could use the medicines as prescribed.

CASE STUDY

STRUCTURED MEDICATION REVIEW

I did a structured medication review on an 89-year-old male who was a new resident at a care home. He came into the home with a salbutamol inhaler, co-codamol, amlodipine and Laxido sachets. The care home was administering the salbutamol one puff twice a day, the co-codamol 2 at four times a day, amlodipine once daily and Laxido twice a day.

The patient had capacity but for the last five years he was staying with his daughter and son-in-law who used to manage his medication. After contacting his daughter, I found out that the patient had hypertension and asthma (which was managed by two inhalers – Fostair and salbutamol. I also found out that the patient had had a fall eight months previously, after which he was started on co-codamol.

I rang the care home and counselled them that the patient should be taking his preventer inhaler Fostair twice a day and using his salbutamol on a 'when required' basis. The patient told me that he was not in any pain given his fall was several months back, therefore we agreed to reduce his co-codamol and give it on a 'when required' basis.

When I followed up with him four weeks later the patient was only taking one co-codamol in the morning and two at night. He subsequently needed less Laxido as his constipation had improved with the dose decrease and he reported that he felt steadier on his feet. His asthma was also controlled on his Fostair inhaler and he had not needed his salbutamol.

Maryam Rehamn
Clinical Pharmacist

CASE STUDY

STRUCTURED MEDICATION REVIEW

A female patient, 58 years old, requested her controlled drug item (Gabapentin) which needed reauthorising so it was referred to me as Pharmacy Technician.

I identified over-ordering of Gabapentin (2-month supply issued every month) and on looking further, also identified over-ordering of co-codamol (1 month supply every 2–3 weeks), Oro dispersible medication with no indication, and an overdue medication review.

I identified that this patient could be referred to a pharmacist for a Structured Medication Review due to polypharmacy and potentially addictive medication. During a conversation with the pharmacist, the patient admitted it was easier to order everything monthly so she had been stockpiling. However, she had been over-using co-codamol.

The pharmacist gave the patient advice regarding potential addiction and was advised to use co-codamol sparingly. Quantities were then amended to monthly and the first few prescriptions were post-dated to ensure the ordering frequency was not exceeded.

Additionally the formulation was checked as to why Oro dispersible medication was being used. It was found that this was due to it being the patient's preference, with no clinical indication. This was discussed with the patient and, after a long conversation, a trial of solid form tablets, which are more cost-effective, was negotiated.

The pharmacist safety netted and advised the patient to call if there were any problems.

Since then I have kept an eye on the patient's record and noted that the ordering pattern is now monthly and appropriate. After this episode reception staff have been trained to identify medication over-ordering.

Graziele Armado
Senior Pharmacy Technician

STAFF FEEDBACK

Having worked for the Federation for over a year now, I find it a supportive, encouraging place to work. The staff are all approachable and I have regular scheduled contact with my manager, which makes it easy to address issues early.

During a recent difficult personal time, I found the Federation very supportive and adapted my work to meet my needs at the time, for which I am very grateful.

I have recommended the Federation as an employer on many occasions and would encourage anyone to join the team.

Laura – Paramedic

So far so good, working hard, learning harder and giving 101%. I think it was a good move to employ Paramedics into GP practices. I'm happy where I am.

Bart – Paramedic

I have thoroughly enjoyed working for Bolton GP Federation. The management is very flexible, understanding and supportive. I have always been made to feel like a valued member of the team. In addition, I have been provided with training opportunities which has helped me to increase my clinical competence.

Maryam – Pharmacist

I have been working for the Federation for over a year and have had an incredibly positive experience. I have felt supported throughout my training and have been fortunate to work with a wonderful team.

We often have team meetings and webinars where we are kept up to date with legislative changes and relevant news to our profession. Being employed by the Federation has enabled myself to connect with individuals from many different fields which has really helped me settle into my new role.

Kiran – Pharmacist

During my time with the GP Federation, I have appreciated the clarity provided for targets to be achieved and job role expectation.

What I like the most about working here is the flexibility at work and positive mood, which encourages me to have a positive attitude.

The management team is always supportive when issues are raised and also open to new ideas.

Thank you for taking extra effort to make sure the entire team is on the same page. You do a great job helping me and my colleagues build new skills and provide the best patient's outcome.

Graziele – Senior Pharmacy Technician

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

The Mental Health Practitioners collected feedback during the last quarter of 2021/22 using a variety of different formats.

Since the team was established in 2018, practitioners have been collecting feedback via paper patient satisfaction questionnaires. However, response rates have been low. Coupled with this, Covid and estate challenges moved many appointments to telephone, meaning paper questionnaires were not appropriate.

With this in mind, the MHPs have been collating feedback using verbal qualitative feedback, online surveys, collating case studies and most recently have developed questionnaires set up through MS teams which can be e-mailed to patients via the GP Accurx system, which will become the main approach taken by the team going forwards.

Overall feedback

Between January and March 2022 in total 72 patient, carer and staff experiences were captured.

Satisfaction questionnaires

44 satisfaction questionnaires were collected. All responses were positive in the following areas:

- ***Do you feel your appointment was helpful today?***
- ***Do you feel the practitioner understood your current difficulties?***
- ***Do you feel you were given enough information and support for your current needs?***
- ***Would you want to see the mental health practitioner again if you had another mental health problem in the future?***

Common themes

Common themes emerging from all of the feedback collected were:

- **The expertise in mental health in a GP surgery was important**
- **Receiving help and support at a time when it was really needed**
- **Receiving psychoeducation was invaluable**
- **The knowledge of other services and signposting to the right service**
- **Patients feel listened to, heard, and understood by MHPs**
- **Having medication reviews is helpful**
- **Having more than 10 minutes**
- **Speaking to a mental health professional in a GP surgery is reassuring**

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

"She is a highly skilled practitioner who has integrated well into the practice. I frequently receive positive feedback from patients." (GP feedback)

"I can't speak highly enough of him." (patient feedback)

"Excellent health professional who listened to me compassionately." (patient feedback)

"Very understanding and allowed me to speak as much as I wanted." (patient feedback)

"The most helpful person I have spoken to in the last 10 years." (patient feedback)

"She was amazing." (patient feedback)

"Brilliant in the support that he has offered and the discussions we have had." (patient feedback)

"I have been told top notch things about you and I agree... I give you a gold star for helping me!" (patient feedback)

COVID-19 PROGRAMMES

Covid-19 Vaccination

The delivery of COVID-19 vaccinations for the Chorley Roads PCN began in mid-January 2021 through a designated site at Avondale Health Centre.

Between 1 April 2021 and 31 March 2022 Avondale Health Centre on behalf of Chorley Roads PCN delivered:

18,332 vaccinations

53 clinics held

1,577 housebound residents were vaccinated in their homes

8 care homes visited with **204** staff and residents vaccinated

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during Covid-19, 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.

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

175 people (**4.8%**) were sent to hospital, of which **115** (**65.7%**) were admitted.

A total of **408** patients from the Chorley Roads PCN area received support through this pathway.

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

The team have been very supportive and kept in touch with me on a regular basis. I appreciate their help and care.

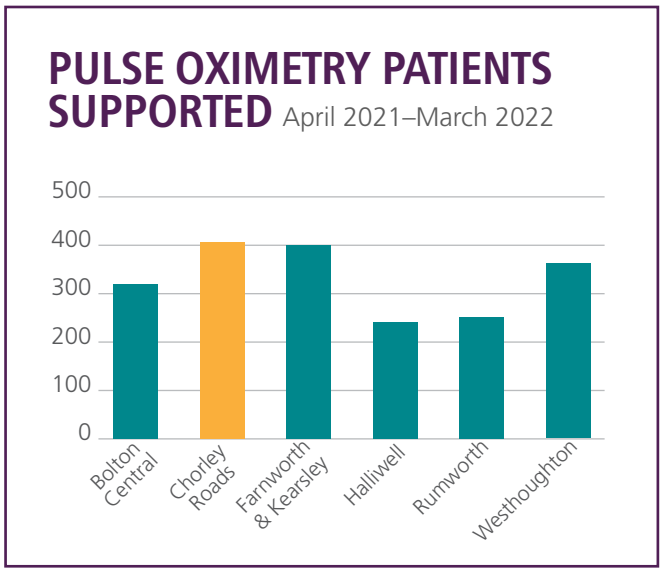
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

Everything was explained in detail and gone over again until I was happy with how to use it. When contacted by phone again everyone was polite and thorough.

I think that it's a brilliant service. The team offers support and reassurance at a scary time. Thankyou.

It took away the stress for me so that I could keep an eye on my oxygen levels.

PCN	No. patients
Breightmet & Little Lever	484
Bolton Central	311
Chorley Roads	**408**
Farnworth & Kearsley	399
Halliwell	241
Horwich	432
Rumworth	255
Turton	653
Westhoughton	378
OOA	56
All Bolton	**3,617**



FINANCE

TYPE	B/F	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
Core	0	49,552	-41,294	8,259
Ext Hours	0	47,570	-47,570	0
CD Funds	0	24,314	-24,314	0
Care Home	135	27,600	-27,600	135
Dev Fund	18,736	8,187	-19,240	7,683
I&I Fund	8,695	38,112	0	46,806
ARRS Fund	0	402,754	-402,754	0
Leadership Funds	0	24,055	-300	23,755
Extra CD Funds	8,897	68,645	-60,095	17,447
GRAND TOTAL	**36,463**	**690,789**	**-623,166**	**104,085**

PRIORITIES AND TARGETS FOR 2022/23

It has been a busy year for Chorley Roads Primary Care Network (PCN). Whilst continuing to deliver the Covid-19 vaccine programme, we have continued to recruit our Additional Roles Reimbursement Scheme (ARRS) staff. We have welcomed to the PCN:

Bart Gadulski – Paramedic
Kirsty Broadbent – Pharmacy Technician
Chloe Jackson – Social Prescribing Link Worker
Naeem Wadiwala – Physicians Associate
Stuart Barker – Musculoskeletal Practitioner

We have also welcomed Dr Sheetal Saagar as our Health Inequalities lead.

We have been successful in meeting a high number of our targets and carried out some exciting projects with new members of the PCN ARRS team. Our Pharmacy team successfully carried out our Learning Disability Quality Improvement Project.

We have also been successful in fulfilling a some of our PCN Impact and Investment Fund targets.

We've been working on the implementation of several new specifications such as Cardiovascular Disease, Extended Access and Tackling Neighbourhood Health Inequalities. I look forward to continuing the partnership working across all sectors to improve the health of our population, whilst also working on the original specifications.

Next year we will be focusing on the ARRS roles and how we can recruit and embed more clinicians into the PCN to support our member practices. We also have Trainee Associate Psychological Practitioners joining the team to support patients with their mental health, which is a new role for our PCN.

I would like to thank each member practice for their continued support during 2021-2022 and the exceptional work each and every member of the ARRS team have contributed over the last 12 months.

