ANNUAL REPORT

APRIL 2020 - MARCH 2021

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Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

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WELCOME FROM OUR CHAIR

This has been a tough 18 months, with the COVID-19 pandemic increasing the strain on health services around the UK. Never before has the work of the Federation been so important in supporting primary care to deliver health and care services to the people of Bolton.

For the Federation, primary care support means helping GP practices and Primary Care Networks to understand and implement national and local guidance, supporting practices that are underperforming and, critically, supporting them with IT and estates functions. These are priorities for the coming months and years that will enable primary care to deliver services on a Bolton-wide footprint.

We also need to tackle the growing challenges of population health, working with other networks and partners in the locality and Greater Manchester to improve poor health outcomes that exist for some of the most deprived populations. The Federation is a key enabler of integration at practice, network, locality and Integrated Care System level and is uniquely positioned to ensure no patients in Bolton are left without an appropriate, high quality service.

George Ogden
Chair

WELCOME FROM OUR CHIEF OFFICER

I have been at Bolton GP Federation for five years and I am excited to share some of our history in our first ever annual report. When I took on this challenging role our primary aim was to create an organisation that was defined by clinical service delivery – owned by practices and for practices.

As time moved on we became more involved in the system on behalf of primary care to ensure we were there to support devolution and transformation of clinical services, but also so we could work together to find new, different, responsive, achievable, practical and affordable ways to fill the gaps.

Our primary aim now is that the people of Bolton see one primary care service across Bolton – consistent and with no variation in clinical service – regardless of the provider. Reducing the gap in health inequalities is something that is really important to me. We are playing our part, along with our partners in Bolton and Greater Manchester, to ensure that primary care has a unified voice in the integrated Care System moving forward.

The last couple of years has seen us support the development of Primary Care Networks and invest in infrastructure. We have learnt a huge amount along the way and I am excited to explore the interesting ideas and effective models we have seen emerging with the wider team and our partners.

What drives us as an organisation is the ambition to deliver great clinical services by having the right people with the right support and resources behind them. We don't just give them enough to get by, we give them enough to thrive. I firmly believe in our autonomous culture. Where we see a gap in skills we get the right person to fill that gap, creating an incredibly strong team and continually growing our reputation.

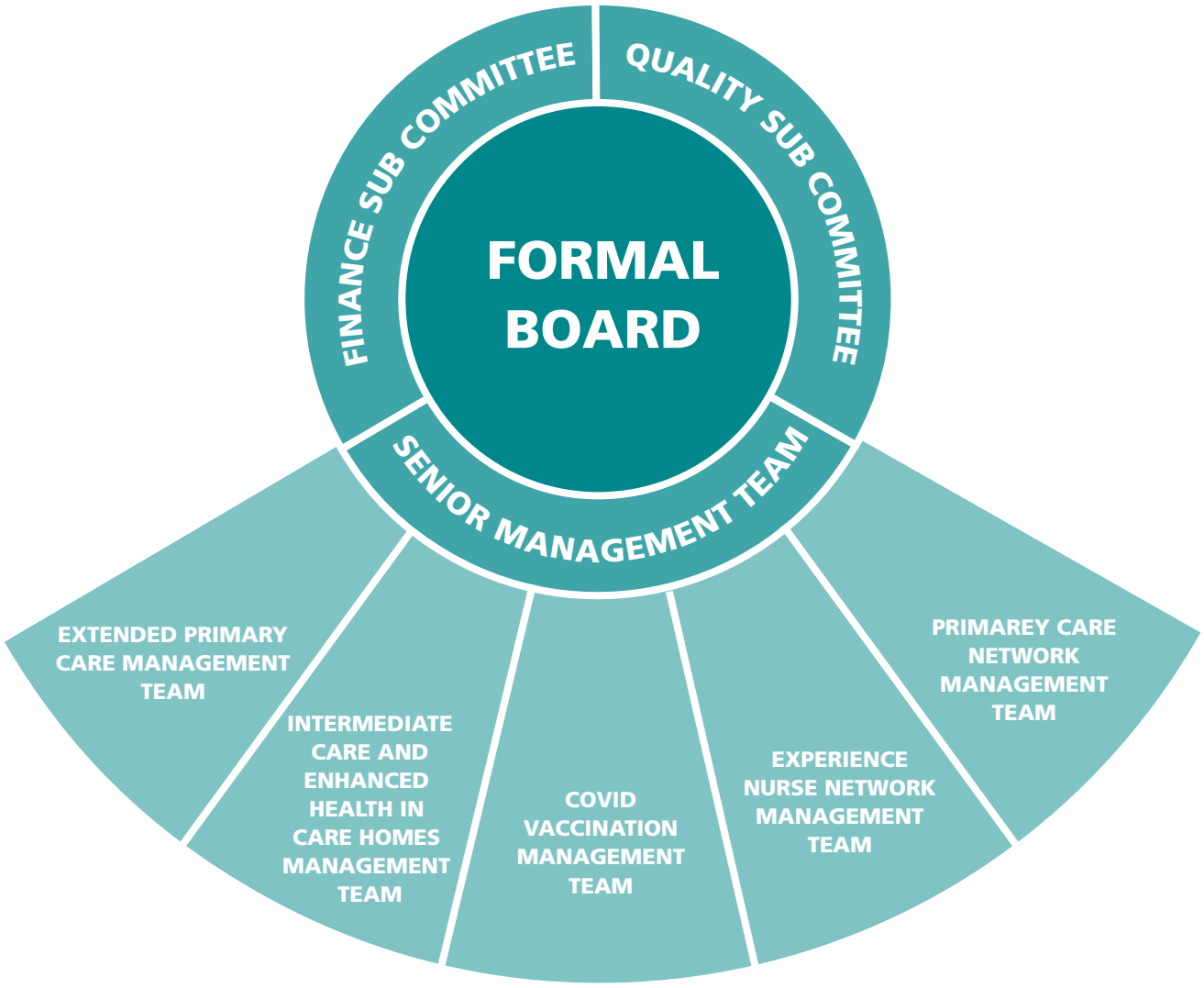
The last 12 months have been challenging for most. For us it's been business as usual with more added on top! Everything from continuing to support the development of our Primary Care Networks and making them work on a practical level; adding value; providing staff; managing contracts; providing business intelligence; managing negotiations; ensuring targets are hit; providing supervision to staff; and training and development. Everything we've done has had patient safety and quality at the heart.

Then there's been the small matter of delivering the COVID-19 vaccine programme at speed! This was achieved through an amazing collective effort between us, our partners and the voluntary sector and I am immensely proud of what we have achieved. Our relationship with the voluntary sector has gone from strength to strength, in particular over the last 12 months. The sector is one of our highly valued, equal partners in the delivery of care across Bolton.

My personal experience of the pandemic has involved everything from delivering sandwiches and emptying bins, to going on the news to talk about the vaccine programme rollout and everything in between. The highlight for me has been delivering clinical services side by side; St John Ambulance, hospital and community staff, Federation staff, all working together to deliver seamless clinical services and truly integrated healthcare – fundamentally all that truly matters to patients.

Michael Smith
Chief Officer

OUR GOVERNANCE STRUCTURE



OUR EXECUTIVE OFFICE

Michael Smith
Chief Officer

Jenny Thomas
Business Manager

Mercedes Grundy
Office Manager

Dawn Lythgoe
Performance and Programme Manager

Kristy Barlow
Operations Manager

Barry Barlow
Service Lead

Matthew Mann
Senior Network Manager

Vicky Westwood
Network Manager

Georgina Kilmartin
Deputy Network Manager

Kath Arrowsmith
Chief Nurse

Mabs Rahman
Chief Finance Officer

OUR TEAM

I am the Business Manager and Company Secretary, have been with the Federation since August 2016. I have been working in the NHS for over 30 years and I can honestly say, this past year has been the most challenging, but one that has also brought a wide range of opportunities.

My real passion is engaging with people, everyone from our clinicians to the patients we serve in Bolton to ensure that their voices are heard and their valuable input is recognised. I firmly believe that through engagement this will support us to continue to grow the infrastructure of the organisation and enable our work in the system to promote integration.

I would like to thank everyone who shared their thoughts with us this year, in particular those who supported us with the speedy roll out of vaccinations and those who have helped shape our future plans.

There are a few highlights from this last year for me, in particular growing the executive team and reaslising the potential for us to do so much more through investing in the organisation.

I am excited for the coming year, I do think one of our major challenges we face will be when the world goes back to normal following the pandemic, but there is real opportunity for us to build this organisation further and I look forward to sharing our business plans.

Jenny Thomas
Business Manager

OUR TEAM

I have been very fortunate to be part of the Federations journey since its initial launch in 2015.

My role has evolved over the last 6 years from Service Managing the Extended Primary Care Service, Senior Network Management and more recently Head of Operations for the COVID vaccination programme.

The vaccination programme in particular has been a testament to how we have forged new relationships and innovation, while working at rapid pace.

It has been a challenging but exciting journey and am looking forward to growing our team and forming new relationships within the integrated care system.

Kristy Barlow
Operations Manager

I am Dawn Lythgoe and I am the strategic lead for performance, programmes and communication at Bolton GP Federation. I am hugely passionate about people being involved in designing and delivering services and it's great that we get to work so closely with our staff and involve our communities here in Bolton.

I started with the Federation in April 2020 after spending 32 years working in local government. I very quickly adapted to the Federation way of working and settled in with the absolutely brilliant team here. The huge challenges brought by COVID-19 and running the vaccination programme has meant that I haven't had a minute to look back!

Over the last 12 months I have seen the Federation grow and go from strength-to-strength. I am particularly proud of the culture here. The innovation, motivation, commitment and passion of our people means we have been able to respond quickly and deliver what's needed to a very high standard. The COVID-19 vaccination programme and our highly-regarded support to primary care networks are the living, breathing proof of this.

I am looking forward to learning more about the world of primary care in Bolton and across Greater Manchester and banging the Bolton drum for what can be achieved through Federations!

Dawn Lythgoe
Performance and Programme Manager

OUR TEAM

I am the Chief Nurse at the Federation and manage a network of experienced General Practice Nurses who support our Primary Care Networks at times of low staffing through sickness absence, recruitment etc. I am currently developing the team further and am looking forward to providing more support with smear mentorship and other training requirements. I am also the lead nurse for the GM Training Hub in Bolton supporting immunisation/ vaccination programmes. I support with training and development of our own staff and am also involved with recruitment.

