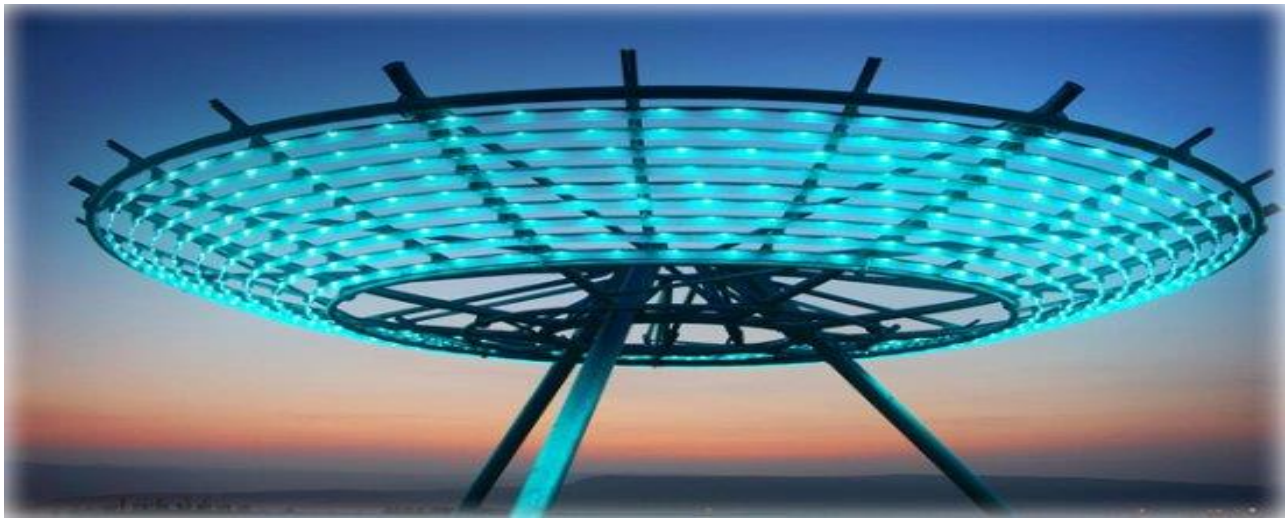
JOINT ROSSENDALE PCNs

RECRUITMENT AND INDUCTION PACK 2020-21



ROSSENDALE WEST PCN & ROSSENDALE EAST PCN

AUGUST 2020

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1. Introducing the Rossendale PCNs

1.1 Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan with General Practices being a part of a network, typically covering 30,000 to 50,000 patients. These networks will provide the structure and funding for services to be developed locally, in response to the needs of patients they serve.

1.2 With a registered population of approximately 74,000 Rossendale has two Primary Care Networks:-

- Rossendale East PCN – Covers the three GP Practices that are located in either Bacup, Waterfoot and Whitworth and collectively at the start of this year had a patient list size of 31,202.

- Rossendale West PCN – Covers the six GP Practices that are located in either Haslingden, Rawtenstall and collectively at the start of this year had a patient list size of 42,890.

1.3 Both Rossendale PCNs aim to work together as much as possible, so that individually they are small enough to provide the personal care valued by both patients and healthcare professionals, but working together, so that they are large enough to have an impact and exploit economies of scale through better collaboration between general practices and others in the local health and social care system.

1.4 The Rossendale PCNs intend to develop expanded neighbourhood teams which will comprise a range of staff such as GPs, Clinical Pharmacists, Pharmacy Technicians, First Contact Physiotherapists, Occupational Therapists, Mental Health Workers, Health & Wellbeing Coaches, Care Co-ordinators and Social Prescribing Link Workers.

1.5 PCNs which went live on 1st July 2019 operate through a Network Agreement which sets out the collective rights and obligations of the general practices in the network, as well as how the network will partner with non GP practice stakeholders.