Victoria Westwood
Chorley Roads 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	
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

PARAMEDIC	
Is educated to degree/diploma level in Paramedicine or equivalent experience	
Is registered with the Health and Care Professions Council (HCPC)	
Has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic"	
Has a further three years' experience as a band 6 (or equivalent) paramedic	
Is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework	
If the Paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.	
Work as part of a MDT within the PCN	
Assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team	
Advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services	
Be able to perform specialist health checks and reviews within their scope of practice and in line with local and national guidance	
Perform and interpret ECGs	
Perform investigatory procedures as required	
Undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance	
Support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)	
Provide an alternative model to urgent and same day GP home visit for the network and clinical audits	
Communicate at all levels across organisations ensuring that an effective, person-centred service is delivered	
Communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required	
Maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice	
Communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices	

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	
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	
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	
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.	
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	
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	
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	
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	
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	
Develop trusting relationships by giving people time and focus on 'what matters to them'	
Take a holistic approach, based on the patient's priorities and the wider determinants of health	
Explore and support access to a personal health budget where appropriate	
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	
Where required and as appropriate, refer patients back to other health professionals within the PCN	

* 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.	

FARNWORTH AND KEARSLEY PCN
ANNUAL REPORT
APRIL 2021–MARCH 2022

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and highlights of Farnworth & Kearsley Primary Care Network (PCN) for the year April 2021 to March 2022

I continue to be honoured to be the PCN Clinical Director and welcome the contribution of colleagues this year, making the PCN an exemplar going forward.

We continue to be recognised as a leader in wider multi-disciplinary team working, and I would like to thank Dr Nicky Barua for his leadership in this area – the model of working with housing and mental health is being taken forward by other PCNs.

In the background, the Federation team do an awful lot of work that is unseen, delivering our recruitment and operational management of 14 clinical staff. We have recruited three separate pharmacy teams, two paramedics and are continuing to work with our mental health team and social prescribers. The work of the Federation team means that this burden is not shouldered by our practice managers or practices, so practices only see the benefit of the staff that are employed.

We have been successful financially this year in no small part due to me being able to contribute some of my Clinical Director payment to the network for use. This is because of the overlap between my role as a Federation Chair and a PCN Clinical Director, meaning that I have been able to release some funds directly to the PCN for investment. We've started to invest some money in resources within the PCN, and have started a monthly operational meeting, funding the practice managers' time to enable practices to invest in backfill as they see appropriately.

We have also welcomed two other Deputy Clinical Directors, Dr Zafar Chowdhury who is leading on the Investment and Impact Fund work and Dr Niruban Ratnarajah, who is leading on work to enable the implementation of our Health Inequalities project. This has been enabled by prudent financial management by our Network Manager, Vicky and the Federation team. This additional leadership resource gives us some resilience and helps us plan the succession in the PCN as I approach retirement.

As we move forward, we are at a point where we need to decide whether there are benefits of at scale working, or whether we want to take resources within our own organisations – this has been highlighted recently by our discussions around the Extended Primary Care service. There are pros and cons to both options. Our network has set itself up as a one practice, one vote system to enable all practices to have an equal voice in the running of the PCN and this has been key to our success, and I hope this will be continued into the future.

I would like to thank all practices and practice managers for their support. I'd like to thank Vicky and the Federation team for their operational support, and I'd like to thank my deputy Clinical Directors for their clinical support in implementing work within the PCN for making it real for clinicians and practices.

This report details our performance this year and the roles of our PCN teams (including the Additional Roles Reimbursement Scheme – ARRS staff) and some case studies highlighting their success.

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 2021/22, the Network Contract DES Directions came into force on 1 April 2021 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.

The requirements for 2021/22 were themed around:

- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

The pages that follow summarise the progress we have made in Farnworth and Kearsley PCN towards these requirements during 2021/22.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

- In place in care homes *and/or*
- For those with complex and problematic polypharmacy, specifically those on 10 or more medications
- Offer and deliver a volume of SMRs determined and limited by the PCNs clinical pharmacist capacity, *and*
- The PCN must demonstrate reasonable ongoing efforts to maximise capacity
- Ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from, SMRs
- Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs
- PCN must ensure that professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills
- Clearly record all SMRs within GP IT systems

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

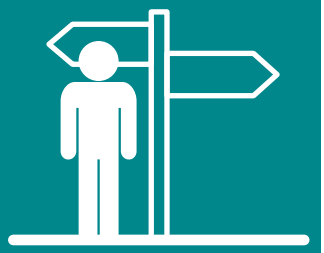
- Agree aligned care homes with commissioner
- Have a plan in place with local partners
- Support residents to register with a practice in aligned PCN
- Ensure lead GP in place per PCN
- Deliver MDTs with partners
- Develop personalised care and support plan
- Establish protocols for info sharing, shared care planning, use of shared care records, etc
- Deliver a weekly home round
- Develop & refresh personalised care and support plans
- Identify/engage in shared learning
- Accurately record care home coding on continuous basis

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

- Review referral practice for suspected and recurrent cancers and work to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas
- Work with local system partners to agree contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations.
- Requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
- Use of teledermatology to support skin cancer referrals where available and appropriate
- Develop and implement plan to increase proactive and opportunistic assessment of patients for potential prostate cancer diagnosis in population cohorts where referral rates have not recovered to pre-pandemic baseline.
- Review use of non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

- Implement new process to enable college referrals
- Implement new process to enable NWAS referrals
- Remind PCNs to refer at monthly PCN meetings
- Ensure coding tallies across Ardens and Elemental
- Monitor uptake using Ardens and Elemental

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 in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, 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 & Kearsley PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 5,028
Number of vaccinations: 4,581
% of patient population vaccinated: 91%

Patients on the LD register who received an LD health check

Patient population: 233
Number of LD checks carried out: 190
% of patients received health check: 82%

Number of patients referred to social prescriber

Threshold: 0.8–1.2%
Target number of referrals for lower threshold: 289
Number of referrals: 282 = 0.78%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme (ARRS) allows Primary Care Networks (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 2021–22, Bolton GP Federation successfully accessed all its ARRS allocation on behalf of the six PCNs it supports. In Farnworth & Kearsley Primary Care Network, during 2021–22, we recruited additional ARRS team members which included:

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

The PCN team will be expanded further during 2022–23.

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

Farnworth & Kearsley ARRS team:

CLINICAL PHARMACISTS

Sabiha Patel
Apryl Yap
Kasim Altaf

PHARMACY TECHNICIANS

Lauren Antoni
Emma Booth
Charlotte Hill

MSK

Paul Edney
Harry Theocharous

MHP

Matthew Wood

SPLW

Tyler O'Neill
Jayne Spotswood

PARAMEDICS

Rachael Glennon
Cheryl Schofield

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

In the Farnworth and Kearsley PCN there are three 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.
- We also have a Paramedic to support with reactive care and to complete a home round weekly, also an integral part of the MDT meetings.

CASE STUDY

MENTAL HEALTH

My patient was a 56-year-old female with a history of struggling with her mental health since her teenage years. She has been struggling with anxiety and depression and has been prescribed several different anti-depressant medications, some of which have helped alleviate distress and helped in the short term. However, the patient felt that no medication had sustained positive results and helped her maintain optimum mental health.

Over many years the patient had engaged in brief psychological therapies including cognitive behaviour therapy – which have concentrated on providing short term support including coping strategies and behaviours. Due to her fluctuating symptoms, experiencing frequent periods of distress, the patient felt like "nothing could help" having tried various options of treatment and support.

Her depression and anxiety have led to relationship difficulties with work colleagues and with her husband. Patterns of emotional dysregulation and irritability, together with poor hope for the future and low self-esteem, have resulted in strained relations and isolation. This has further led to a lack of understanding of, and self-awareness for, the patient regarding her own mental wellbeing, leading others to label her as angry or irritable. All of this has led to a lowered quality of life for the patient and her family.

Throughout our consultations we took time to discuss a detailed psycho-social/developmental history, from which early life trauma and adverse childhood experiences were identified. I used psychoeducation to help the patient gain a better understanding of her life and how her experiences may have contributed towards her current difficulties. We used the theory of the 'stress vulnerability model' to help her understand why some people can appear to struggle more at certain points in life. I used motivational interviewing techniques to build self-esteem and hope for the future. We discussed different types of psychological therapies used to treat different problems and spoke about possible medication changes using NICE guidance and evidence-based practice.

The outcomes of these approaches included the patient engaging in appropriate psychological therapies and improved relationships both at work and at home. The patient is feeling subjectively happier with an improved quality of life. Support was also offered to help engage in relationship counselling between herself and her husband.

I learned that spending that extra time, understanding a patient's journey, often makes the difference when thinking about appropriate treatment choices.

Matthew Wood
Senior Mental Health Practitioner

STAFF FEEDBACK

I have worked as a Social Prescribing Link Worker since April 2020, working on a vast range of cases in two Primary Care Networks, including Farnworth & Kearsley, for Bolton GP Federation. The team that I work with is very supportive of one another and look out for each other, giving advice and support when you need it. I feel that professional support with clinical supervision is still a big gap and something that we should have and not have to keep mentioning. Luckily, the team gets me through the more challenging cases. Being in an area with another social prescriber is helpful as we talk the referrals through and work out strengths. I get regular 1-2-1 catch ups with Amy and Vicky, so I am able to feed back any issues regarding the surgeries. Overall, the Federation is easy to work for and when I need something I ask.

Jayne – Social Prescriber Link Worker

I joined the team in November 2021 and work across two surgeries within the Farnworth & Kearsley PCN. My working day is usually very busy and fast-paced, and no two days are the same. As well as working at a practice level, I work collaboratively alongside my colleagues across the network to help achieve the IIF targets.

I have enjoyed my time working for the GP Federation so far and feel very lucky to have joined such a supportive PCN team. I am looking forward to starting my CPPE course and seeing how my role evolves in the future.

Emma – Pharmacy Technician

Throughout my employment with the GP Federation over the past sixteen months, I feel very much supported by my manager and assistant managers at the times I require their knowledge and help - it is a great to know that this is there when I need it. Despite this, I do feel distanced from the inner workings and activities of the Federation as a whole.

I also feel that as paramedic, practitioners within different PCNs and having multiple paramedics working within a PCN and for the Federation, we have very little contact with each other to form solid working relationships and a robust support network for each other to help us develop as individuals, a team and within the Federation.

However, I do feel very supported with respect to CPD opportunities identified by myself and the allowance to be able to attend and undertake this vital component of my role.

Rachel – Paramedic

I have settled into my role and thoroughly enjoy the flexibility allowed. The 4-week shadowing really helped me understand my role better. It allowed me to meet and integrate with other pharmacy members in the Federation. It also allowed me to learn the different computer systems that different surgeries use, so I can work confidently on my own.