I have worked for Bolton GP Federation for around three years now, beginning my current role in November 2020. Previous roles have included specialist nurse supporting general practice, practice nurse, end of life care associate facilitator, specialist practitioner district nurse, community staff nurse, Marie Curie nurse and Health Care Assistant. I started my career in palliative care in the community, an area which has always remained close to my heart. Providing care for people who wish to spend the last months, weeks or days of their life at home is a very privileged role and an area in which community nursing comes into its own. I found working as a General Practice Nurse an equally rewarding role. Having the opportunity to advise and support people, plan patient care and see the benefits and outcomes of the interventions implemented is wonderful.

Whilst the COVID-19 pandemic has been an exceedingly sad and challenging time it has also been a source of great professional pride in the way we have dealt with it. Being involved in the vaccination programme has been a real highlight for me. Without having been offered the opportunity to join such an amazing team, I doubt I would have been quite so involved in the vaccination programme. It has been an honour to work alongside the Federation team in developing the vaccination clinics, supporting Bolton and fighting back against this unyielding virus that has brought the world to a standstill. It has been fantastic and something which I will never forget. I can honestly say the commitment and resilience of the whole team has been outstanding and I am very, very proud to have worked alongside some truly amazing people.

I am looking forward to continuing the vaccination roll out, booster vaccines and adapting more services to suit the needs of the people of Bolton. We have devised new ways of working through the use of our mobile vaccination unit which we can now replicate in order to provide services in a more people friendly way. This will support us with raising awareness of cancer screening, taking services out into the community and delivering care to our most vulnerable population groups.

Kath Arrowsmith
Chief Nurse

OUR TEAM

I have 12 years' experience within Primary Care, working in a GP practice setting before moving on to work in the tax industry and then returning to general practice because I missed it so much! I joined Bolton GP Federation in July 2018 and my role has progressed to now being the Senior Network Manager. I love working with different healthcare professionals on how we can streamline and improve healthcare in Bolton. I am particularly interested in growing and developing our Primary Care Network workforce in line with NHS England's five year forward view.

Last year was a difficult yet rewarding year. The team at the Federation pushed themselves to provide the COVID-19 vaccination programme on behalf of four of our Primary Care Networks, which was successful and is currently ongoing. I extremely proud to be part of a team that pulls together and works so hard to deliver the services we do, for the health of our patients, even when things get tough!

Within my Primary Care Networks, I am extremely proud of the relationships we have developed with our member practices, expansion of the Primary Care Network workforce and my promotion to senior network manager.

I am looking forward to focussing on the requirements for the Primary Care Networks, expanding the workforce and developing our team within a primary care setting.

Matthew Mann
Senior Network Manager

I joined Bolton GP Federation in April 2020, prior to which I worked in primary care for 11 years as a Practice Manager and Regional Manager supporting three practices. My role as a network manager is very different, but I love the variety and all the different challenges and opportunities it brings – especially during the COVID-19 pandemic.

Last year was a challenging yet rewarding year. The team here at HQ were heavily involved in providing the vaccination roll out within my Primary Care Networks and helping to set up the sites the week before Christmas! Increasing Additional Roles Reimbursement Scheme staff was another big part of my new role as well as helping them transition into their new roles within the networks.

I am looking forward to hopefully getting back to some normality after the pandemic, expanding the current workforce and ensuring the Directed Enhanced Service is being delivered throughout both my networks.

Victoria Westwood
Netowrk Manager

OUR TEAM

I am the Deputy Network Manager for the Rumworth, Halliwell and Central Networks and my role is to support the Network Manager and Clinical Directors with management, recruitment, contracts and delivery of services. Outside of work my interests revolve around food and fitness.

I started my NHS career in 2014 working as an apprentice in General Practice and worked my way to Assistant Practice Manager before joining the Primary Care Network team with Bolton GP Federation in 2020.

My highlights from last year include working on the delivery of the Covid Vaccine Clinics, our successful recruitment of the Additional Roles Reimbursement Scheme workforce and integrating myself into the Networks.

Next year I am looking forward to having meetings face to face (hopefully over a cake and a brew!)

Georgina Kilmartin
Deputy Network Manager

I started off working part time but gradually became full time and am now the assistant service manager, helping to oversee the safe delivery of the COVID vaccination service and also to ensure the Extended Primary Care Service is still delivering to our PCNs.

I have worked for the Federation for four years and this last year has flown by, a real highlight for me was to see how resolute we all are. We have all taken on a mammoth task with COVID but have shown great strength and determination

Next year I am looking forward to seeing the GP Federation growing and showing it's true potential. Lots of planning is already going ahead ready for what next year has to throw at us.

Barry Barlow
Service Lead

OUR TEAM

Hi, I'm Mercedes I am the Office Manager here at the Federation. My role is to assist the Business Manager with tasks whilst support the Care Homes and Wilfred Geere intermediate care services.

I joined the Federation in 2020 to support the Resilience Hub which was set up to support practices during the pandemic prior to becoming the Office Manager.

My highlights for 20/21 has been seeing the workforce expand and the community support delivering the covid vaccines.

I am looking forward to watching our growing team work together and produce amazing outcomes for 21/22!

Mercedes Grundy
Office Manager

Hi I'm Ellie and I am the Finance Officer at the Federation. I enjoy taking my dog on hikes and fell walks.

I first started my journey in finance as a Trainee Accountant back in 2017 in an accountancy firm where I completed my Level 3 AAT Qualification as an apprentice I stayed there until I joined Bolton GP Federation in 2020 where I am now currently studying towards my level 4 AAT.

My highlights from last year were getting to know the team here at head office as well as being able to get involved in various job roles in the Covid Clinics.

I am most looking forward to completing my Level 4 qualification and being able to develop my role further to contribute even more to the Federation and Primary Care Networks.

Ellie Smith
Finance Officer

OUR SERVICES

At the Federation during 2020-21 we developed, implemented and tested some new services, and continued to run a number of existing 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.

GP streaming pilot – we ran a 6-week pilot during May & June 2020 to help reduce demand on A&E.

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

In December 2019 we began the delivery of the **Covid Vaccination programme** on behalf of 4 of Bolton's Primary Care Networks.

The Training Hub is a new area for us - we were approached by Greater Manchester Health and Social Care Partnership to run the hub following the involvement of our Lead Nurse and the need to upskill workforce quickly in response to Covid vaccination programme.

Extended Primary Care

EXTENDED PRIMARY CARE (EPC) OVERVIEW

CURRENT PROVISION AND CONTRACTUAL REQUIREMENTS | FUTURE POSSIBILITIES

CURRENT CLINICAL SERVICE PER 1000 PEOPLE

START CONSULTATION WITHIN 15 MINS OF AGRRED APPOINTMENT TIME

45 MINS
225 HRS PER WEEK

30 min
150 HRS PER WEEK

365 DAYS/YEAR
7 DAYS/WEEK
6:30-9:30PM MON-FRI
9AM-1PM/10AM-2PM WEEKENDS

IT
BARDOC COST £50K

REMOTE VIDEO / TELEPHONE CONSULTATION CAPABILITY

MEDICINES MANAGEMENT
COST CURRENTLY MET THROUGH BARDOC ELEMENT OF PCLS CONTRACT AT 30K

REGISTERED AND INSPECTED AS URGENT CARE PROVIDER BY CQC

MINIMUM 1 GP
PER CLINICAL SYSTEM AVAILABLE AT EACH SESSION, EACH DAY

ACCESS TO GP RECORD AND EPS
ELECTRONIC PRESCRIPTION SERVICE

MINIMUM 1 FEMALE CLINICIAN
AVAILABLE AT EACH SESSION, EACH DAY

ACCURATE RECORDING
OF ALL DNA'S (MANUALLY & CLINCAL SYSTEM) AND ALL CANCELLATIONS (WITH ANALYSIS AVAILABLE OF WHETHER PROVIDER / PATIENT CX)

DATA SHARING

ESTATES

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

?

URGENT CARE?

OOH?

GP CO-OP MODEL OF DELIVERY?

EXTENDED PRIMARY CARE (EPC)
BOLTON GP FEDERATION STAFFING

52 GPs

6 ANPs

6 HCAs

2 MSKs

28 NURSES

14 ADMIN

5 PHARMACISTS

3 MH

FEBRUARY HOURS OF APPOINTMENTS (COVID/RESILIENCE)

331	41	20	18		
GP HRS	ANP HRS	MSK HRS	MH HRS		
	43	12	328		
	NURSE HRS	HCA HRS	ADMIN HRS		

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

CARING

- Patient feedback
- Interpretation services

RESPONSIVE

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

WELL LED

- 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

- 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

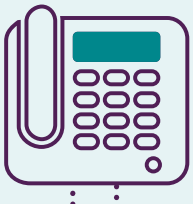
- Rota
- Staffing
- Appraisal
- Professional development

