WESTHOUGHTON PCN
ANNUAL REPORT
APRIL 2021–MARCH 2022

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BOLTON GPFEDERATION

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EXECUTIVE SUMMARY AND INTRODUCTION

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

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

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

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

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

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

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

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

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

Dr Bev Matta
Clinical Director, Westhoughton Primary Care Network

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

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

The requirements for 2021/22 were themed around:

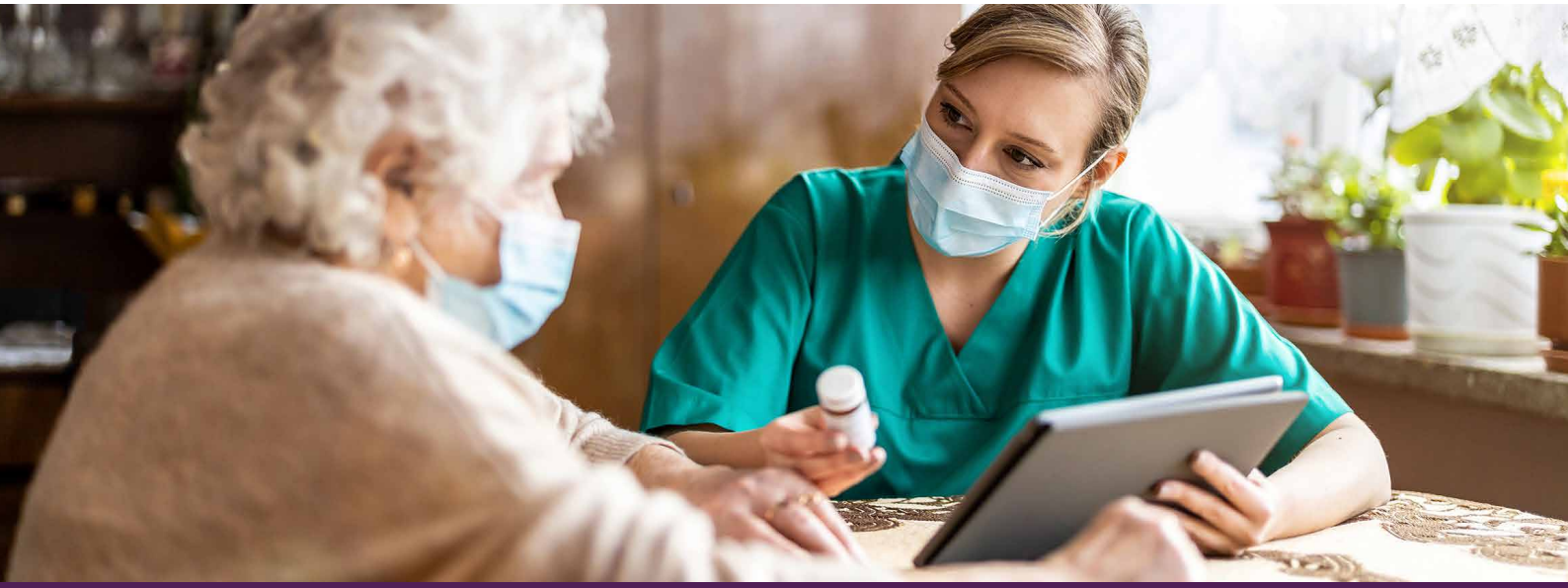
- Early Cancer Diagnosis
- Structured Medication Reviews
- Enhanced Health in Care Homes
- Social Prescribing