I am enjoying my current role and look forward to starting my pathway training.

Apryl – Pharmacist

YOU SAID, WE DID

You felt that SPLWs needed clinical support

We have ensured SPLWs have access to PCN Clinical Director should they need it

We have organised regular peer review meetings with paramedics, including attendance from the Federation Chair, where cases and issues can be discussed and clinical and non-clinical advice can be shared.

You wanted more contact between paramedics and other team members to form solid working relationships and a more robust support network

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

The Mental Health Practitioners collected feedback during the last quarter of 2021/22 using a variety of different formats.

Since the team was established in 2018, practitioners have been collecting feedback via paper patient satisfaction questionnaires. However, response rates have been low. Coupled with this, Covid and estate challenges moved many appointments to telephone, meaning paper questionnaires were not appropriate.

With this in mind, the MHPs have been collating feedback using verbal qualitative feedback, online surveys, collating case studies and most recently have developed questionnaires set up through MS teams which can be e-mailed to patients via the GP Accurx system, which will become the main approach taken by the team going forwards.

Overall feedback

Between January and March 2022 in total 72 patient, carer and staff experiences were captured.

Satisfaction questionnaires

44 satisfaction questionnaires were collected. All responses were positive in the following areas:

- ***Do you feel your appointment was helpful today?***
- ***Do you feel the practitioner understood your current difficulties?***
- ***Do you feel you were given enough information and support for your current needs?***
- ***Would you want to see the mental health practitioner again if you had another mental health problem in the future?***

Common themes

Common themes emerging from all of the feedback collected were:

- **The expertise in mental health in a GP surgery was important**
- **Receiving help and support at a time when it was really needed**
- **Receiving psychoeducation was invaluable**
- **The knowledge of other services and signposting to the right service**
- **Patients feel listened to, heard, and understood by MHPs**
- **Having medication reviews is helpful**
- **Having more than 10 minutes**
- **Speaking to a mental health professional in a GP surgery is reassuring**

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

"She is a highly skilled practitioner who has integrated well into the practice. I frequently receive positive feedback from patients." (GP feedback)

"I can't speak highly enough of him." (patient feedback)

"Excellent health professional who listened to me compassionately." (patient feedback)

"Very understanding and allowed me to speak as much as I wanted." (patient feedback)

"The most helpful person I have spoken to in the last 10 years." (patient feedback)

"She was amazing." (patient feedback)

"Brilliant in the support that he has offered and the discussions we have had." (patient feedback)

"I have been told top notch things about you and I agree... I give you a gold star for helping me!" (patient feedback)

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Farnworth 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, which then moved to the Market Place in July 2021.

In the period between 1 April 2021 and 31 March 2022 the Central, Farnworth and Kearsley, Halliwell and Rumworth collaboration delivered:

139,717 vaccinations

198 clinics held between Lever Chambers & Market Place

174 bus/pop up clinics including Essa Acadamy, Victoria Square, Asda (Burnden Park and Farnworth), Bolton College/University and Moses Gate

1,577 housebound residents were vaccinated in their homes

14 care homes visited with **1,535** staff and residents vaccinated

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during Covid-19, 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.

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

175 people (**4.8%**) were sent to hospital, of which **115** (**65.7%**) were admitted.

A total of **399** patients from the Farnworth and Kearsley PCN area received support through this pathway.

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

The team have been very supportive and kept in touch with me on a regular basis. I appreciate their help and care.

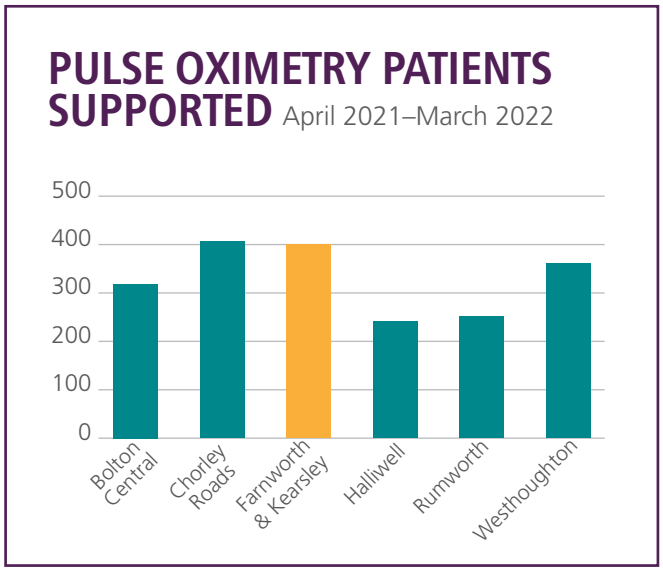
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

Everything was explained in detail and gone over again until I was happy with how to use it. When contacted by phone again everyone was polite and thorough.

I think that it's a brilliant service. The team offers support and reassurance at a scary time. Thankyou.

It took away the stress for me so that I could keep an eye on my oxygen levels.

PCN	No. patients
Breightmet & Little Lever	484
Bolton Central	311
Chorley Roads	408
Farnworth & Kearsley	**399**
Halliwell	241
Horwich	432
Rumworth	255
Turton	653
Westhoughton	378
OOA	56
All Bolton	**3,617**



FINANCE

TYPE	B/F	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
Core	0	53,639	-44,699	8,940
Ext Hours	0	51,493	-51,493	0
CD Funds	0	26,319	-26,319	0
Care Home	0	21,360	-21,360	0
Dev Fund	18,445	8,884	-19,494	7,834
I&I Fund	12,907	43,994	0	56,901
ARRS Fund	0	467,891	-467,891	0
Leadership Funds	0	27,456	-12,240	15,216
Extra CD Funds	12,943	74,487	-36,979	50,451
GRAND TOTAL	**44,295**	**775,523**	**-680,476**	**139,342**

PRIORITIES AND TARGETS FOR 2022/23

It has been a busy year for Farnworth and Kearsley Primary Care Network (PCN). Whilst continuing to deliver the Covid-19 vaccine programme, we have continued to recruit our Additional Roles Reimbursement Scheme (ARRS) staff. We have welcomed:

Rachel Glennon – Paramedic
Harry Theocharus – Musculoskeletal Practitioner
Cheryl Schofield – Paramedic
Jane Spotswood – Social Prescribing Link Worker
Emma Booth – Pharmacy Technician
Lauren Antoni – Pharmacy Technician
Apryl Yip – Pharmacist
Matthew Wood – Mental Health Practitioner

We have also recruited two Deputy Clinical Directors Dr Zafar Chowdhury who leads on the Investment and Impact Fund and Dr Nikki Barua who leads on the community multidisciplinary teams.

We have been successful in meeting a high number of our targets and carried out some exciting projects with new members of the PCN ARRS team. Our Pharmacy team successfully carried out our Learning Disability Quality Improvement Project.

We have been working on the implementation of several new specifications such as Cardiovascular Disease, Extended Access and Tackling Neighbourhood Health Inequalities. I look forward to continuing the partnership working across all sectors to improve the health of our population, whilst continuing to work on the original specifications.

We will also be focusing on the ARRS roles and how we can recruit and embed more clinicians into the PCN to support our member practices.

I would like to thank each member practice for their continued support during 2021–2022 and the exceptional work each and every member of the ARRS team have contributed over the last 12 months.

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	
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	
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	
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	
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	
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.	
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	
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	
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	
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	
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	
Develop trusting relationships by giving people time and focus on 'what matters to them'	
Take a holistic approach, based on the patient's priorities and the wider determinants of health	
Explore and support access to a personal health budget where appropriate	
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	
Where required and as appropriate, refer patients back to other health professionals within the PCN	

* 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.	

HALLIWELL PCN
ANNUAL REPORT
APRIL 2021–MARCH 2022

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and highlights of Halliwell Primary Care Network (PCN) for the year April 2021 to March 2022

At the end of another financial year, we are seeing developments within our PCN and a significant increase in the staff we are employing under the Additional Roles Reimbursement Scheme (ARRS).

We have recruited a number of Pharmacists who are settling in well, a Pharmacy Technician, Paramedics, Mental Health Practitioner, and have a new Social Prescribing Link Worker. We look forward to welcoming back two Pharmacists from maternity leave too. We have recently seen our first Nursing Associate join the team, with a Trainee Nursing Associate joining us soon to support our practice nurse team and the PCN targets. Whilst we know we have had teething issues, I hope you agree that things seem to be moving in the right direction.

Now that Covid and the vaccination service is slipping hopefully into the past (as it has been an extremely busy couple of years for all involved), we can look at improving our other targets, such as the learning disability register, cancer screening and working on the PCN contractual targets. We are also considering how we can reinstate the Multidisciplinary Team meetings so that they feel worthwhile and can actually achieve something.

I would like to thank everyone for their co-operation and hard work in what has been a difficult year all round and hope things ease in the subsequent one.

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 2021/22, the Network Contract DES Directions came into force on 1 April 2021 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.

The requirements for 2021/22 were themed around:

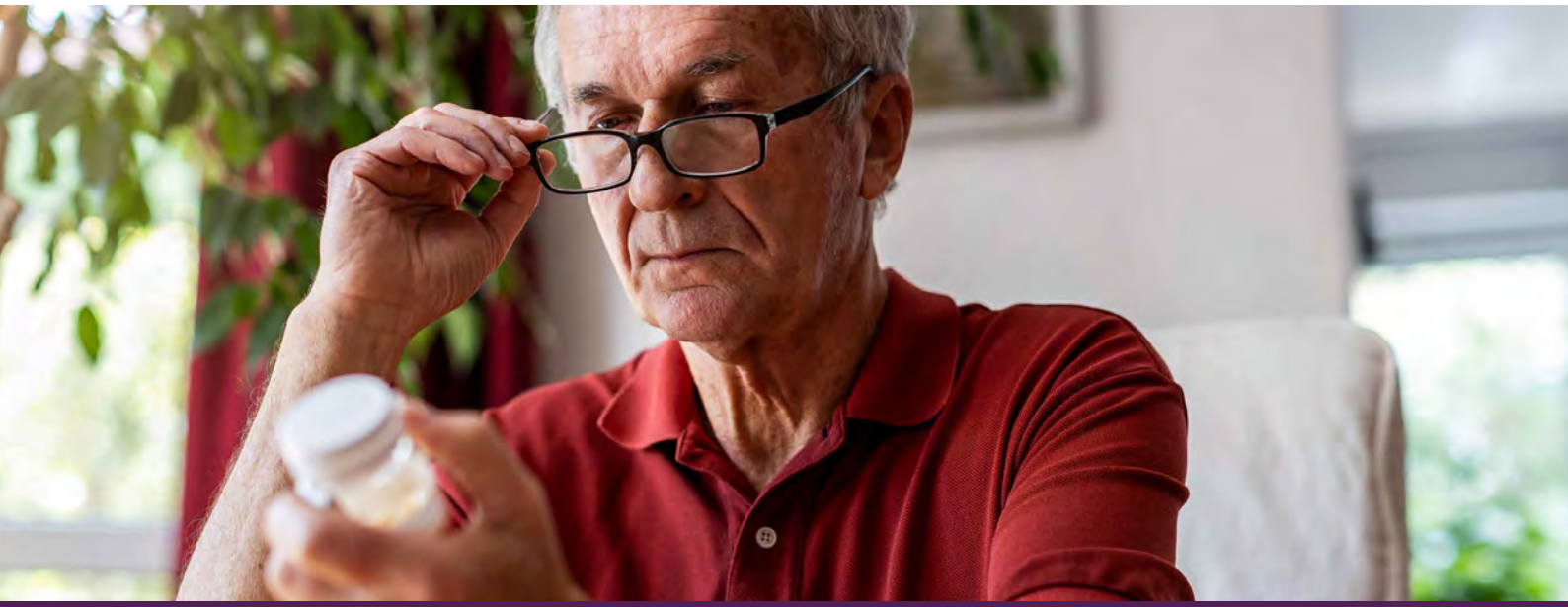
- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