- Contracts
- Induction
- Registration
- Training

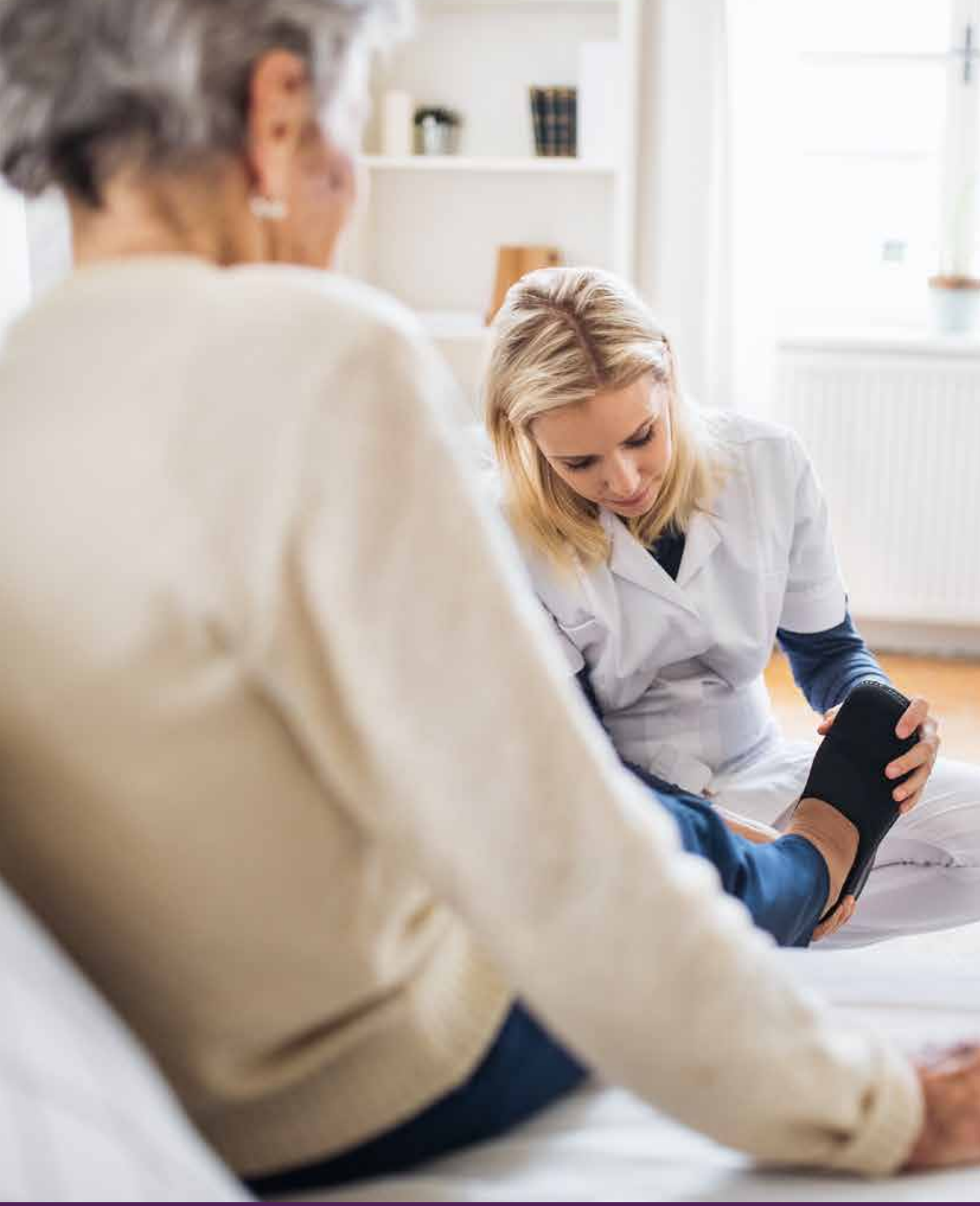
- Mentorship
- Staff survey/ meetings
- DBS checks

IT

- Access to pt 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



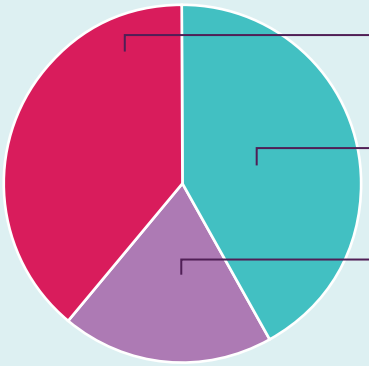
INTERMEDIATE CARE

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

In 2020-21, we provided this support to 12 beds in Wilfred Geere House. During this time:

- 95 patients were admitted
- We carried out patient-centred geriatric assessments upon admission
- We followed a multi-disciplinary approach that enable joined-up care for patients, meaning:
  - 63% of patients with dementia were able to return to their homes
  - 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

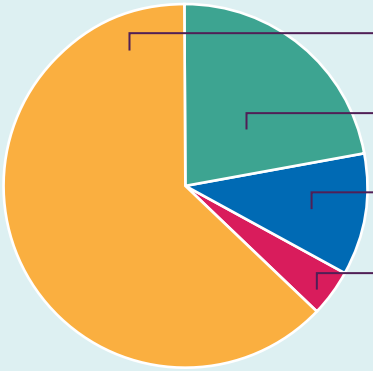


within 28 days
39% / 37 patients

within 42 days
42% / 40 patients

over 43 days
19% / 33 patients

DESTINATION ON DISCHARGE

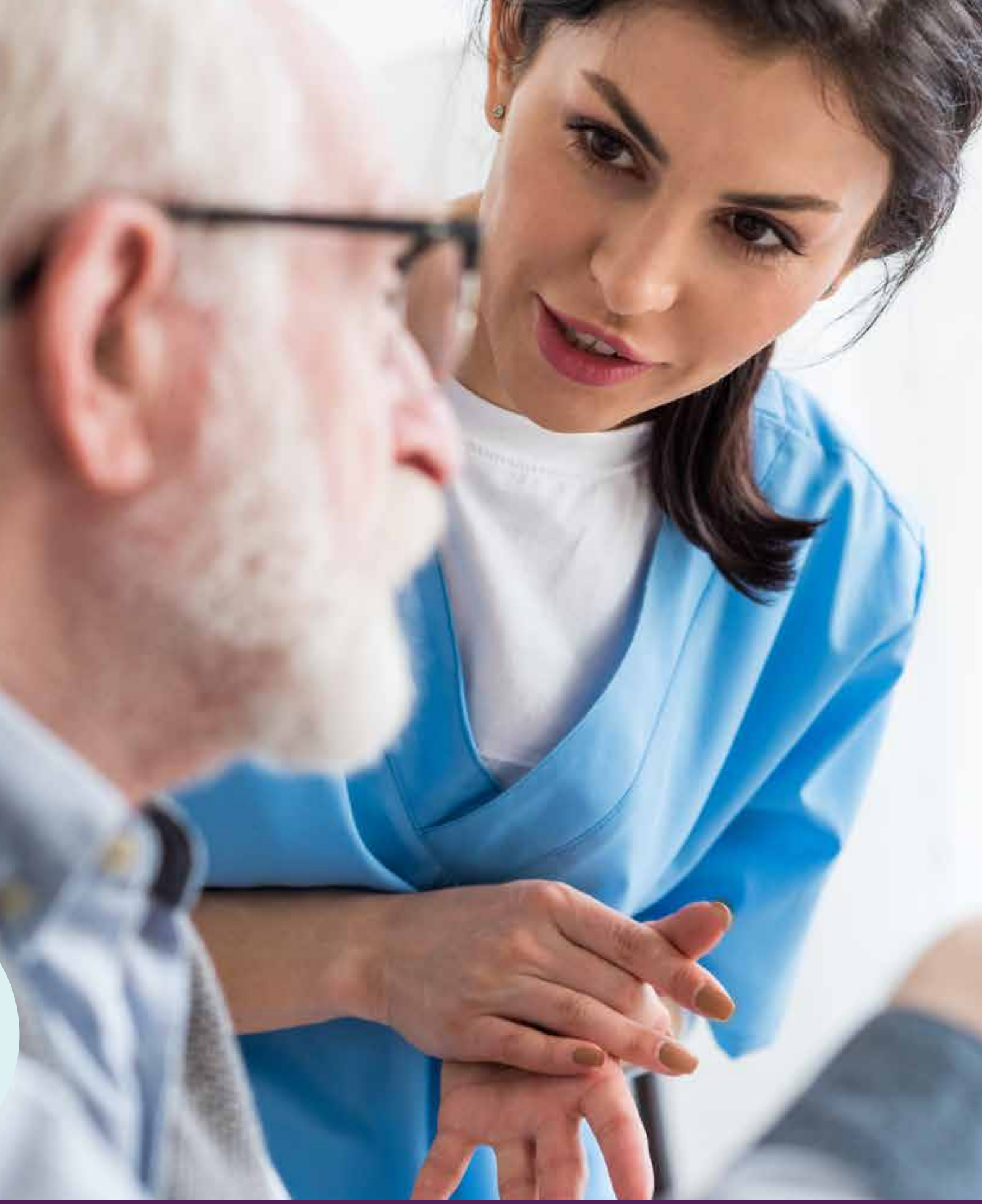


Home
63% / 59 patients

Long term care
22% / 21 patients

Hospital
11% / 11 patients

Deaths
4% / 4 patients

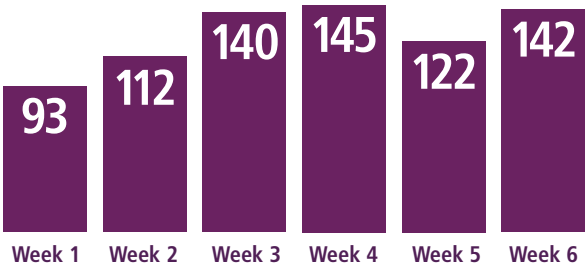


GP Streaming Pilot

754 patients were seen over the 6-week pilot

20 patients were referred back to emergency department (ED) after discussion with the ED consultants

Number of patients seen



47 onward referrals to other specialities

DEPARTMENT	NUMBERS
USS	15
Ortho	9
ENT	4
Cardiology	3
Lower GI	2
Ophthalmology	2
Paediatrics	2
Allergy clinic	1
Audiology	1
Breast	1
District nurses	1
Echo	1
Haematology	1
Minor surgery	1
Neurology	1
Psychology	1
SPOA	1

FEEDBACK FROM PATIENTS

60% of all patients seen provided feedback

100% of feedback about service delivery and staff was positive

- Kind and helpful
- Listened and understood
- Excellent service and kind GP
- Quick and efficient, safe environment
- Good service, friendly
- Lovely staff, seen very quickly
- Friendly receptionist
- Quick and professional

FEEDBACK FROM CLINICIANS

Both clinical and non-clinical staff were vital in the setup of the services and have provided constructive feedback and ideas about service delivery.

- Feedback loop with A&E working well
- Happy with support from management and daily check-ins by coordinator
- Would like more shifts
- Collecting greater patient feedback
- Built good relationships with FT and BARDOC

Experienced Nurse Network

EXPERIENCED NURSE NETWORK (ENN)

Following consultation with and requests from GP Practices, during 2020 the Federation developed a new Experienced Nurse Network to provide:

- **Cover in practices that were struggling to recruit a permanent practice nurse.**
- **Cover or extra support for Clinics such as smear & Flu clinics.**
- **Cover while current Nurses take up an advanced practitioner course.**
- **Cover for sickness and maternity leave.**

Since we launched the service in July, we have expanded the network from three nurses to eight.