1.6 Partnership working is an important feature of the Rossendale PCNs and they have benefited from a long standing level of co-operation with key stakeholders such as Rossendale Borough Council, Rossendale Leisure Trust and the Burnley, Pendle & Rossendale Council for Voluntary Service. The rationale for these relationships is that many of the services that the PCNs community partners provide contribute either directly or indirectly towards the health and wellbeing of its registered patients. The national review of health inequalities in 2010 reaffirmed that health is intrinsically linked to a number of determinants, in particular, employment, housing, community cohesion, the environment, sport and other leisure activities.

1.7 The Clinical Directors

Dr John O'Malley

John, who is a GP Partner at Irwell Medical Practice in Bacup, was elected as the Clinical Director of Rossendale East PCN in 2019. John completed his training in both St Andrews and Manchester and qualified in 1991. He then worked in various hospitals and practices around Manchester before coming to Bacup in 2001. Professionally he enjoys minor surgery and has a special interest in diabetes. Outside work John is a keen water sports enthusiast.

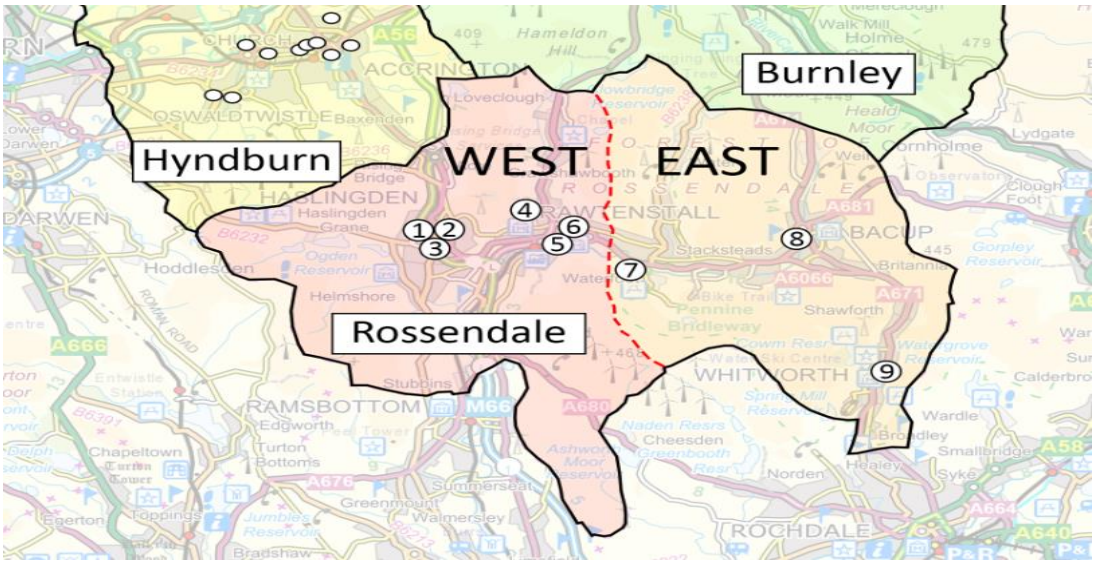
Dr Abdul Manan

Abdul is a GP Partner at The Surgery in Haslingden alongside Dr Moujaes. He was elected as the Clinical Director of Rossendale West PCN in 2019 and lives in Rossendale. Abdul is passionate about working with the community and promoting a 'healthy Rossendale'. He is approved for minor surgery, CHS and obstetrics. Outside of work he is a keen mountain biker and supports Manchester United.