The pages that follow summarise the progress we have made in Halliwell PCN towards these requirements during 2021/22.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

- In place in care homes *and/or*
- For those with complex and problematic polypharmacy, specifically those on 10 or more medications
- Offer and deliver a volume of SMRs determined and limited by the PCNs clinical pharmacist capacity, *and*
- The PCN must demonstrate reasonable ongoing efforts to maximise capacity
- Ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from, SMRs
- Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs
- PCN must ensure that professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills
- Clearly record all SMRs within GP IT systems



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

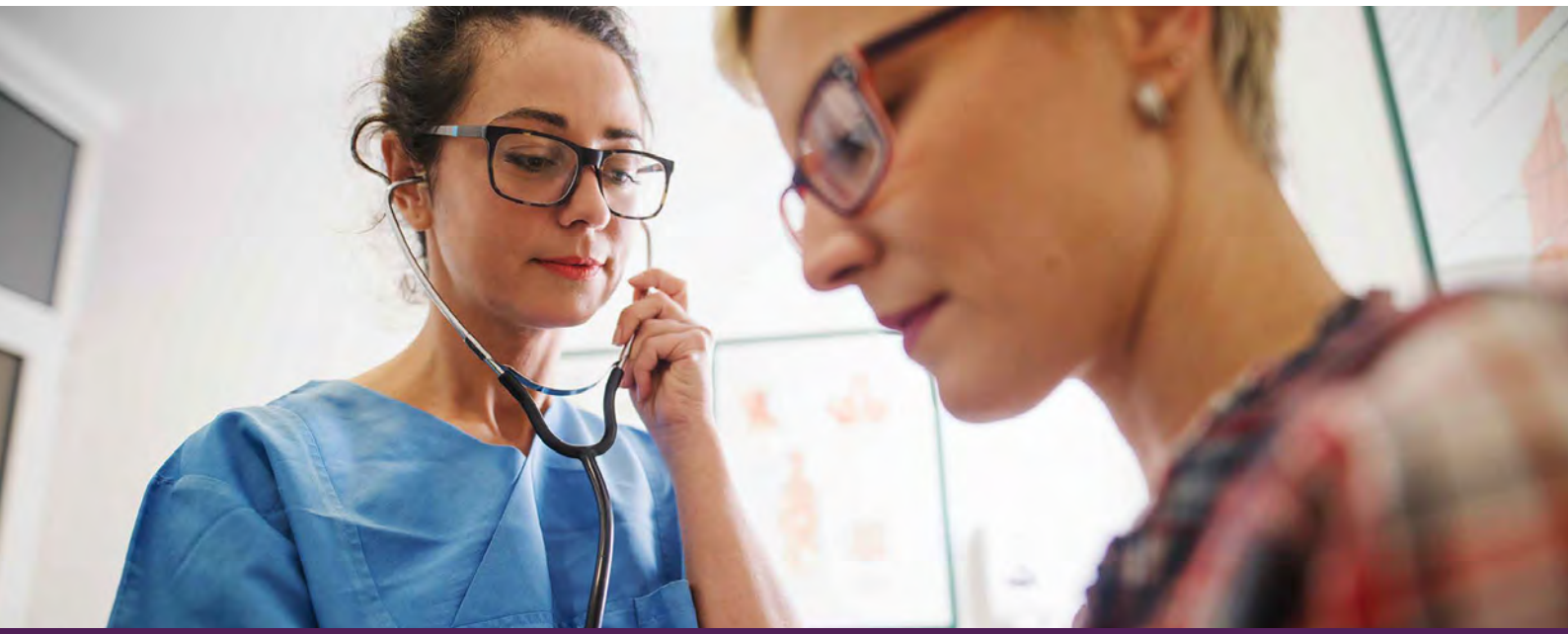
ENHANCED HEALTH IN CARE HOMES

- Agree aligned care homes with commissioner
- Have a plan in place with local partners
- Support residents to register with a practice in aligned PCN
- Ensure lead GP in place per PCN
- Deliver MDTs with partners
- Develop personalised care and support plan
- Establish protocols for info sharing, shared care planning, use of shared care records, etc
- Deliver a weekly home round
- Develop & refresh personalised care and support plans
- Identify/engage in shared learning
- Accurately record care home coding on continuous basis

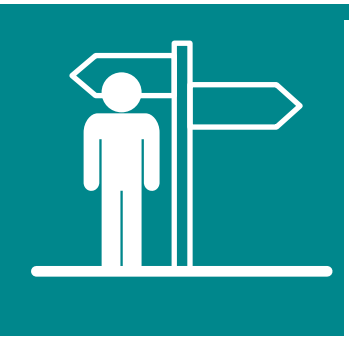
DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

- Review referral practice for suspected and recurrent cancers and work to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas
- Work with local system partners to agree contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations.
- Requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
- Use of teledermatology to support skin cancer referrals where available and appropriate
- Develop and implement plan to increase proactive and opportunistic assessment of patients for potential prostate cancer diagnosis in population cohorts where referral rates have not recovered to pre-pandemic baseline.
- Review use of non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

- [x] Implement new process to enable college referrals
- [x] Implement new process to enable NWAS referrals
- [x] Remind PCNs to refer at monthly PCN meetings
- [x] Ensure coding tallies across Ardens and Elemental
- [x] Monitor uptake using Ardens and Elemental

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 in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, 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: 3,431
Number of vaccinations: 4,581
% of patient population vaccinated: 91%

Patients on the LD register who received an LD health check

Patient population: 233
Number of LD checks carried out: 190
% of patients received health check: 82%

Number of patients referred to social prescriber

Threshold: 0.8–1.2%
Target number of referrals for lower threshold: 211
Number of referrals: 255 = 0.97%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme (ARRS) allows Primary Care Networks (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 2021–22, Bolton GP Federation successfully accessed all its ARRS allocation on behalf of the six PCNs it supports. In Halliwell Primary Care Network, during 2021–22, we recruited additional ARRS team members which included:

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

The PCN team will be expanded further during 2022–23.

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

Halliwell Primary Care Network ARRS team:

CLINICAL PHARMACISTS

Nabeela Illahi
Bhavisha Jariwala
Amirah Khan
Rebena Khan
Raeesa Ali

PHARMACY TECHNICIAN

Jane Melia

MSK

James Limbert
Simon Brewer

NURSING ASSOCIATE

Elizabeth Spence

MHP

Ian Hadlow

SPLW

Andrea Hollman

PARAMEDIC

Stephen Fielding
David Haslam

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

My patient was a 92 year old male who was referred for support for attendance allowance.

His friend, who is power of attorney for him, had filled in the attendance allowance form and, once assessed, he had been denied the benefit.

I rang the patient to get his permission to help him with the form and liaise with his power of attorney. He brought the letter into the surgery for me to look at and we agreed I would submit a letter for mandatory reconsideration on the patient's behalf. Dr Hawarth also provided a supporting letter and everything was sent over to the DWP.

After a few follow up calls on the patient's behalf, the DWP agreed with the new evidence to pay him the benefit. When no letter arrived I checked with welfare rights who advised of a delay and so I could reassure the patient not to worry.

I got a call from the patient to thank me and Dr Hawarth. He had received the benefit, had a letter from DWP and was very pleased with the outcome.

Jayne Spotswood
Social Prescribing Link Worker

STAFF FEEDBACK

Staff feedback is important to us. This year the staff working remotely and on location within our Primary Care Networks said...

Our staff tell us they ***"Feel supported by management"***

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

The Mental Health Practitioners collected feedback during the last quarter of 2021/22 using a variety of different formats.

Since the team was established in 2018, practitioners have been collecting feedback via paper patient satisfaction questionnaires. However, response rates have been low. Coupled with this, Covid and estate challenges moved many appointments to telephone, meaning paper questionnaires were not appropriate.

With this in mind, the MHPs have been collating feedback using verbal qualitative feedback, online surveys, collating case studies and most recently have developed questionnaires set up through MS teams which can be e-mailed to patients via the GP Accurx system, which will become the main approach taken by the team going forwards.

Overall feedback

Between January and March 2022 in total 72 patient, carer and staff experiences were captured.

Satisfaction questionnaires

44 satisfaction questionnaires were collected. All responses were positive in the following areas:

- ***Do you feel your appointment was helpful today?***
- ***Do you feel the practitioner understood your current difficulties?***
- ***Do you feel you were given enough information and support for your current needs?***
- ***Would you want to see the mental health practitioner again if you had another mental health problem in the future?***

Common themes

Common themes emerging from all of the feedback collected were:

- **The expertise in mental health in a GP surgery was important**
- **Receiving help and support at a time when it was really needed**
- **Receiving psychoeducation was invaluable**
- **The knowledge of other services and signposting to the right service**
- **Patients feel listened to, heard, and understood by MHPs**
- **Having medication reviews is helpful**
- **Having more than 10 minutes**
- **Speaking to a mental health professional in a GP surgery is reassuring**

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

"She is a highly skilled practitioner who has integrated well into the practice. I frequently receive positive feedback from patients." (GP feedback)

"I can't speak highly enough of him." (patient feedback)

"Excellent health professional who listened to me compassionately." (patient feedback)

"Very understanding and allowed me to speak as much as I wanted." (patient feedback)

"The most helpful person I have spoken to in the last 10 years." (patient feedback)

"She was amazing." (patient feedback)

"Brilliant in the support that he has offered and the discussions we have had." (patient feedback)

"I have been told top notch things about you and I agree... I give you a gold star for helping me!" (patient feedback)

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Halliwell PCN began in September 2021 through a designated site at Market Place.