We have provided a range of cover to practices and covered 75% of all requests received. This includes:

- **General Practice Nurse cover**
- **Cervical smears**
- **Child immunisations**
- **Flu vaccinations**

Practices have found this service most helpful to support them with:

- **Filling recruitment gaps**
- **Covering whilst their practice nurse is on holiday / sick leave / training /**

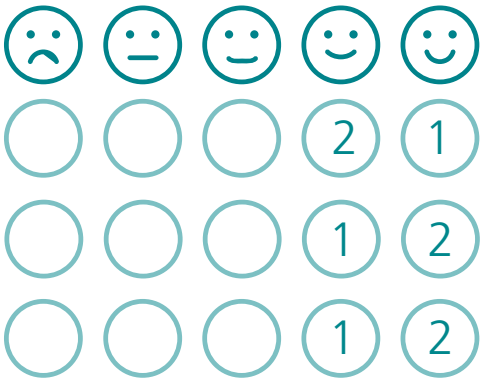
EXPERIENCED NURSE NETWORK (ENN)

Nurse Feedback

How have you found the administration, booking and general contact from the Federation?

How welcoming are the practices that you have supported?

How safe is your working environment?



	YES	NO	SOMETIMES	COMMENTS
Do practices make time for introductions and inductions, including sharing their practices protocol with you?	3			
Are the rooms set up with all of the equipment and stock in readiness for the clinics?	2	1		Usually are. However, if not, know where to obtain the equipment.
Are the PGDs available and ready for you to sign in advance of the clinics?	3			
Are your IT requirements set up appropriately in advance of your clinics?	1	2		There were issues at first that have now been resolved – always made sure that have gone a few days earlier to set up.
Are appropriate bookings/times allocated for your consultations?	2	1		Stonehill – issues with the amount of time booked for appointments (15 mins) for smear and ECG – Not sufficient cleaning time either.
Do you feel you get the right support when you are on site, such as GP support, other practice nurse support?	3			

COVID Vaccination Service

COVID-19 VACCINATIONS PROGRAMME

In December 2019 we began the delivery of the Covid Vaccination programme on behalf of 4 of Bolton's Primary Care Networks; Central, Chorley Roads, Farnworth & Kearsley and Rumworth.

This involved:

Setting up designated sites to meet NHSE standards and requirements

Employing a huge team of clinicians, pharmacists, vaccinators, runners, receptionists and admin support staff

Developing and co-ordinating a new site steward volunteering role in partnership with Bolton CVS

Working closely with Greater Manchester to ensure vaccine supply was able to meet the demand

Working closely with partners, such as Bolton NHS FT and the CCG to ensure our vaccine clinics were accessible to everyone who needed the vaccine

from december 2019 up to 31 March 2020, we had delivered over **1,050** hours of vaccinating

By 31 March we had given **36,879** people given their first dose and

1,530 people their second dose

68 clinics through Lever Chambers Health Centre and Avondale Health Centre

vaccinated **742** housebound residents in their homes

worked with GP practices and Bolton Council to deliver to **32** care homes, including staff and residents

We were the first in Bolton to take the vaccines out of the static sites and into the community, setting up and delivering pop-up clinics at Farnworth Health Centre, BRASS, Pikes Lane, Memory Lane and Great Lever and Harvey Children's Centres.

Our vaccine training hub is one of the first hubs in Greater Manchester and the only one in Bolton. It is led by Primary Care Workforce Development Team at Greater Manchester Health & Social Care Partnership.

Set up mid-January

20 people trained as vaccinators

including... physiotherapist, pharmacists, GP, learning disability nurses, dental professionals, retired GP, retired healthcare professionals

We aim to train at least **4** new vaccinators per week going forwards

> Kathryn was professional, very good with her delivery and had a wonderful calmness about her.

> It was really good, Kath is such a good teacher! I really enjoyed it and felt I got loads out of it.

> The session was very good, most useful to gain knowledge on the practical aspects of giving both vaccines... I have found it to be the most useful session in terms of vaccine training.

> Very good, personalised session with some hands on experience of vaccinating.

> I found the session really helpful and I valued the process pathway from start to finish. Kath was really easy to talk with and answered all my questions. I felt at ease and would definitely recommend [it].

> Great training session/refresher. Everything explained really well by Kath.

> I really enjoyed the session...Kathryn put you at ease and the small group of three made it more personal and a safe environment to ask questions. The support with then providing the injections was also excellent... I fail to see how you could make this set up any better to be honest.

OUR PRIMARY CARE NETWORKS

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

Central
Chorley Roads
Farnworth & Kearsley
HWL
Rumworth
Westhoughton

The Federation has employed a dedicated team to support PCNs, which includes the PCN Network Managers who assist the Clinical Directors with the organisation and project management of the contractual specifications, including the Directed Enhanced Service, such as early cancer diagnosis and support to care homes.

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

Social Prescribing Link Workers
Pharmacists
Pharmacy Technicians
First Contact Physiotherapists
Physician Associates

Training and development at the Federation is a high priority, and a number of opportunities which would further support networks were provided during 2020-21, including:

- **Network Managers undertaking Level 7 Diploma in Advanced Primary Care Management**
- **Social Prescribing Link Workers specialist training with NHSE**
- **Enrolling 10 newly recruited Pharmacists and 5 Pharmacy Technicians onto the CPPE path way**
- **One Pharmacist commenced on Level 7 MSc Advanced Clinical Practice – with plans for a further three to commence in 2021-22**

Each of the PCNs have a detailed Annual Report which sets out in more detail the progress they made during 2020-21 and the priorities they face for 2021-22 (See Appendix 1).

OUR PRIMARY CARE NETWORKS

In July 2019 PCNs became mandated by NHSE. As they were in the early stages of development, the Network Managers established the PCN boards during 2020 to further establish the relationships of all involved. This included working more closely with secondary care, community care and the voluntary and community sector.

As part of the Federation's role in supporting the development of PCNs, during Autumn 2020 a special event was developed and hosted on behalf of all 9 of Bolton's PCNs with care homes and other partners. This focussed on how PCNs could build on their good practice and work more closely with their local care homes.

During 2020-21, PCN Clinical Directors were also co-opted onto the Federation's formal board.

Alongside PCN 'business as usual' activities, the Federation has also developed and successfully delivered the Covid19 Vaccination programme on behalf of Central, Chorley Roads, Farnworth & Kearsley and Rumworth PCNs. This included the setting up and running of two main designated sites, plus delivering a variety of pop-up clinics to help take the vaccine out into the community.

VISION AND VALUES REVIEW

The Bolton GP Federation vision and objectives were written in 2016. These were:

Working Together to Support and Provide High Quality Services for Patients in Bolton, by

- **Developing Primary Care at scale on behalf of shareholder Bolton GP Practices.**
- **Providing and leading GP Provider voice in development of new models of care.**
- **Playing a significant role in meeting the challenges described in Bolton's Locality Plan to deliver a clinical and financially stable Health and social care system.**

In November 2020, Board agreed to review these and to develop a set of values which reflected our priorities and our culture.

In December 2020 and internal and external survey was carried out. The top answers from staff and partners included:

	INTERNAL (STAFF)	EXTERNAL (STAKEHOLDERS)
What makes you proud to be a part of the GP Fed team?	Teamwork! Patient centred care Good management	
What are your top three priorities?	Patient centred care PCN/GP support Serving the Bolton community	Supporting GPs Collaboration Bridging gaps in healthcare provision
What makes us stand out?	Staff support Providing access to services Innovation	Local community links Responsivity and solution focus Approachability
What would you change?	Better communication Better IT Rota/more sites/more team meetings/ more respect from partners	Be more visible / Communicative
What would you like to see?	Growth Improve relationships with partners Recognition	Growth Integration with ICP
Where could we expand?	Specialist clinics More sites A&E Streaming	Working at scale and understanding gaps and opportunities
Our biggest challenges are...	Pushback from partners ICP Capacity	System changes / changes to CCGs Funding Working with ICP

VISION AND VALUES NEXT STEPS

Our first next step will be to hold a staff away day to gather thoughts on our values and priorities for 2021-22.

Following this, we will work with our external brand and strategic communications partner to:

- **review our brand strategy and presence**
- **define our value propositions**
- **develop a communications strategy that is insight and commercially driven**
- **bring our vision and values to life in meangingful ways for our stakeholders**
- **undertake effective workforce engagement and training to promote integration and improve communication**

OUR PRIORITIES FOR 2021/2022

Organisation

- Organisational rebrand
- Review of organisational entity

PCNs

- To provide our PCNs with the Managerial support and workforce to deliver the DES
- To provide our PCNs with assurance that the DES requirements are being met
- To provide the 9 PCN's with an offer for the Extended Primary Care delivery that meets the needs of the PCNs and delivers a robust, equitable service
- To develop our operational development offer to PCNs
- To integrate our PCNs into neighbourhood teams

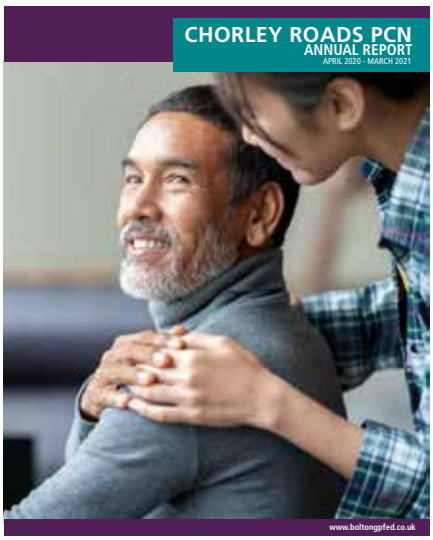
System

- Working in partnership to improve urgent care access and look to provide a primary care offer to A&E
- Working in partnership to improve local population health
- Working in partnership to develop innovation for improving health outcomes
- Working in partnership to improve GM wide population health and how this fits into a local delivery model.
- Bridge the gap between local primary care and GM delivery of primary care across Bolton

