

# FARNWORTH AND KEARSLEY PCN ANNUAL REPORT

APRIL 2021–MARCH 2022



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



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## EXECUTIVE SUMMARY AND INTRODUCTION

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

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

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

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

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

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

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

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

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



Dr George Ogden  
Clinical Director  
Farnworth & Kearsley Primary Care Network

## **DELIVERING THE DIRECTED ENHANCED SERVICE (DES)**

The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2021/22, the Network Contract DES Directions came into force on 1 April 2021 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, have applied from that date.

The requirements for 2021/22 were themed around:

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

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

## DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



### STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

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



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## DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

### ENHANCED HEALTH IN CARE HOMES

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



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## DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

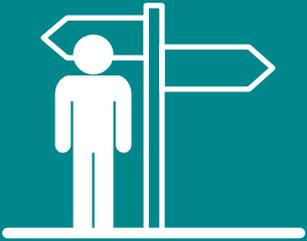


### EARLY CANCER DIAGNOSIS

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



## DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



### SOCIAL PRESCRIBING SERVICE

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



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

### In Farnworth & Kearsley PCN:

#### **Patients aged 65+ who received a seasonal influenza vaccination**

Patient population: 5,028

Number of vaccinations: 4,581

% of patient population vaccinated: 91%

#### **Patients on the LD register who received an LD health check**

Patient population: 233

Number of LD checks carried out: 190

% of patients received health check: 82%

#### **Number of patients referred to social prescriber**

Threshold: 0.8–1.2%

Target number of referrals for lower threshold: 289

Number of referrals: 282 = 0.78%

## DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

During 2021–22, Bolton GP Federation successfully accessed all its ARRS allocation on behalf of the six PCNs it supports. In Farnworth & Kearsley Primary Care Network, during 2021–22, we recruited additional ARRS team members which included:

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

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

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

### Farnworth & Kearsley ARRS team:

#### CLINICAL PHARMACISTS

Sabiha Patel  
Apyrl Yap  
Kasim Altaf

#### PHARMACY TECHNICIANS

Lauren Antoni  
Emma Booth  
Charlotte Hill

#### MSK

Paul Edney  
Harry Theocharous

#### MHP

Matthew Wood

#### SPLW

Tyler O'Neill  
Jayne Spotswood

#### PARAMEDICS

Rachael Glennon  
Cheryl Schofield

## DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

## CASE STUDY

## MENTAL HEALTH

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

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

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

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

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

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

**Matthew Wood**  
Senior Mental Health Practitioner

## STAFF FEEDBACK

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

### **Jayne – Social Prescriber Link Worker**

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

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

### **Emma – Pharmacy Technician**

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

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

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

### **Rachel – Paramedic**

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

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

### **Apryl – Pharmacist**

## YOU SAID, WE DID

*You felt that SPLWs needed clinical support*

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

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

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

## MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

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

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

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

### Overall feedback

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

### Satisfaction questionnaires

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

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

### Common themes

Common themes emerging from all of the feedback collected were:

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

## MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:



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

***“I can’t speak highly enough of him.”*** (patient feedback)

***“Excellent health professional who listened to me compassionately.”*** (patient feedback)

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

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

***“She was amazing.”*** (patient feedback)

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

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



## COVID-19 PROGRAMMES

### COVID-19 vaccination

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

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

**139,717** vaccinations

**198** clinics held between Lever Chambers & Market Place

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

**1,577** housebound residents were vaccinated in their homes

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



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## COVID-19 PROGRAMMES

### Pulse oximetry

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

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



## COVID-19 PROGRAMMES

### Pulse oximetry

#### BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

**3,617** people were supported through the pathway.

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

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

## PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

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

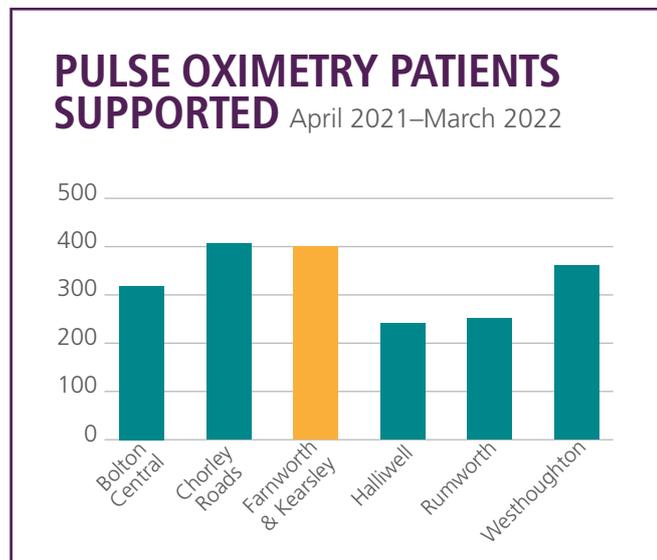
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

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

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

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

PCN	No. patients
Brightmet & Little Lever	484
<b>Bolton Central</b>	311
<b>Chorley Roads</b>	408
<b>Farnworth &amp; Kearsley</b>	<b>399</b>
Halliwell	241
Horwich	432
<b>Rumworth</b>	255
Turton	653
<b>Westhoughton</b>	378
OOA	56
<b>All Bolton</b>	<b>3,617</b>



## FINANCE

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

## PRIORITIES AND TARGETS FOR 2022/23

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

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

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

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

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



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

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

Victoria Westwood  
Farnworth and Kearsley Network Manager  
Bolton GP Federation

## **APPENDIX 1 ADDITIONAL ROLES REIMBURSEMENT SCHEME (ROLE REQUIREMENTS)**

■ Complete
 ■ Ongoing

<b>CLINICAL PHARMACISTS</b>	
<b>Ensure that the CP is enrolled in, or has qualified from, an approved 18-month training pathway or equivalent that equips the CP to:</b>	
Be able to practice and prescribe safely and effectively in a Primary Care setting	
Deliver the key responsibilities outlined in section B1.2	
<b>Ensure that each CP has the following responsibilities:</b>	
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-centred 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

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

■ Complete
 ■ Ongoing

<b>MUSCULOSKELETAL (MSK) FIRST CONTACT PRACTITIONER</b>	
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	

<b>MSK FIRST CONTACT PRACTITIONER (CONTINUED)</b>	
<b>Develop integrated and tailored care programmes in partnership with patients through:</b>	
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

<b>MENTAL HEALTH PRACTITIONER</b>	
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	

## 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

<b>SOCIAL PRESCRIBING LINK WORKER (CONTINUED)</b>	
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	
<b>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:</b>	
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.	
<b>A PCN must be satisfied that organisations and groups to who the SPLW directs patients:</b>	
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.	