In the period between 1 April 2021 and 31 March 2022 the Central, Farnworth & Kearsley, Halliwell and Rumworth collaboration delivered:

139,717 vaccinations

198 clinics held between Lever Chambers & Market Place

174 bus/pop up clinics including Essa Acadamy, Victoria Square, Asda (Burnden Park and Farnworth), Bolton College/University and Moses Gate

1,577 housebound residents were vaccinated in their homes

14 care homes visited with **1,535** staff and residents vaccinated

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during Covid-19, 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.

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

175 people (**4.8%**) were sent to hospital, of which **115** (**65.7%**) were admitted.

A total of **241** patients from the Halliwell PCN area received support through this pathway.

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

The team have been very supportive and kept in touch with me on a regular basis. I appreciate their help and care.

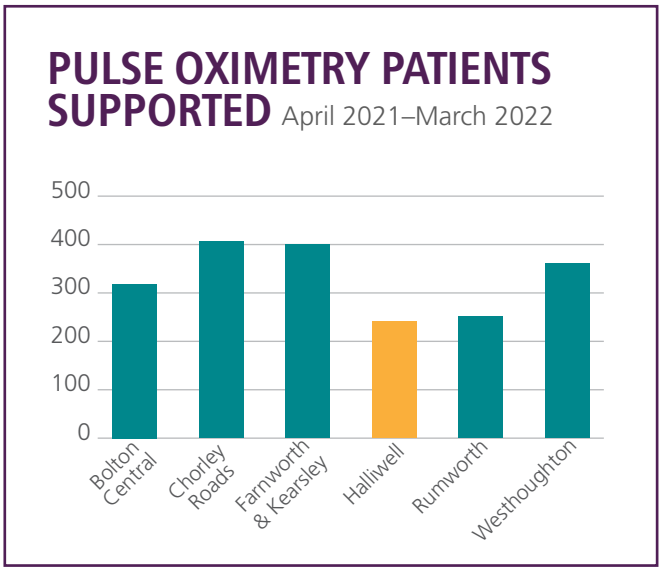
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

Everything was explained in detail and gone over again until I was happy with how to use it. When contacted by phone again everyone was polite and thorough.

I think that it's a brilliant service. The team offers support and reassurance at a scary time. Thankyou.

It took away the stress for me so that I could keep an eye on my oxygen levels.

PCN	No. patients
Breightmet & Little Lever	484
Bolton Central	311
Chorley Roads	408
Farnworth & Kearsley	399
Halliwell	**241**
Horwich	432
Rumworth	255
Turton	653
Westhoughton	378
OOA	56
All Bolton	**3,617**



FINANCE

TYPE	B/F	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
Core	3,011	45,983	-33,584	15,410
Ext Hours	0	37,272	-37,272	0
CD Funds	0	22,562	-19,050	3,512
Care Home	0	3,600	-3,600	0
Dev Fund	11,905	6,433	-5,491	12,848
I&I Fund	700	31,568	2,180	34,449
ARRS Fund	0	335,425	-335,425	0
Leadership Funds	0	22,051	-100	21,951
Extra CD Funds	13,984	45,402	-15,987	43,399
GRAND TOTAL	**29,601**	**550,295**	**-448,327**	**131,569**

REFLECTIONS AND PRIORITIES FOR 2022/23

It has been a busy year for our Halliwell Primary Care Network (PCN). Whilst practices are still recovering from the effects the pandemic has had on them and their patients.

We have welcomed to the PCN team:

Dr Aiyub Nakhuda – Deputy Clinical Director
Social Prescribing Link Worker – Andrea
Pharmacists – Rebena and Raeesah
Nursing Associate – Lizzi

We have been successful in meeting some of our PCN Impact and Investment Fund targets, and have been working on the implementation of a number of new specifications such as Cardiovascular Disease, Extended Access and Tackling Neighbourhood Health Inequalities.

I look forward to continuing the partnership working across all sectors to improve the health of our population, whilst continuing to work on the original specifications.

Next year we will be focusing on the ARRS roles and how we can recruit and embed more clinicians into the PCN to support our member practices.

We are currently in the process of recruiting additional Musculoskeletal Practitioners and a Trainee Nursing Associate, which will be our first TNA role within the PCN.

We also have Trainee Associate Psychological Practitioners joining the team to support patients with their mental health, which is a new role for our PCN.

I would like to thank each member practice for their continued support during 2021–2022 and I look forward to coming year.

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	
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

PARAMEDIC	
Is educated to degree/diploma level in Paramedicine or equivalent experience	
Is registered with the Health and Care Professions Council (HCPC)	
Has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic"	
Has a further three years' experience as a band 6 (or equivalent) paramedic	
Is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework	
If the Paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.	
Work as part of a MDT within the PCN	
Assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team	
Advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services	
Be able to perform specialist health checks and reviews within their scope of practice and in line with local and national guidance	
Perform and interpret ECGs	
Perform investigatory procedures as required	
Undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance	
Support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)	
Provide an alternative model to urgent and same day GP home visit for the network and clinical audits	
Communicate at all levels across organisations ensuring that an effective, person-centred service is delivered	
Communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required	
Maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice	
Communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices	

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	
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	
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	
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.	
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	
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	
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	
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	
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	
Develop trusting relationships by giving people time and focus on 'what matters to them'	
Take a holistic approach, based on the patient's priorities and the wider determinants of health	
Explore and support access to a personal health budget where appropriate	
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	
Where required and as appropriate, refer patients back to other health professionals within the PCN	

* 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.	

RUMWORTH PCN
ANNUAL REPORT
APRIL 2021–MARCH 2022

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and highlights of Rumworth Primary Care Network (PCN) for the year April 2021 to March 2022

Despite the ongoing pandemic, the four practices within Rumworth PCN have worked cohesively, resulting in a productive year. This has included the addition of more additional roles colleagues to help and assist with patient care. We now have Paramedics, Social Prescribing Link Workers, Pharmacists, Pharmacy Technicians, Musculoskeletal Practitioners, and a Mental Health Practitioner in place.

We have been actively reviewing our patients with learning disabilities and severe mental health conditions and undertaking structured medication reviews of care home residents together with regular multidisciplinary reviews. We have also worked to consider health inequalities and how to best identify and manage those most at need.

Together, with our newly appointed cancer lead, we have actively reviewed our processes and engaged in joint learning to promote early cancer diagnoses and had an introduction to a new medication to treat high cholesterol levels in those with pre-existing cardiac disease.

We have recognised that the incidence of mental health conditions has increased throughout the last year and are accessing pathways to help and support vulnerable patients, which includes adding in a Trainee Associate Psychological Practitioner to the network team and student Counsellors to support some of these patients.

The practices have also been heavily involved in the promotion of the Covid-19 vaccination programme.

As a co-operative group of four practices, we remain enthusiastic in supporting our patients and providing the highest standard of care. We look forward to the challenges that the new year will bring.

Dr Saveena Ghai
Clinical Director
Rumworth PCN

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 2021/22, the Network Contract DES Directions came into force on 1 April 2021 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.

The requirements for 2021/22 were themed around:

- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

The pages that follow summarise the progress we have made in Rumworth PCN towards these requirements during 2021/22.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

- In place in care homes *and/or*
- For those with complex and problematic polypharmacy, specifically those on 10 or more medications
- Offer and deliver a volume of SMRs determined and limited by the PCNs clinical pharmacist capacity, *and*
- The PCN must demonstrate reasonable ongoing efforts to maximise capacity
- Ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from, SMRs
- Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs
- PCN must ensure that professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills
- Clearly record all SMRs within GP IT systems

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

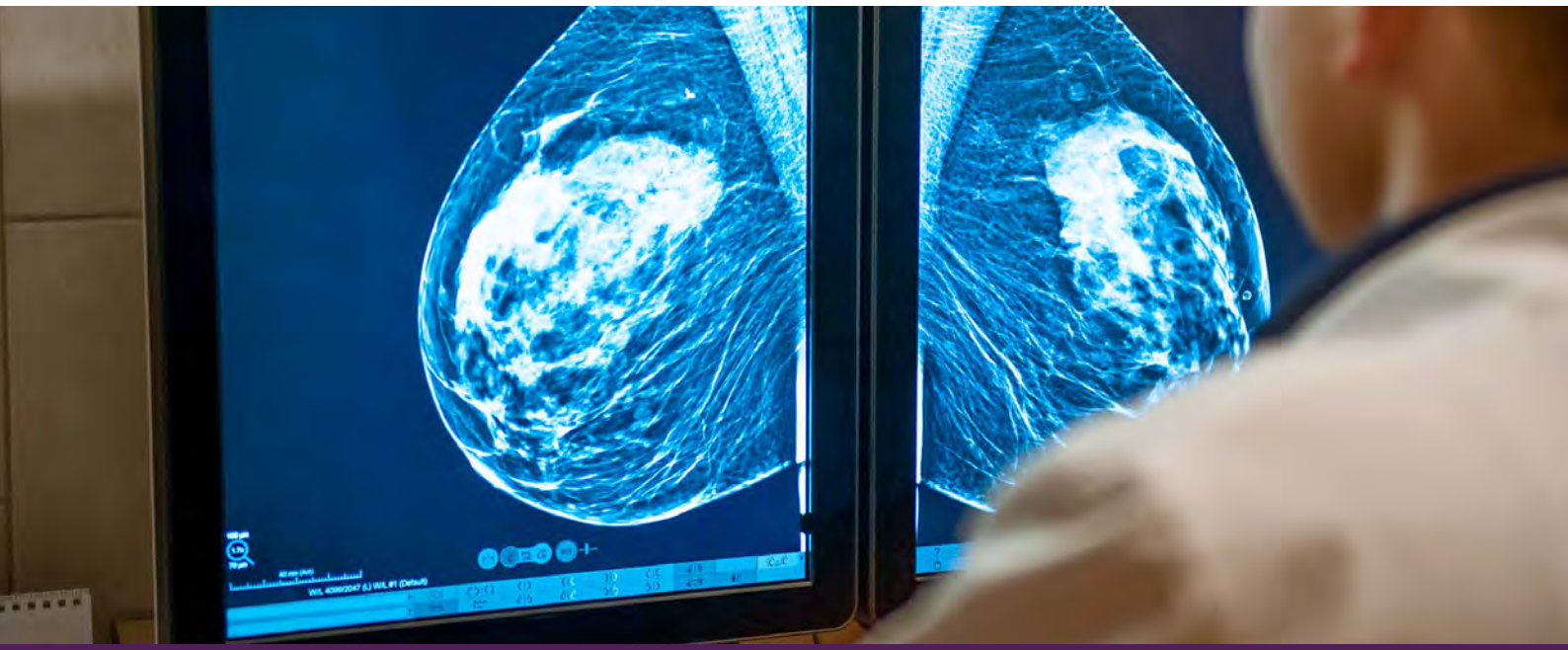
ENHANCED HEALTH IN CARE HOMES

- Agree aligned care homes with commissioner
- Have a plan in place with local partners
- Support residents to register with a practice in aligned PCN
- Ensure lead GP in place per PCN
- Deliver MDTs with partners
- Develop personalised care and support plan
- Establish protocols for info sharing, shared care planning, use of shared care records, etc
- Deliver a weekly home round
- Develop & refresh personalised care and support plans
- Identify/engage in shared learning
- Accurately record care home coding on continuous basis