ANNUAL ACCOUNTS

PROFIT & LOSS £000s	2020/21	2019/20
Commissioned Income	4,459	2,571
Cost of Service	-3,952	-2,385
Gross Profit	507	366
Admin Expenses	-443	-360
Interest Payable	-7	-3
Corporation Tax	-12	-1
NET PROFIT	**45**	**2**

APPENDIX 1 - PCN ANNUAL REPORTS



Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

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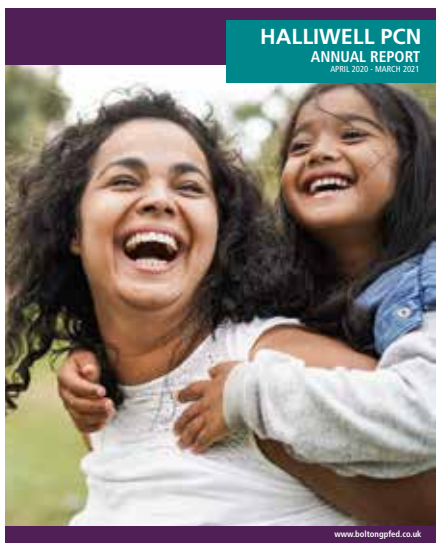

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CHORLEY ROADS PCN
ANNUAL REPORT
APRIL 2020 - MARCH 2021

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

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

It has simply been an extraordinary year. I have to thank the Practices for their regular attendance and engagement at the network meetings and hope that to some degree it has helped their resilience. The fact that we are all still standing, smiling and interacting suggests we are doing something right.

Initially, the show of support and offer of help to each other if needed in the early stages of the pandemic, whether it was used or not, is a testament to our cohesive nature, the sharing of information and willingness to share concerns and problems. Agreeing to be involved in the vaccination programme and working with the GP Federation to successfully hit high levels of coverage in Chorley Roads is something to be proud of, as well has maintaining fantastic levels of patient contacts throughout the pandemic well above the Bolton average.

We have worked cohesively to utilise our ARRS employees in helping achieve our network requirements. Hopefully, we can continue to do this and going forward look to try to integrate more with other services and work more effectively to deliver patient care.

I would like to thank our Network Manager who has made a huge difference in supporting me as Clinical Director.

Looking forward to working with you all in 2021-22.

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 2020/21, the Network Contract DES Directions come into force on 1 April 2020 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, have applied from that date.

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

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS (SMRS) AND MEDS OPTIMISATION
from 01/10/20

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

by 31/07/20

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

by 30/09/20

- Deliver Multi-Disciplinary Team (MDT) meetings with partners — ONGOING
- Develop personalised care and support plan — ONGOING

by 31/03/21

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

from 01/10/20

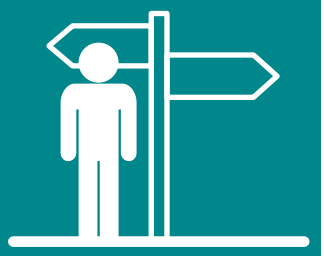
- Deliver a weekly home round — ONGOING
- Develop & refresh personalised care and support plans — ONGOING
- Identify/engage in shared learning — ONGOING
- Support with patient's discharge from hospital — ONGOING

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS
from 01/04/21

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

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

INVESTMENT AND IMPACT FUND

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

In Chorley Roads PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 5845
Number of vaccinations: 5008
% of patient population vaccinated: 85%

Patients on the LD register who received an LD health check

Patient population: 88
Number of LD checks carried out: 82
% of patients received health check: 93%

Number of patients referred to social prescriber

Target number of referrals: 262
Number of referrals: 273

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

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

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

This team will be expanded further during 2021/22

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

Enhanced Care in Care Homes workforce

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 was 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 within the network and complete a structured medication review. They also:

- attended weekly MDTs 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 with care home residents, and reduced medication waste.
- agreed what medicine the resident will take after the structured medication review and made sure they could use the medicines as prescribed.

CASE STUDY

STRUCTURED MEDICATION REVIEW

I carried our a structured medication review on a 96 year old lady in a care home on co-dydramol 10/500mg tablets. She took two tablets, four times a day. When I spoke to the carers they reported she was not in any pain, just took these tablets as prescribed regularly.

Co-dydramol is addictive, causes memory impairment, drowsiness, constipation and falls.

I discussed with the carer and the patient and we agreed to reduce it according to her pain. I reduced the co-dydramol from two tablets four times a day to two tablets twice a day for four weeks. The patient was fine, so we then reduced it to two tablets at night only and now the patient is taking it on a when-required basis. We have agreed to review this next week, with the intention of stopping co-dydramol and replacing with paracetamol on a when-required basis.

Overall, carers report the patient is not in any pain and her dose of laxative has reduced from 1–3 sachets daily to one daily.

Maryam Rehamn
PCN Pharmacist

STAFF FEEDBACK

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

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

Comments from staff included:

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

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

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

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

YOU SAID, WE DID

You wanted more face to face training /meetings

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

You wanted Improved digital presence and data

We set up a Chorley Roads website and purchased Arden's, improving our access to templates and reports

You said you wanted further training on Mental Health

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

You said you needed devices to allow working from home

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

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

We have structured presentations for the team

COVID-19 PROGRAMMES

Covid-19 Vaccination

The delivery of COVID-19 vaccinations for the Chorley Roads PCN began in mid-January 2021 through a designated site at Avondale Health Centre.
In the 10-week period through to 31 March 2021, Chorley Roads PCN delivered:

18 first dose clinics held at Avondale Health Centre

10,852 people given their first doses in the clinic

98 housebound patients visited and vaccinated

6 care homes visited and **335** staff and residents vaccinated

That's over **250** hours of vaccinating!

COVID-19 PROGRAMMES

Pulse oximetry

To help support the demand on GP Practices during Covid19, on 25 January 2021 Bolton's NHS Foundation Trust established a 14-day oximetry pathway for patients who had received a positive COVID-19 test result. This included providing the patient with an oximetry machine at home to monitor their oxygen levels, with regular calls from a health professional and clinical decisions on admission to hospital for further observations/treatment should the levels drop.

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

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

COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

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

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

BETWEEN 25 JANUARY AND 31 MARCH 2021

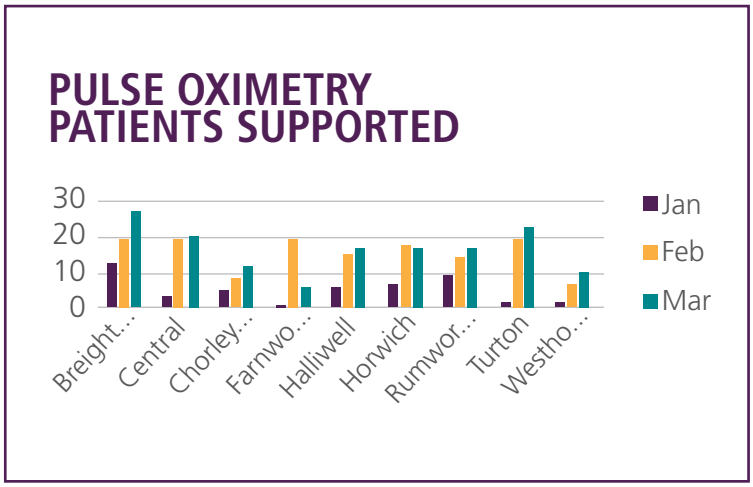
285 people were supported through the pathway.

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

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

A total of 25 patients from the Chorley Roads PCN area received support through this pathway

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



FINANCE

TYPE	TRANSACTION	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
ARRS Fund	ARRS - Staff	238,938	-238,938	0
CD	CD Payments	23,703	-23,703	0
Core	Fee by GPFed (1.25p/p)	49,244	-49,244	0
Ext Hours	Ext Hours Payment	47,602	-47,602	0
I&I Fund	Invoice to CCG	22,625	-5,637	16,988
Care Home Fund	Invoice to CCG	13,500	-13,365	135
Dev Fund 19/20	Development Costs	10,677	-5,275	5,402
Dev Fund 20/21	Development Costs	9,344	0	9,344
CD Extra Q4	CD Payments	17,793	-8,896	8,897
GRAND TOTAL		**433,424**	**-392,659**	**40,766**

PRIORITIES AND TARGETS FOR 2021/2

As the Network Manager for Chorley Roads PCN, my main priorities for 2021-22 will be:

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

Victoria Westwood
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

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

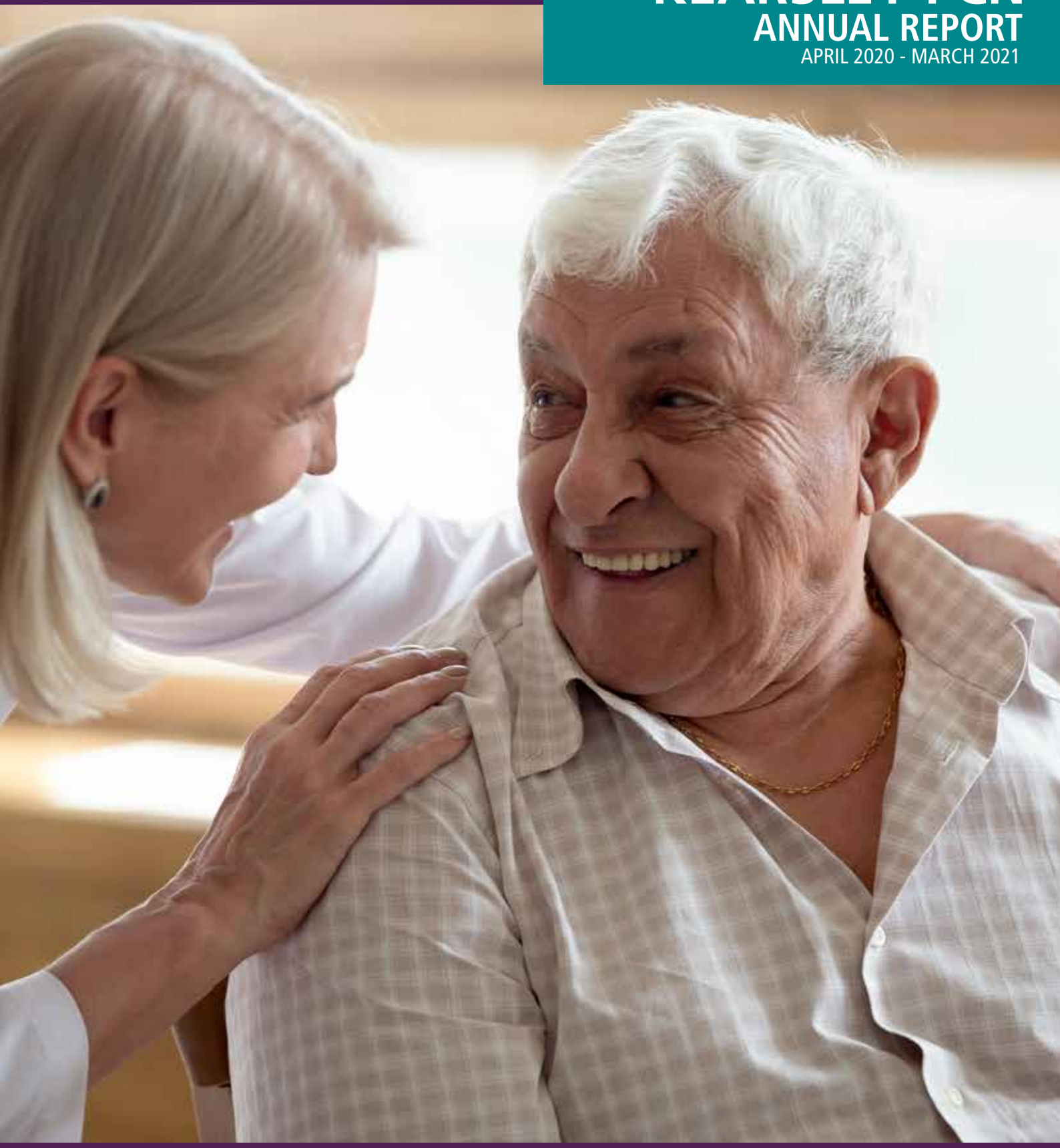
A PCN must provide to the PCNs patients access to a social prescribing service. To comply with this, a PCN may:	
Directly employ Social Prescribing Link Workers, or	
Where a PCN employs or engages a SPLW under the ARRS, the PCN must ensure that the SPLW:	
Has completed the NHS England and NHS Improvement 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 2020 - MARCH 2021



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Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

Dr George Ogden
Clinical Director
Farnworth & Kearsley Primary Care Network

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

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

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

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

by 31/07/20

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

by 30/09/20

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

by 31/03/21

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

from 01/10/20

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS
from 01/04/21

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

SOCIAL PRESCRIBING SERVICE

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

INVESTMENT AND IMPACT FUND

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

In Farnworth and Kearsley PCN:

Patients aged 65+ who received a seasonal influenza vaccination

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

Patients on the LD register who received an LD health check

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

Number of patients referred to social prescriber

Target number of referrals: 287
Number of referrals: 376

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

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

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

This team will be expanded further during 2021/22.

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

Enhanced Care in Care Homes

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

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

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

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

BACKGROUND

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

SUPPORT OFFERED

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

SERVICES OFFERED

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

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

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

PATIENT OUTCOME

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

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

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

Tyler O'Neill
PCN Social Prescribing Link Worker

STAFF FEEDBACK

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

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

Comments from staff included:

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

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

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

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

YOU SAID, WE DID

You wanted regular monthly reviews

All members of staff are offered regular catch ups

You wanted more face to face training /meetings

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

You said you wanted further training on Mental Health

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

You said you needed devices to allow working from home

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

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

We have structured presentations for the team

COVID-19 PROGRAMMES

COVID-19 vaccination

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

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

50 first dose clinics held at Lever Chambers

26,027 first dose vaccinations given at Lever Chambers

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

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

644 housebound residents were vaccinated in their homes

26 care homes visited

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

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

COVID-19 PROGRAMMES

Pulse oximetry

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

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

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

COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

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

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

BETWEEN 25 JANUARY AND 31 MARCH 2021

285 people were supported through the pathway.

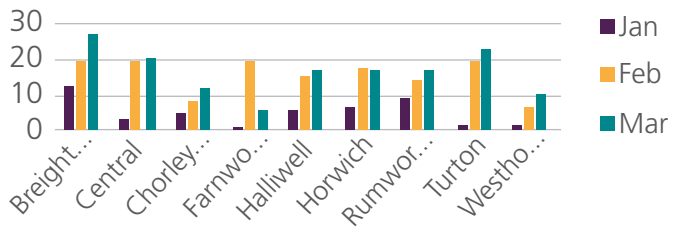
28 people (**9.8%**) were sent to hospital with **96.4%** of these being admitted for treatment.

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

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

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

PULSE OXIMETRY PATIENTS SUPPORTED



FINANCE

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

PRIORITIES AND TARGETS FOR 2021/2

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

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

Victoria Westwood
Farnworth and Kearsley Network Manager
Bolton GP Federation

APPENDIX 1
ADDITIONAL ROLES REIMBURSEMENT SCHEME (ROLE REQUIREMENTS)

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

SOCIAL PRESCRIBING LINK WORKER

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

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

Complete Ongoing

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

WESTHOUGHTON PCN

ANNUAL REPORT

APRIL 2020 - MARCH 2021

Marge Bradshaw Photography

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

The past 12 months has been a very challenging year.

I am really proud that with the GP Federation support we have managed to spend the majority of our Additional Roles Reimbursement Scheme (ARRS) budget in 2020-21. These staff members have been integral in supporting practices through the Covid pandemic. I am excited to welcome a new Physician Associate in the next few months and it will be interesting to see how these roles fit within our PCN.

Our network has done a phenomenal job with the Covid vaccination programme and I'm hugely proud of how the network practices have worked together to deliver this. The support and advice from the Federation and across all networks has been vital to me as Clinical Director, ensuring this success.

Our social media campaign which we utilised PCN development funding to springboard has been a hugely successful method of information delivery to patients, with over a thousand followers across Facebook and Twitter. This is run with the support of our Social Prescribers, who have done a fabulous job alongside the wonderful work they are doing to connect patients with community assets.

Next year I'm looking forward to expanding the workforce further. I'm keen to continue to share successes of the network with our 'highlight reports' and patient stories. I'm looking for some simple and straightforward assurance documents to ensure that I'm confident that we are delivering our DES contracts and maximising our potential income, whilst delivering good patient care across our network.

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 2020/21, the Network Contract DES Directions come into force on 1 April 2020 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, have applied from that date.

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

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

by 31/07/20

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

by 30/09/20

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

by 31/03/21

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

from 01/10/20

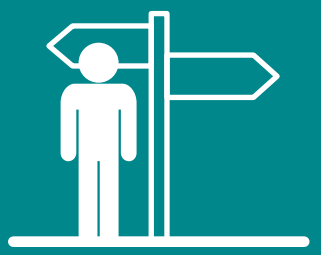
- Deliver a weekly home round — ONGOING
- Develop & refresh personalised care and support plans — ONGOING
- Identify/engage in shared learning — ONGOING
- Support with patient's discharge from hospital — COMPLETE

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS
from 01/04/21

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

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

INVESTMENT AND IMPACT FUND

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

In Westhoughton PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 1462
Number of vaccinations: 1204
% of patient population vaccinated: 82%

Patients on the LD register who received an LD health check

Patient population: 20
Number of LD checks carried out: 11
% of patients received health check: 55%

Number of patients referred to social prescriber

Target number of referrals: 222
Number of referrals: 227

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

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

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

This team will be expanded further during 2021/22.

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

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

CASE STUDY

I work with a lady who has mental health concerns and Agrophobia, she lives with her son who suffers with severe anxiety. Her personal independence payment (PIP) was taken off her which resulted in her getting into debt, not even having enough money to buy food, this led her to feeling low and isolated. My first action was to get her an emergency food parcel and showed her the website where she could buy subsidised parcels from in the future, she found this very helpful. I referred her to Money Skills to help with her debts and for some Bereavement Counselling to support her with recent loss. I introduced a Befriender to support her and they are in regular contact. My next step was to make contact with Starts with You and they are going to support her to appeal the PIP decision. I noticed that she spoke very slowly and seemed a little confused, she shared that is on a lot of medication, we talked about it and I have referred her for a medications review. My work with this lady is ongoing.

CASE STUDY

I received a referral for a lady in her 40's with low mood and wanting to lose weight.

She has 2 adult sons who live at home who can become quite aggressive at times. The house only has 2 bedrooms, so she sleeps on the couch. She was very isolated, not happy about how she struggled to get around and her weight.

Her parents bought her a laptop which she was struggling to use, she shared that she would like to attend a college course but couldn't send them an email to ask about registration.

We discussed the IRIS programme and how they could offer some help around the tensions in the home, we also discussed options of looking for a house with more bedrooms and how I could support her with the process.

She agreed to a referral to the HIP and she has been engaging with the service, is losing weight and is starting to feeling better about herself.

I referred her to Ava the digital assistant from Starts with You to support her with using technology. Ava speaks with her once a week. She now has her email and internet set up, has attended a college course and completed it. She has also made enquiries about starting a new course later in the year.

Independent Living had been to meet with her previously and provided some adaptations in her home, however, they didn't bring a toilet frame and it was a struggle for her to get on/off the toilet – I made a referral for the toilet seat.

I worked with this lady for a number of months, until she said that she was feeling good. I have now signed her off from Social Prescribing.

Julie Wright
PCN Social Prescribing Link Worker

STAFF FEEDBACK

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

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

Comments from staff included:

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

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

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

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

YOU SAID, WE DID

You wanted regular monthly reviews

All members of staff are offered regular catch ups

You wanted more face to face training /meetings

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

You said you wanted further training on Mental Health

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

You said you needed devices to allow working from home

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

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

We have structured presentations for the team

COVID-19 PROGRAMMES

Covid-19 Vaccination

The delivery of COVID-19 vaccinations for the Westhoughton PCN began in mid-January 2021 through a designated site at Peter House Surgery.
In the 10-week period through to 31 March 2021, Westhoughton PCN delivered:

12 first dose clinics held

10,050 people given their first doses in the clinic

142 housebound patients visited and vaccinated

4 care homes visited and **3** assisted living care homes visited

235 care home staff and residents vaccinated

That's over **84** hours of vaccinating!