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

DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

STRUCTURED MEDICATION REVIEWS AND MEDS OPTIMISATION

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



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

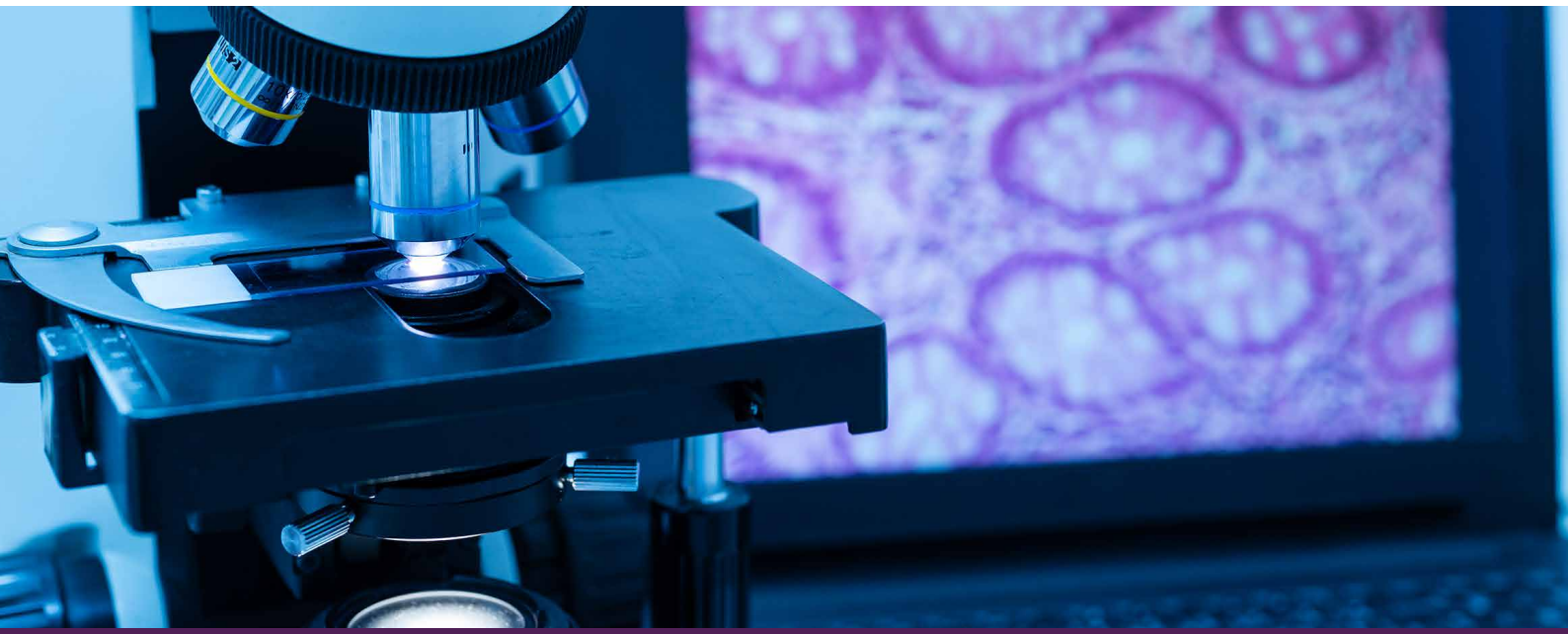
ENHANCED HEALTH IN CARE HOMES

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

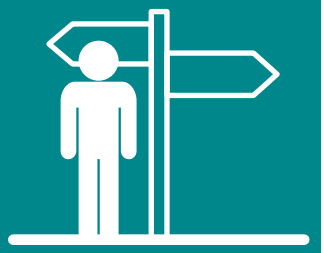
DELIVERING THE DIRECTED ENHANCED SERVICE (DES)

EARLY CANCER DIAGNOSIS

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



DELIVERING THE DIRECTED ENHANCED SERVICE (DES)



SOCIAL PRESCRIBING SERVICE

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

INVESTMENT AND IMPACT FUND

The Investment and Impact Fund (IIF) was introduced as part of the amended 2020/21 Network Contract Directed Enhanced Service (DES). The IIF in 2021/22 had a number of suspended elements, due to PCNs focussing on the delivery of Covid-19 vaccinations to their populations. There were a number of targets which remained in place, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

In Westhoughton PCN:

Patients aged 65+ who received a seasonal influenza vaccination

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

Patients on the LD register who received an LD health check

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

Number of patients referred to social prescriber

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

DELIVERING THE ADDITIONAL ROLES REIMBURSEMENT SCHEME

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

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

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

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

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

Westhoughton Primary Care Network ARRS team:

CLINICAL PHARMACISTS

Irem Mahmood
Sumaiya Sajid
Raisah Shazad

PHARMACY TECHNICIAN

Andrea Moffatt

MSK

Alisha Walters

MHP

Samantha Barker

SPLW

Julie Wright
Jenna Scholes
Alison Lowe

PHYSICIAN ASSOCIATE

David Carter

CASE STUDY

SOCIAL PRESCRIBING LINK WORKER

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

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

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

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

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

Julie Wright
PCN Social Prescribing Link Worker

STAFF FEEDBACK

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

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

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

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

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

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

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

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

Overall feedback

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

Satisfaction questionnaires

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

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

Common themes

Common themes emerging from all of the feedback collected were:

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

MENTAL HEALTH PRACTITIONER (MHP) FEEDBACK

Quotes from patients, carers and staff included:

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

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

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

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

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

"She was amazing." (patient feedback)

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

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

COVID-19 PROGRAMMES

COVID-19 vaccination

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

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

20,538 vaccinations

30 clinics held

4 care homes and

3 assisted living care homes visited

COVID-19 PROGRAMMES

Pulse oximetry

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

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

COVID-19 PROGRAMMES

Pulse oximetry

BETWEEN 01 APRIL 2021 AND 31 MARCH 2022

3,617 people were supported through the pathway.

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

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

PATIENTS SAID

Very supportive and helpful team.

Great service, friendly helpful staff.

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

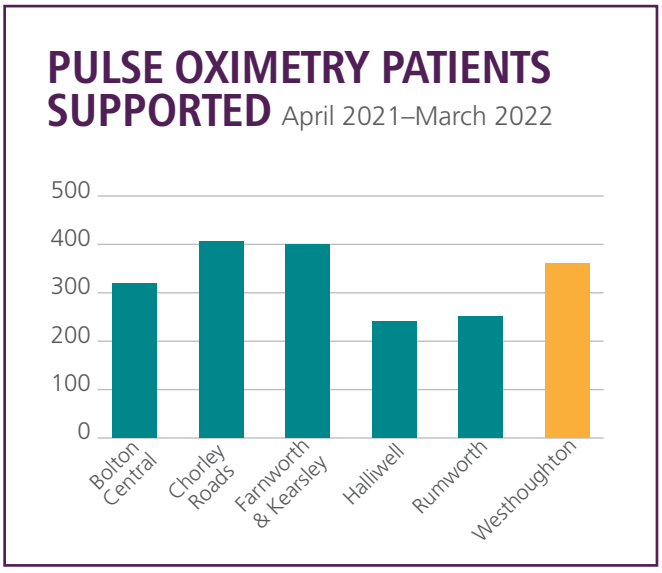
Everyone I spoke to was pleasant and polite. I was contacted on the day of my referral and the monitor was delivered the same day.

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

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

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

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



FINANCE

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

REFLECTIONS AND PRIORITIES FOR 2022/23

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

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

We have welcomed to the PCN team:

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

Our prioritises for the forthcoming year include:

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

Kristy Barlow
Westhoughton Network Manager
Bolton GP Federation

APPENDIX 1
ADDITIONAL ROLES REIMBURSEMENT SCHEME (ROLE REQUIREMENTS)

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

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

Complete Ongoing

SOCIAL PRESCRIBING LINK WORKER

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

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

Complete Ongoing

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