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

- Review referral practice for suspected and recurrent cancers and work to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas
- Work with local system partners to agree contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations.
- Requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
- Use of teledermatology to support skin cancer referrals where available and appropriate
- Develop and implement plan to increase proactive and opportunistic assessment of patients for potential prostate cancer diagnosis in population cohorts where referral rates have not recovered to pre-pandemic baseline.
- Review use of non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

SOCIAL PRESCRIBING SERVICE

- [x] Implement new process to enable college referrals
- [x] Implement new process to enable NWAS referrals
- [x] Remind PCNs to refer at monthly PCN meetings
- [x] Ensure coding tallies across Ardens and Elemental
- [x] Monitor uptake using Ardens and Elemental

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 in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

In Rumworth PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 3,787
Number of vaccinations: 3,369
% of patient population vaccinated: 89%

Patients on the Learning Disability (LD) register who received an LD health check

Patient population: 135
Number of LD checks carried out: 93
% of patients received health check: 69%

Number of patients referred to social prescriber

Threshold: 0.8–1.2%
Target number of referrals for lower threshold: 238
Number of referrals: 313 = 1.05%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme (ARRS) allows Primary Care Networks (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 2021–22, Bolton GP Federation successfully accessed all its ARRS allocation on behalf of the six PCNs it supports. In Rumworth Primary Care Network, during 2021–22, we recruited additional ARRS team members which included:

- Clinical Pharmacists
- Pharmacy Technicians
- Musculoskeletal (MSK) First Contact Physiotherapists
- Mental Health Practitioner
- Social Prescribing Link Workers
- Paramedics
- Nursing Associate

The PCN team will be expanded further during 2022–23.

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

Rumworth Primary Care Network ARRS team:

CLINICAL PHARMACISTS

Graeme King
Ali Mitha
Mehraj Essa
Fehmida Yusuf

PHARMACY TECHNICIAN

Rebecca Viney

MSK

Simon Pendlebury
Simon Brewer

MHP

Elaine Shamlou

SPLW

Jayne Filio
Raeesah Mangera

PARAMEDICS

Declan Fraser-Higgins
Adam Blaney

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

A referral was received for a patient (PB) who lives alone and was socially isolated. Due to health conditions she found it difficult to get out and also felt very anxious about going out as she had been in for so long due to Covid-19 restrictions.

I first contacted this lady by phone to introduce myself and to find out a little more about her. She told me about her hobbies and interest but also said she was now restricted in what she could do as she suffered with COPD and needed oxygen with her at all times.

I talked about the wellbeing centre at the Bolton Hospice as I thought this would be a good place for her to attend. I explained what they did and how they may be able to support her. We agreed I would contact the centre to arrange a visit and I would also attend to provide support as she was anxious about going out and worried about how she would manage.

We both attended the wellbeing centre on the day arranged and spoke to the therapy team who made PB feel very welcome. She made further arrangements to attend a session the following Tuesday and this time she would get a taxi on her own.

I have since spoken with PB and she was very grateful for the service and all the support she had received which has enabled her to be a little more socially included.

She commented that she could not believe how nice people can be, and is now looking at getting back to her local church which she once thought would not be possible.

Jayne Filio
Social Prescribing Link Worker

STAFF FEEDBACK

Staff feedback is important to us. This year the staff working remotely and on location within our Primary Care Networks said...

Our staff tell us they ***"Feel supported by management"***

For me the feedback is all positive! I love working for the Fed! I've never worked anywhere that is so supportive of its staff, not only in terms of professional development and work-related support, but actually appreciates how when the work/life balance is maintained it actually makes you more productive at work. I've had unforeseen situations whilst working here that, in the past, I'd have had to take time off work to manage and then been penalized for, but here the support and flexibility with working has meant that I could handle those situations but was still able to work. I feel like everyone genuinely cares about you as a person, not just how you perform as a cog in the machine which was a new experience for me starting out with the Fed. I'd recommend working here to anyone!

Becky – Senior Pharmacy Technician

The Federation is very supportive, proactive in ongoing learning and progression and is an open, honest and safe place to work.

Declan – Paramedic

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

The Mental Health Practitioners collected feedback during the last quarter of 2021/22 using a variety of different formats.

Since the team was established in 2018, practitioners have been collecting feedback via paper patient satisfaction questionnaires. However, response rates have been low. Coupled with this, Covid and estate challenges moved many appointments to telephone, meaning paper questionnaires were not appropriate.

With this in mind, the MHPs have been collating feedback using verbal qualitative feedback, online surveys, collating case studies and most recently have developed questionnaires set up through MS teams which can be e-mailed to patients via the GP Accurx system, which will become the main approach taken by the team going forwards.

Overall feedback

Between January and March 2022 in total 72 patient, carer and staff experiences were captured.

Satisfaction questionnaires

44 satisfaction questionnaires were collected. All responses were positive in the following areas:

- ***Do you feel your appointment was helpful today?***
- ***Do you feel the practitioner understood your current difficulties?***
- ***Do you feel you were given enough information and support for your current needs?***
- ***Would you want to see the mental health practitioner again if you had another mental health problem in the future?***

Common themes

Common themes emerging from all of the feedback collected were:

- **The expertise in mental health in a GP surgery was important**
- **Receiving help and support at a time when it was really needed**
- **Receiving psychoeducation was invaluable**
- **The knowledge of other services and signposting to the right service**
- **Patients feel listened to, heard, and understood by MHPs**
- **Having medication reviews is helpful**
- **Having more than 10 minutes**
- **Speaking to a mental health professional in a GP surgery is reassuring**

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

"She is a highly skilled practitioner who has integrated well into the practice. I frequently receive positive feedback from patients." (GP feedback)

"I can't speak highly enough of him." (patient feedback)

"Excellent health professional who listened to me compassionately." (patient feedback)

"Very understanding and allowed me to speak as much as I wanted." (patient feedback)

"The most helpful person I have spoken to in the last 10 years." (patient feedback)

"She was amazing." (patient feedback)

"Brilliant in the support that he has offered and the discussions we have had." (patient feedback)

"I have been told top notch things about you and I agree... I give you a gold star for helping me!" (patient feedback)

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Rumworth PCN began in mid-December 2020 following a collaboration agreement to run the clinic through a designated site at Lever Chamber Health Centre, which then moved to the Market Place in July 2021.

In the period between 1 April 2021 and 31 March 2022 the Central, Farnworth & Kearsley, Halliwell and Rumworth collaboration delivered:

139,717 vaccinations

198 clinics held between Lever Chambers & Market Place

174 bus/pop up clinics including Essa Acadamy, Victoria Square, Asda (Burnden Park and Farnworth), Bolton College/University and Moses Gate

1,577 housebound residents were vaccinated in their homes

14 care homes visited with **1,535** staff and residents vaccinated

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during Covid-19, 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.

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

175 people (**4.8%**) were sent to hospital, of which **115** (**65.7%**) were admitted.

A total of **255** patients from the Rumworth PCN area received support through this pathway.

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

The team have been very supportive and kept in touch with me on a regular basis. I appreciate their help and care.

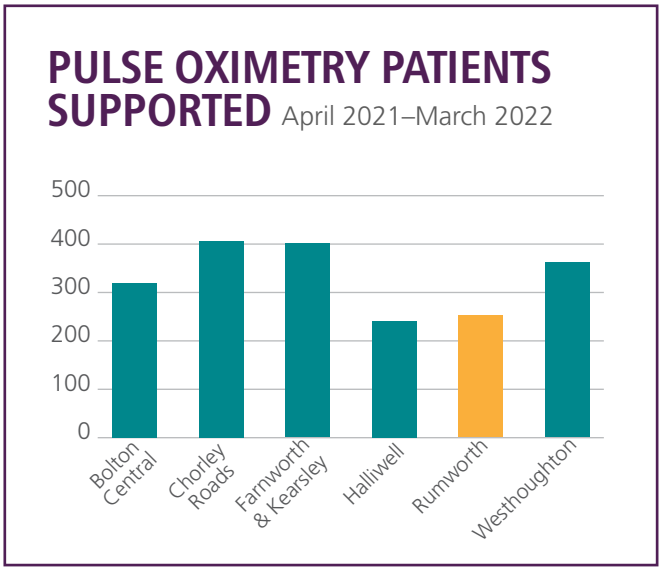
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

Everything was explained in detail and gone over again until I was happy with how to use it. When contacted by phone again everyone was polite and thorough.

I think that it's a brilliant service. The team offers support and reassurance at a scary time. Thankyou.

It took away the stress for me so that I could keep an eye on my oxygen levels.

PCN	No. patients
Breightmet & Little Lever	484
Bolton Central	311
Chorley Roads	408
Farnworth & Kearsley	399
Halliwell	241
Horwich	432
Rumworth	**255**
Turton	653
Westhoughton	378
OOA	56
All Bolton	**3,617**



FINANCE

TYPE	B/F	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
Core	7,385	44,340	-36,950	14,775
Ext Hours	0	42,566	-42,566	0
CD Funds	0	21,756	-21,756	0
Care Home	-120	30,480	-30,480	-120
Dev Fund	12,702	7,383	-9,952	10,133
I&I Fund	-1,899	35,048	2,180	35,329
ARRS Fund	0	371,147	-371,147	0
Leadership Funds	0	21,740	-400	21,340
Extra CD Funds	8,005	61,899	-60,572	9,333
GRAND TOTAL	**26,073**	**636,359**	**-571,642**	**90,790**

REFLECTIONS AND PRIORITIES FOR 2022/23

It has been a busy year for our Rumworth Primary Care Network (PCN). Whilst practices are still recovering from the effects the pandemic has had on them and their patients.

We have welcomed to the PCN team:

Emily Lucas – Musculoskeletal (MSK) Practitioner
Adam Blaney – Paramedic
Declan Fraser Higgins – Paramedic
Fehmida Yusuf – Pharmacist

We have been successful in meeting some of our PCN Impact and Investment Fund targets, and have been working on the implementation of a number of new specifications such as Cardiovascular Disease, Extended Access and Tackling Neighbourhood Health Inequalities.

I look forward to continuing the partnership working across all sectors to improve the health of our population, whilst continuing to work on the original specifications.

We will also be focusing on the Additional Roles Reimbursement Scheme (ARRS) roles and how we can recruit and embed more clinicians into the PCN to support our member practices.

We are currently in the process of recruiting additional MSK Practitioners and a Trainee Nursing Associate which will be our first TNA role within the PCN.

We also have Trainee Associate Psychological Practitioners joining the team to support patients with their mental health, which is a new role for our PCN.