Marge Bradshaw Photography

COVID-19 PROGRAMMES

Pulse oximetry

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

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

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

COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

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

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

BETWEEN 25 JANUARY AND 31 MARCH 2021

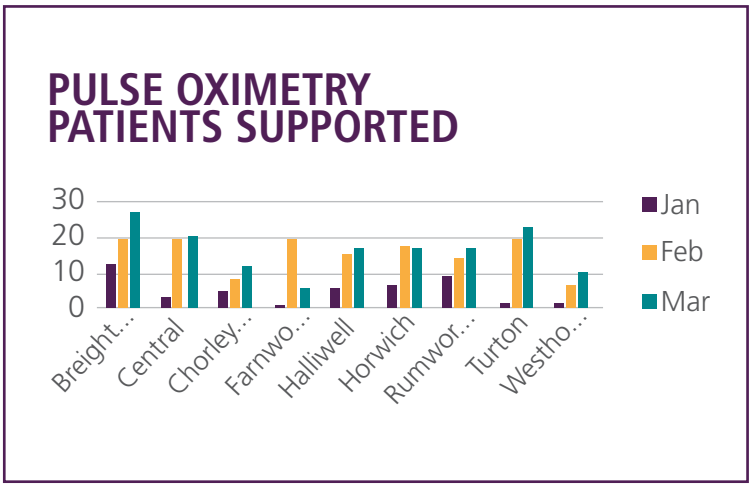
285 people were supported through the pathway.

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

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

A total of 19 patients from the Westhoughton PCN area received support through this pathway.

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



FINANCE

TYPE	TRANSACTION	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
ARRS Fund	ARRS - Staff	199,911	-199,911	0
CD	CD Payments	20,012	-20,012	0
Core	Fee by GPFed (1.25p/p)	41,576	-34,646	6,929
Ext Hours	Ext Hours Payment	40,190	-40,190	0
I&I Fund	Invoice to CCG	21,457	0	21,457
Care Home Fund	Invoice to CCG	8,880	-8,880	0
Dev Fund 19/20	Development Costs	9,975	-9,975	0
Dev Fund 20/21	Development Costs	7,889	-2,547	5,341
CD Extra Q4	CD Payments	15,023	-15,023	0
GRAND TOTAL		**364,911**	**-331,184**	**33,728**

REFLECTIONS AND PRIORITIES FOR 2021/2

Working alongside Dr Matta and the practices in Westhoughton PCN has been an absolute pleasure. Although it has been a tough year both with the pandemic and embedding lots of new recruits into the network, it has truly strengthened relationships and shaped the way forward for joint working.

While having oversight of the DES requirements for this year I also hope to provide the PCN with some valuable data and ideas for future project work. I am looking forward to seeing how the PCN will continue to develop over the next 12 months.

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

SOCIAL PRESCRIBING LINK WORKER

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

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

Complete Ongoing

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

CENTRAL PCN
ANNUAL REPORT
APRIL 2020 - MARCH 2021

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

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

The past 12 months have proven the resilience of Bolton Central Primary Care Network's services and adaptability to face the unforeseen challenges posed by impact of Covid 19 under leadership of Clinical Director Dr. Abdul Atcha and co-ordination of PCN Manager Kristy Barlow.

A major challenge was around Covid vaccination campaign. The staff in all the GP practices and Bolton GP Federation worked very hard to invite the patients and co-ordinate the vaccination respectively. Multiple sites were set up with a structured plan to manage the demand and flow of patients with appropriate clinical governance. The supply of Covid Vaccine would become available on short notice and all the appointments will fill up rapidly.

The concerns around worsening spread of Covid infection were met with urgent changes in strategy and a walk-in & bus service were set up to facilitate our patient's uptake of Covid vaccination. The hard work continues around inviting the difficult to reach population groups for this campaign.

A major challenge laid around workforce planning and hiring the additional clinical staff including Pharmacists and acquiring support of Physiotherapists and Mental Health Practitioners in Primary Care. There are strict criteria around hiring of staff and it was tactfully co-ordinated by the Network Manager.

All the DES work has been overseen by the Bolton GP federation's managerial staff and timely submissions have been completed by the Network Manager.

Having stepped into the post of Clinical Director since April, I feel humbled by the responsibility and I have seen the fascinating hard work and co-ordination of Dr Atcha & Kristy Barlow. My priorities in the course of this year would be to help standardize some of the work across the practices in our Network and look at system efficiencies which are within the remit of Primary Care Network's services.

I would aim to work constructively with member practices and ensure that the workforce of Primary Care Network is able work in a standardised and efficient way supporting our patients, particularly the vulnerable patients with Learning Difficulties and those who are living in nursing homes.

I would aim to work on sharing good practice in optimising medication to reduce any risks associated with prescribed medication as well.

I feel well supported by our new Network Manager Matthew Mann and Deputy Manager Georgina Kilmartin and I am grateful for the confidence by my GP colleagues and Practice Managers.

Dr Adil Khan
Clinical Director
Central Primary Care Network

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by 31/07/20

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- Have a simple plan in place — COMPLETE
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- SPLW to comply with para3 Annex B (see appendix 1 for details of requirements and compliance) — ONGOING

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

In Central PCN:

The table below shows the points that were achieved and IIF awarded. These awards were based on:

- The number of patients aged 65+ who received a seasonal influenza vaccination
- The number of patients on the Learning Disability (LD) register who received and LD health check
- The number of patients referred to a social prescriber

ACHIEVED POINTS	ACHIEVED POUNDS	MAXIMUM POINTS
142.20	£8,957.98	194.00

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

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

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

This team will be expanded further during 2021/22.

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

CASE STUDY

STRUCTURED MEDICATIONS REVIEW

Video consultations via AccuRx have been helpful during the lockdown period. Where you would usually call a patient and say the name of the medication you are trying to counsel them about, accuRx allows me to see the patient and ask them to hold up the medication box for me to see – this helps the patients understanding.

It's been interesting to see how patients store medications in their own homes. I've now seen cupboards full of Movicol all very neatly stacked up and medication bags left on windowsills where they can be degraded by the sun. Video consultations have allowed us to have an insight you could never gain unless you attend the house in person.

There is still a long way to go with the over 70s; the IT is too technical for some.

Hafeeza Bhaiyat
Senior PCN Practice Based Pharmacist

STAFF FEEDBACK

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

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

Comments from staff included:

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

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

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

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

YOU SAID, WE DID

You wanted regular monthly reviews

All members of staff are offered regular catch ups

You wanted more face to face training /meetings

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

You said you wanted further training on Mental Health

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

You said you needed devices to allow working from home

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

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

We have structured presentations for the team

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Central PCN began in mid-December 2020 following a collaboration agreement to run the clinic through a designated site at Lever Chamber Health Centre. In the 14-week period through to 31 March 2021, the Rumworth, Central and Farnworth & Kearsley collaboration delivered:

50 first dose clinics held at Lever Chambers

26,027 first dose vaccinations given at Lever Chambers

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

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

644 housebound residents were vaccinated in their homes

26 care homes visited

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

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

COVID-19 PROGRAMMES

Pulse oximetry

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

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

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

COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

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

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

BETWEEN 25 JANUARY AND 31 MARCH 2021

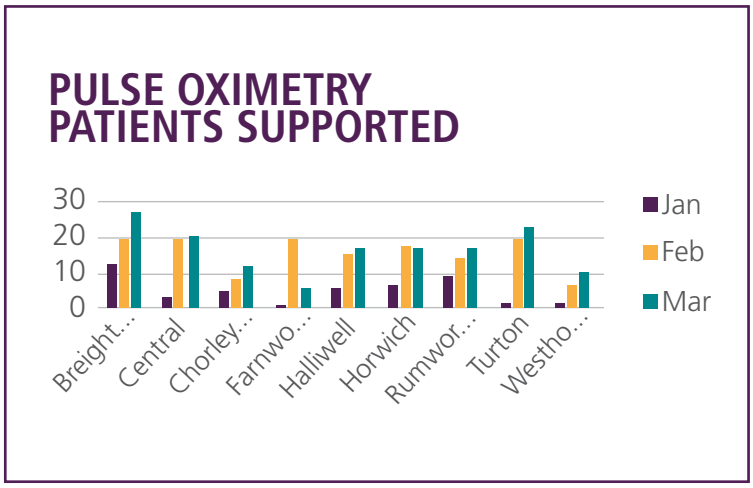
285 people were supported through the pathway.

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

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

A total of 32 patients from the Central PCN area received support through this pathway.

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



FINANCE

TYPE	TRANSACTION	INCOME £	EXPENDITURE £	BALANCE UNSPENT £
ARRS Fund	ARRS - Staff	319,178	-319,178	-0
2019/20 b/f	Clawback Retainer	11,415	0	11,415
CD	CD Payments	34,000	-34,000	-0
Core	Fee by GPFed (1.25p/p)	70,637	-58,864	11,773
Ext Hours	Ext Hours Payment	68,282	-68,282	0
I&I Fund	Invoice to CCG	21,043	-5,532	15,511
Care Home Fund	Invoice to CCG	17,580	-13,035	4,545
Dev Fund 19/20	Development Costs	12,541	-6,220	6,321
Dev Fund 20/21	Development Costs	13,403	0	13,403
CD Extra Q4	CD Payments	25,523	0	25,523
GRAND TOTAL		**593,601**	**-505,110**	**88,491**

REFLECTIONS AND PRIORITIES FOR 2021/2

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

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

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

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

Matthew Mann
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

SOCIAL PRESCRIBING LINK WORKER

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

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

Complete Ongoing

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

HALLIWELL PCN
ANNUAL REPORT
APRIL 2020 - MARCH 2021

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

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

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

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

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

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

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

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

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

Alison Lyon
Clinical Director
Halliwell Primary Care Network

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

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

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

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

by 31/07/20

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

by 30/09/20

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

by 31/03/21

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

from 01/10/20

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS
from 01/04/21

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

SOCIAL PRESCRIBING SERVICE

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

INVESTMENT AND IMPACT FUND

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

In Halliwell PCN:

Patients aged 65+ who received a seasonal influenza vaccination

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

Patients on the LD register who received an LD health check

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

Number of patients referred to social prescriber

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

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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- Clinical Pharmacists
- Pharmacy Technician
- Musculoskeletal (MSK) First Contact Physiotherapists

This team will be expanded further during 2021/22.

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

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

CASE STUDY

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

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

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

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

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

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

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

CASE STUDY

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

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

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

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

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

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

Jayne Spotswood
PCN Social Prescribing Link Worker

STAFF FEEDBACK

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

- The majority of staff strongly agreed or agreed that the last year working in a primary care network for Bolton GP Federation had been professionally satisfying.
- 96% of people would recommend the GP Federation to their colleagues and peers.
- Most people strongly agreed or agreed that they felt well integrated into their network.
- 80% of people felt supported by management and know who to come to with any issues.
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Comments from staff included:

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

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

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

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

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

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

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

COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

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

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

BETWEEN 25 JANUARY AND 31 MARCH 2021

285 people were supported through the pathway.

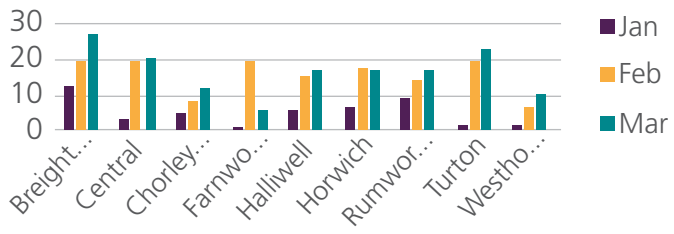
28 people (**9.8%**) were sent to hospital with **96.4%** of these being admitted for treatment.

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

A total of 38 patients from the Halliwell PCN area received support through this pathway.

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

PULSE OXIMETRY PATIENTS SUPPORTED



FINANCE

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

REFLECTIONS AND PRIORITIES FOR 2021/2

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

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

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

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

Matthew Mann
Halliwell Network Manager
Bolton GP Federation

APPENDIX 1
ADDITIONAL ROLES REIMBURSEMENT SCHEME (ROLE REQUIREMENTS)

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

SOCIAL PRESCRIBING LINK WORKER

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

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

Complete Ongoing

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

RUMWORTH PCN
ANNUAL REPORT
APRIL 2020 - MARCH 2021

www.boltongpfed.co.uk

Prepared by:
Dawn Lythgoe, Strategic Lead for Performance and Programmes

BOLTON GPFEDERATION

CONTENTS

EXECUTIVE SUMMARY AND INTRODUCTION

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

The 2020/21 year has been challenging with the wide-reaching effects of Covid. The priorities of the PCN altered rapidly as a result, especially more recently with the Rumworth area being hard hit with the new variant and there being a major vaccine push.

Rumworth has been exceptionally well supported by Bolton GP Federation and by network manager Matthew Mann including the recruitment and management of ARRS staff and with the vaccine action programme. In addition, Matthew has ensured that all submissions such as the DES requirements work and information for the CCG has been completed in a timely manner. He has coordinated the monthly PCN meetings and gathered local speakers such as those involved in cancer screening.

Matthew has been invaluable in the support he has provided and Rumworth network would not be as successful if not for his input.

We are looking forward to the addition of Georgina Kilmartin to the network team and our continued working with the Federation in the year to come.

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 2020/21, the Network Contract DES Directions come into force on 1 April 2020 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, have applied from that date.

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

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

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS (SMRS) AND MEDS OPTIMISATION
from 01/10/20

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

ENHANCED HEALTH IN CARE HOMES

by 31/07/20

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

by 30/09/20

- Deliver Multi-Disciplinary Team (MDT) meetings with partners — ONGOING
- Develop personalised care and support plan — ONGOING

by 31/03/21

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

from 01/10/20

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS
from 01/04/21

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

SOCIAL PRESCRIBING SERVICE

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

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INVESTMENT AND IMPACT FUND

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

In Rumworth PCN:

Patients aged 65+ who received a seasonal influenza vaccination

Patient population: 4,195
Number of vaccinations: 3,335
% of patient population vaccinated: 79%

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

Patient population: 116
Number of LD checks carried out: 106
% of patients received health check: 91%

Number of patients referred to social prescriber

Target number of referrals: 242
Number of referrals: 237
% of target reached: 98%

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

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

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

This team will be expanded further during 2021/22.

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

Enhanced Care in Care Homes

In the Rumworth PCN there are 4 care homes with 243 residents.

CASE STUDY

STRUCTURED MEDICATION REVIEW

The patient had been struggling with compliance with Atorvastatin, forgetting to take it as all their other medicines were taken in the morning. The discussion was initiated around the risk-benefit of taking the statin as the patient is over 85 years of age. After discussion, the patient decided to stop taking it and medication was stopped.

We also discussed the patient taking aspirin and rivaroxaban with no PPI gastro-protection. I explained the NICE guidance and we talked through the risks of GI haemorrhage and the patient opted to start PPI after a discussion of risks/benefits.

We also talked about diet, bowel habit, lifestyle and exercise. I was able to answer queries regarding compression stockings and gave them an emollient for dry skin on lower limbs along with advice on application.

Graeme King
PCN Pharmacist

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

I received a referral from a GP after he had visited a patient who was getting mixed up with her medication. She had lots of medication in the house as she was forgetting to take it.

I contacted the patient and we discussed the problem she was having. Her medication was already set up and delivered from the chemist in a dosette box but this was not working for her.

I informed her of the medication prompt boxes that Telecare can provide for a small cost. We spoke about how they work and I explained someone would contact her to arrange a visit to demonstrate and to see if it was something she could manage.

The patient agreed for me to send in a referral to Telecare on her behalf so we completed the form together over the phone and I emailed it to them. I received an email back to say it had been received and would be triaged and actioned as soon as possible. Telecare were dealing with a lot of hospital discharges at this time due to COVID-19.

I rang the patient back to inform her it may be a few weeks due to the current situation and she was happy with this.

Four weeks after the referral I contacted the patient and all was in place. She was now able to take her medication at the right time and not miss any.

This has enabled this patient to keep her independence and she does not have to rely on family members or carers to prompt her to take her medication.

I have been contacting patients who are on the learning disability list who are due an annual review or have recently had one.

During our conversation this patient mentioned they had received a letter from Bolton Council about the level access shower. They had tried to contact them on a few occasions. As the council were unable to make contact on the telephone number provided they sent a letter giving the patient a 14 day period to get in contact.

The patient not been able to contact the person named on the letter and was worried the issue with the shower would not get resolved or would take longer to resolve.

The letter highlighted that the land line number was not working, but as the patient uses a mobile they never realised there was a fault.

With their permission, I contacted Bolton Council with an alternative contact number. The council have since been in contact and the issue with the shower is being looked into.

The phone company has been out and fixed the fault with the land line. The patient said she is now checking the phone regularly to make sure it works.

She thanked me for my initial call, without which this issue would still be ongoing. The patient didn't know this service was avilable and was very thankful for the support.

Jayne Filio
PCN Social Prescribing Link Worker

STAFF FEEDBACK

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

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

Comments from staff included:

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

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

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

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

YOU SAID, WE DID

You wanted regular monthly reviews

All members of staff are offered regular catch ups

You wanted more face to face training /meetings

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

You said you wanted further training on Mental Health

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

You said you needed devices to allow working from home

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

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

We have structured presentations for the team

COVID-19 PROGRAMMES

COVID-19 vaccination

The delivery of COVID-19 vaccinations for Rumworth PCN began in mid-December 2020 following a collaboration agreement to run the clinic through a designated site at Lever Chamber Health Centre. In the 14-week period through to 31 March 2021, the Rumworth, Central and Farnworth & Kearsley collaboration delivered:

50 first dose clinics held at Lever Chambers

26,027 first dose vaccinations given at Lever Chambers

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

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

644 housebound residents were vaccinated in their homes

26 care homes visited

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

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

COVID-19 PROGRAMMES

Pulse oximetry

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

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COVID-19 PROGRAMMES

Pulse oximetry

PATIENTS SAID

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

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

BETWEEN 25 JANUARY AND 31 MARCH 2021

285 people were supported through the pathway.

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

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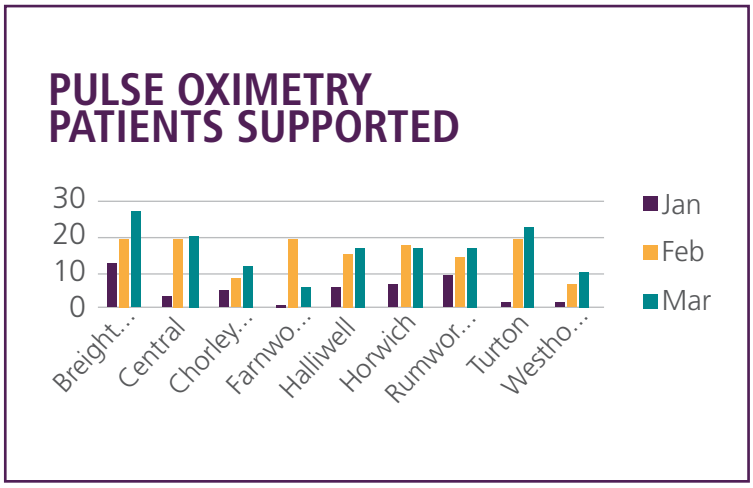

FINANCE

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Ext Hours	Ext Hours Payment	42,833	-42,833	0
I&I Fund	Invoice to CCG	20,410	-14,665	5,745
Care Home Fund	Invoice to CCG	15,240	-15,360	-120
Dev Fund 19/20	Development Costs	10,218	-9,600	618
Dev Fund 20/21	Development Costs	8,407	0	8,407
CD Extra Q4	CD Payments	16,011	-8,005	8,005
GRAND TOTAL		**398,997**	**-368,957**	**30,040**

REFLECTIONS AND PRIORITIES FOR 2021/2

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

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

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

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

Matthew Mann
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

SOCIAL PRESCRIBING LINK WORKER

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

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

Complete Ongoing

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