I would like to thank each member practice for their continued support during 2021–2022 and I look forward to coming year.

Matthew Mann
Rumworth 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	
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

PARAMEDIC	
Is educated to degree/diploma level in Paramedicine or equivalent experience	
Is registered with the Health and Care Professions Council (HCPC)	
Has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic"	
Has a further three years' experience as a band 6 (or equivalent) paramedic	
Is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework	
If the Paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.	
Work as part of a MDT within the PCN	
Assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team	
Advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services	
Be able to perform specialist health checks and reviews within their scope of practice and in line with local and national guidance	
Perform and interpret ECGs	
Perform investigatory procedures as required	
Undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance	
Support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)	
Provide an alternative model to urgent and same day GP home visit for the network and clinical audits	
Communicate at all levels across organisations ensuring that an effective, person-centred service is delivered	
Communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required	
Maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice	
Communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices	

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	
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	
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	
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.	
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	
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	
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	
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	
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	
Develop trusting relationships by giving people time and focus on 'what matters to them'	
Take a holistic approach, based on the patient's priorities and the wider determinants of health	
Explore and support access to a personal health budget where appropriate	
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	
Where required and as appropriate, refer patients back to other health professionals within the PCN	

* 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.	

Complete Ongoing

NURSING ASSOCIATE	
Where a PCN employs or engages a Nursing Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Nursing Associate:	
Meets the specific qualification and training requirements as specified in the Nursing Midwifery Standards of proficiency by having undertaken and completed the two-year Foundation Degree delivered by a Nursing and Midwifery Council (NMC)	Complete
Is registered with the NMC and revalidation is undertaken in line with NMC requirements	Complete
Where a PCN employs or engages one or more Nursing Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each nursing associate has the following key responsibilities in relation to delivering health services:	
Work as part of the PCN's MDT to provide and monitor care, under direct or indirect supervision	Complete
Improve safety and quality of care at every opportunity	Complete
Contribute to the delivery of integrated care	Complete
Work with the PCN MDT to ensure delivery of nursing associate duties complement existing workforce	Complete
Provide support and supervision to training nursing associates, healthcare assistants, apprentices, and those on learning assignments/placements as required	Ongoing
Support registered nurses to enable them to be able to focus on the more complex clinical care	Complete
Develop relationships across the MDT to support integration of the role across health and social care including primary care, secondary care, and mental health	Ongoing
Perform and record clinical observations such as blood pressure, temperature, respirations, and pulse	Complete
After undertaking additional training, provide flu vaccinations, ECGs, and venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role	Ongoing
Promote health and wellbeing to all patients, for example undertaking the NHS health check	Complete
Care for individuals with dementia, mental health conditions, and learning disabilities	Ongoing
Advise patients on general healthcare and promote self-management where appropriate, including signposting patients to personalised care colleagues and local community and voluntary sector services	Complete
Communicate proactively and effectively with all MDT colleagues across the PCN, attending and contributing to meetings as required	Complete
Maintain accurate and contemporaneous patient health records	Complete
Enhance own performance through continuous professional development, imparting own knowledge and behaviours to meet the needs of the service	Complete
A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.	

WESTHOUGHTON PCN
ANNUAL REPORT
APRIL 2021–MARCH 2022

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance, Programmes and Communications, and Steph Psujek, Project Manager

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

This report contains the key achievements and highlights of Westhoughton Primary Care Network (PCN) for the year April 2021 to March 2022

Westhoughton PCN has continued to forge strong relationships between the practices within the network. Our exceptionally close working throughout the pandemic has continued to ensure another productive year. I'm hugely proud as the Clinical Director to say we have continued to provide a covid vaccination service to our patients, whilst also delivering core primary care work.

We recognise the huge strain the NHS faces, and the frustrations patients continue to have accessing care, as well as the challenges that clinicians have with workload and overwhelm. We have taken time to share good practice and learning, reflect on what could be done better and promote innovation across our teams. We continually strive to improve our processes to maximise best care for patients within the resources we have.

With the (often unrecognised) huge support from the Federation, we have utilised all our recruitment spend on our additional roles colleagues, employing Pharmacists, Pharmacy Technicians, Musculoskeletal Practitioners, Social Prescribing Link Workers and a Mental Health Practitioner all within our network. We have championed the way for recruitment of Physician Associates, a new role which has proven to be a huge asset to our team.

We are passionate about supported training for these staff and have made close contact with the Greater Manchester Training Hub and universities which have facilitated multiple training placements. We are proud to be a fully accredited learning environment for trainees in a range of roles. We have implemented a mentorship scheme to ensure these clinicians are guided during their careers in Primary Care.

With the increasing prevalence of mental health conditions, we are excited to have secured a Trainee Associate Psychological Practitioner to support our patients. It has been hugely beneficial to staff and patients to be exposed to professionals with differing backgrounds and skills. I really feel this has helped develop a diverse network of staff with whom our patients can interact.

We have invested in our communications with patients and have updated all Practice websites and social media, as well as embracing new online technology to better inform our population. Our PCN has led the way in Bolton with a strong social media presence and our social prescribing team support us in keeping these updated, whilst also ensuring we share information with our patients without computer access. We are developing information to inform and promote cancer screening amongst our population.

There has been a focus on our patients with learning disabilities and severe mental health conditions, ensuring they receive a holistic review. Our practices have excellent relationships with our local care homes and we ensure these more vulnerable patients are regularly reviewed within a multidisciplinary setting. More recently, we have been considering a health inequalities project and we are excited to be embarking on some work with our voluntary sector colleagues around the promotion of physical activity and nutrition in our younger population.

During an exceptionally challenging time within primary care, I remain enthused and motivated to ensure that, with the help of my Network Manager and wider Federation colleagues, we continue to provide a quality service to patients with a happy, well-trained workforce.

Dr Bev Matta
Clinical Director, Westhoughton 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 2021/22, the Network Contract DES Directions came into force on 1 April 2021 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.

The requirements for 2021/22 were themed around:

- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

The pages that follow summarise the progress we have made in Westhoughton PCN towards these requirements during 2021/22.

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

- In place in care homes *and/or*
- For those with complex and problematic polypharmacy, specifically those on 10 or more medications
- Offer and deliver a volume of SMRs determined and limited by the PCNs clinical pharmacist capacity, *and*
- The PCN must demonstrate reasonable ongoing efforts to maximise capacity
- Ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from, SMRs
- Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs
- PCN must ensure that professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills
- Clearly record all SMRs within GP IT systems

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

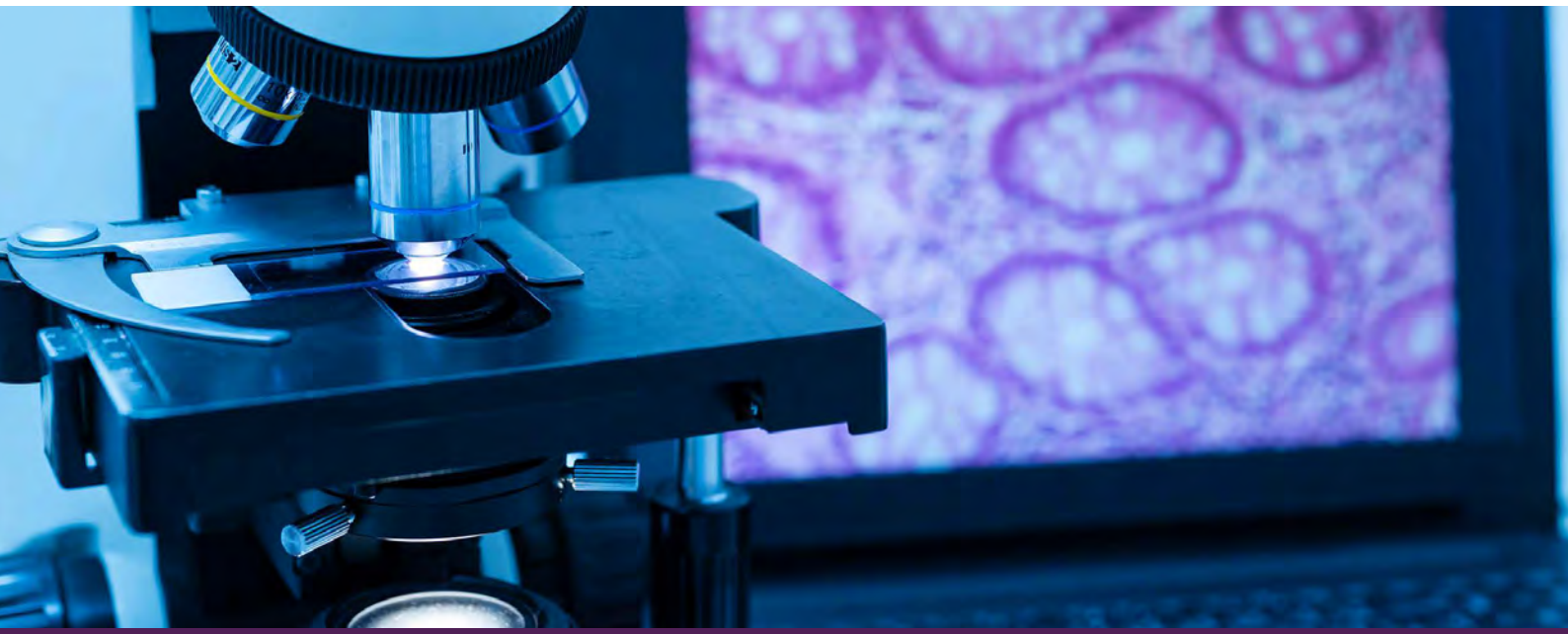
ENHANCED HEALTH IN CARE HOMES

- Agree aligned care homes with commissioner
- Have a plan in place with local partners
- Support residents to register with a practice in aligned PCN
- Ensure lead GP in place per PCN
- Deliver MDTs with partners
- Develop personalised care and support plan
- Establish protocols for info sharing, shared care planning, use of shared care records, etc
- Deliver a weekly home round
- Develop & refresh personalised care and support plans
- Identify/engage in shared learning
- Accurately record care home coding on continuous basis

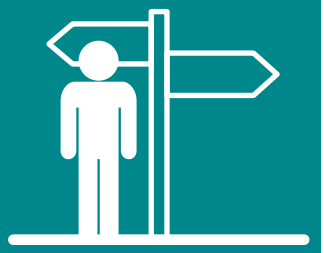
DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

- Review referral practice for suspected and recurrent cancers and work to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas
- Work with local system partners to agree contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations.
- Requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer
- Use of teledermatology to support skin cancer referrals where available and appropriate
- Develop and implement plan to increase proactive and opportunistic assessment of patients for potential prostate cancer diagnosis in population cohorts where referral rates have not recovered to pre-pandemic baseline.
- Review use of non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

- [x] Implement new process to enable college referrals
- [x] Implement new process to enable NWAS referrals
- [x] Remind PCNs to refer at monthly PCN meetings
- [ ] IN PROGRESS Ensure coding tallies across Ardens and Elemental
- [x] Monitor uptake using Ardens and Elemental

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 in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

In Westhoughton PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 5,728
Number of vaccinations: 5,053
% of patient population vaccinated: 88%

Patients on the LD register who received an LD health check

Patient population: 120
Number of LD checks carried out: 73
% of patients received health check: 60%

Number of patients referred to social prescriber

Threshold: 0.8–1.2%
Target number of referrals for lower threshold: 220
Number of referrals: 463 = 1.69%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

The Additional Roles Reimbursement Scheme (ARRS) allows Primary Care Networks (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 2021-22, Bolton GP Federation successfully accessed all its ARRS allocation on behalf of the six PCNs it supports. In Westhoughton Primary Care Network, during 2021-22, we recruited additional ARRS team members which included:

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

The PCN team will be expanded further during 2022/23.

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

Westhoughton Primary Care Network ARRS team:

CLINICAL PHARMACISTS

Irem Mahmood
Sumaiya Sajid
Raisah Shazad

PHARMACY TECHNICIAN

Andrea Moffatt

MSK

Alisha Walters

MHP

Samantha Barker

SPLW

Julie Wright
Jenna Scholes
Alison Lowe

PHYSICIAN ASSOCIATE

David Carter

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

I've been supporting BC for a while as he has been struggling with post traumatic stress disorder and he was feeling very isolated and low. He said he was looking for things to do and wanted to feel 'useful'.

I've met BC a few times. I have taken him to the Westhoughton One Stop Shop to help with the technology (where he fixed two laptops) and accompanied him to one of the MHIST support groups. He now goes alone twice a week and goes out socially with a few of them.

I also referred him to the Ageing Well Centre at Farnworth, initially to attend the groups, but he now has a designated role there as a Volunteer Activities Co-ordinator and he goes regularly!

I've just seen a post on Facebook from Age UK and BC is in the background with an apron and a big smile – it's really warmed my heart!

I'm still involved with BC as there are a few things he still needs support with (finances and housing) but it's lovely to see him smiling.

Julie Wright
PCN Social Prescribing Link Worker

STAFF FEEDBACK

Staff feedback is important to us. This year our staff working remotely and on location within our Primary Care Networks asked for some additional support. We listened to this and here are some examples of the difference we made together:

I thoroughly enjoy working with the Westhoughton PCN. All staff are friendly and approachable.
Alisha – MSK Practitioner

I really enjoy working in Westhoughton PCN and for the GP Federation. I have the support I need and the chance to learn and apply the learning. I feel like I matter and make a difference.
Andrea – Pharmacy Technician

I thoroughly enjoy my role as a PCN Pharmacist in Westhoughton. We have a large team which means more tasks are routed to the appropriate professionals. Not only does this improve efficiency for us, but it also enables more personalised and timely care for our patients. The Westhoughton PCN is a supportive network which has allowed me to develop and build greater resilience whilst allowing for a more sustainable work/life balance.
Sumaiya – Pharmacist

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

The Mental Health Practitioners collected feedback during the last quarter of 2021/22 using a variety of different formats.

Since the team was established in 2018, practitioners have been collecting feedback via paper patient satisfaction questionnaires. However, response rates have been low. Coupled with this, Covid and estate challenges moved many appointments to telephone, meaning paper questionnaires were not appropriate.

With this in mind, the MHPs have been collating feedback using verbal qualitative feedback, online surveys, collating case studies and most recently have developed questionnaires set up through MS teams which can be e-mailed to patients via the GP Accurx system, which will become the main approach taken by the team going forwards.

Overall feedback

Between January and March 2022 in total 72 patient, carer and staff experiences were captured.

Satisfaction questionnaires

44 satisfaction questionnaires were collected. All responses were positive in the following areas:

- ***Do you feel your appointment was helpful today?***
- ***Do you feel the practitioner understood your current difficulties?***
- ***Do you feel you were given enough information and support for your current needs?***
- ***Would you want to see the mental health practitioner again if you had another mental health problem in the future?***

Common themes

Common themes emerging from all of the feedback collected were:

- **The expertise in mental health in a GP surgery was important**
- **Receiving help and support at a time when it was really needed**
- **Receiving psychoeducation was invaluable**
- **The knowledge of other services and signposting to the right service**
- **Patients feel listened to, heard, and understood by MHPs**
- **Having medication reviews is helpful**
- **Having more than 10 minutes**
- **Speaking to a mental health professional in a GP surgery is reassuring**

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

"She is a highly skilled practitioner who has integrated well into the practice. I frequently receive positive feedback from patients." (GP feedback)

"I can't speak highly enough of him." (patient feedback)

"Excellent health professional who listened to me compassionately." (patient feedback)

"Very understanding and allowed me to speak as much as I wanted." (patient feedback)

"The most helpful person I have spoken to in the last 10 years." (patient feedback)

"She was amazing." (patient feedback)

"Brilliant in the support that he has offered and the discussions we have had." (patient feedback)

"I have been told top notch things about you and I agree... I give you a gold star for helping me!" (patient feedback)

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for the Westhoughton PCN began in mid-January 2021 through a designated site at Peter House Surgery.

Between the 1 April 2021 and 31 March 2022 Westhoughton PCN delivered:

20,538 vaccinations

30 clinics held

4 care homes and

3 assisted living care homes visited

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP practices during Covid-19, Bolton 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 patients on how to use the machine and what to do if symptoms worsened.

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

175 people (**4.8%**) were sent to hospital, of which **115** (**65.7%**) were admitted.

A total of **378** patients from the Westhoughton PCN area received support through this pathway.

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

The team have been very supportive and kept in touch with me on a regular basis. I appreciate their help and care.

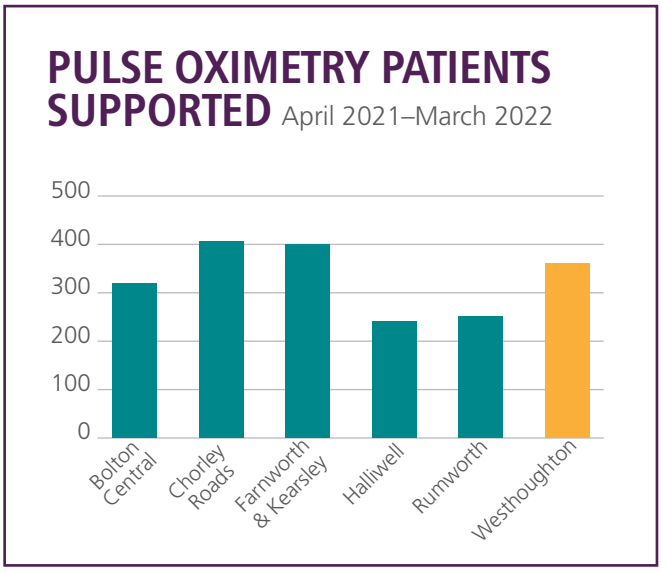
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

Everything was explained in detail and gone over again until I was happy with how to use it. When contacted by phone again everyone was polite and thorough.

I think that it's a brilliant service. The team offers support and reassurance at a scary time. Thankyou.

It took away the stress for me so that I could keep an eye on my oxygen levels.

PCN	No. patients
Breightmet & Little Lever	484
Bolton Central	311
Chorley Roads	408
Farnworth & Kearsley	399
Halliwell	241
Horwich	432
Rumworth	255
Turton	653
Westhoughton	**378**
OOA	56
All Bolton	**3,617**



FINANCE

TYPE	B/F	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
Core	6,929	41,150	-34,292	13,788
Ext Hours	0	39,504	-39,504	0
CD Funds	0	20,191	-20,191	0
Care Home	0	17,760	-17,760	0
Dev Fund	8,677	6,845	-7,115	8,407
I&I Fund	14,519	31,864	-7,742	38,641
ARRS Fund	0	336,737	-336,737	0
Leadership Funds	0	17,828	-100	17,728
Extra CD Funds	0	57,392	-42,197	15,194
GRAND TOTAL	**30,125**	**569,272**	**-505,638**	**93,758**

REFLECTIONS AND PRIORITIES FOR 2022/23

The Westhoughton PCN has continued to excel this year with hitting the Directed Enhanced Service (DES) and Impact and Investment Fund (IIF) targets, alongside providing regular COVID-19 vaccination sessions to the local population.

We have welcomed new Additional Roles Reimbursement Scheme (ARRS) staff to the PCN, and I look forward to continuing to recruit new roles into the team over the next 12 months, as well as working through the new and ever growing DES requirements for 2022/23.

We have welcomed to the PCN team:

- David Carter – Physician Associate
- Alisha Walters – Musculoskeletal (MSK) Practitioner
- Alison Lowe – Social Prescribing Link Worker

Our prioritises for the forthcoming year include:

- Presentation to the ARRS staff on the new DES/IIF targets
- Mobilisation of the Health Inequalities project
- Provide monthly updates to the PCN on targets and achievements
- Commence the use of ARDENS templates manager
- Induct the new Pharmacy Technician into the practices

Kristy Barlow
Westhoughton 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	
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

PHYSICIAN ASSOCIATE	
Has completed a post-graduate physician associate course (either PG Diploma or MSc);	
Has maintained professional registration with the Faculty of Physician Associates and/or the General Medical council following implementation of statutory regulation, working within the latest code of professional conduct (CIPD); and	
Has passed the UK Physician Associate (PA) National Re-Certification Exam, which needs to be retaken every six years;	
Participates in continuing professional development opportunities by keeping up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for continuing professional development (CPD), and	
Is working under supervision of a doctor as part of the medical team,	
Provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable)	
Support the management of patient's conditions through offering specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes, and anticoagulation	
Provide health/disease promotion and prevention advice, alongside analysing and actioning diagnostic test results;	
Develop integrated patient-centred care through appropriate wording with the wider primary care multi-disciplinary team and social care networks;	
Utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks;	
Participate in duty rotas; undertaking face-to-face, telephone, and online consultations for emergency or routine problems as determined by the PCN, including management of patients with long-term conditions;	
Undertake home visits when required.	
Develop and agree a personal development plan (PDP) utilising a reflective approach to practice, operating under appropriate clinical supervision.	
A PCN's Core Network practices must identify a suitable named GP supervisor for each physician associate, to enable them to work under appropriate clinical supervision.	

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	
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	
Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute, and	
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.	
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	
Assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community	
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	
Evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs	
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	
Develop trusting relationships by giving people time and focus on 'what matters to them'	
Take a holistic approach, based on the patient's priorities and the wider determinants of health	
Explore and support access to a personal health budget where appropriate	
Manage and prioritise their own caseload, in accordance with the health and wellbeing needs of the population	
Where required and as appropriate, refer patients back to other health professionals within the PCN	

* 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.	