1.8 The Rossendale Practices and list sizes as at 1st January 2020.

Rossendale West PCN				Rossendale East PCN		
Map Ref	**Name**	**List size**		**Name**	**List size**	**Map Ref**
1	Drs Moujaes & Mannan	4,870		Waterfoot Med Practice	9,094	**7**
2	Rossendale Valley Med P	2,629		Irwell Medical Practice	14,750	**8**
3	Drs Mackenzie & Partners	10,707		Whitworth Med Practice	7,358	**9**
4	St James Medical Practice	10,048				
5	Ilex View Medical Practice	8,457				
6	Fairmore Medical Practice	6,179				
	PCN Total	**42,890**		**PCN Total**	**31,202**	

1.9 The Rossendale Practices approximate locations:-



1.10 Practice addresses

PCN	Map Ref	Practice Code	Practice Address
WEST	1	P81212	The Surgery (Drs Mannan & Moujaes), Haslingden BB4 5SL
	2	P81686	Rossendale Valley Medical Practice, Haslingden Health Centre BB4 5SL
	3	P81099	Drs Mackenzie & Partners, Haslingden Health Centre BB4 5SL
	4	P81003	St James Medical Practice, Burnley Road, Rawtenstall BB4 8HH
	5	P81118	Ilex View Medical Practice, Rossendale PHCC, Rawtenstall BB4 7PL
	6	Y02606	Fairmore Medical Practice, Rossendale PHCC, Rawtenstall BB4 7PL
EAST	7	P81132	Waterfoot Medical Practice, Waterfoot Health Centre, Cowpe Road, Waterfoot BB4 7DN
	8	P81027	Irwell Medical Practice, Bacup Health Centre, Bacup OL13 9NR
	9	P81088	Whitworth Medical Practice, Whitworth Health Centre, Market Street, Whitworth OL12 8QS

2. Rossendale Vision, Values, Initial Ambitions, Plan on a Page and Governance Structure

2.1 The Rossendale PCNs have jointly developed the following vision:-

''Our vision is for health and social care to work hand in hand in order to make for a happier and healthier Rossendale in which everyone can reach their full potential''

2.2 The Rossendale PCNs have jointly developed the following values for the working collaboratively:-

a. To uphold the highest standards of financial management, probity, transparency, democracy and inclusiveness.
b. For Rossendale practices to work together and with other NHS and non-NHS organisations, towards achieving the best possible health and wellbeing outcomes for the people who live and work in Rossendale.
c. To consult with, listen to and serve our patients and the wider community from all backgrounds.
d. To strengthen primary care and develop its staff.
e. To help the development of community assets in Rossendale.

2.3 The PCNs have developed a list of initial ambitions jointly:-

a. Draw up and agree a Data Sharing Agreement and Network Agreement between practices.
b. Implement the three PCN Direct Enhanced Service (DES) specifications for 2020-21 and achieve maximum points in the Investment Impact Fund (IIF) indicators.

c. Directly help with core member practice work.
d. We will fully utilise and recruit to our PCN Additional Role Reimbursement Staff entitlement.
e. We will work with other East Lancashire PCN's to establish the East Lancashire PCN Alliance.
f. We will work with community partners, with the aim of achieving better health outcomes for our population, including working closely with the Rossendale Connected initiative.

2.4 A Plan on a Page has been developed by the PCNs jointly and takes a more detailed look at how the PCN realise their vision through the stages of developing strategic priorities and strategic change whilst developing relevant work streams and using the various enablers as a means of progressing its ambitions. The Plan on a Page is shown at Appendix 1.

2.5 The two Rossendale PCNs have developed a draft Governance Structure that shows the inter relationships between PCN groups (PCN Clinical, PCN Community and PCN Committee) the stakeholders (RLT, RBC & BPR CVS) and most importantly with the Patient participation Groups and GP Practices. The structure is shown on Appendix 2.

3. Joint Rossendale PCNs – Additional Roles intentions

3.1 Jointly both PCNs have spent some time finalising their employment plans which currently stand as:-

- **Clinical Pharmacists & Pharmacy Technicians** - The PCNs are committed to employing in this financial year four Clinical Pharmacists to work across Rossendale. One of these Pharmacists is starting later this month with a further appointment from 1st September 2020. Two further appointments will then be made before 31 Marth 2021. In addition two Pharmacy Technicians are to be employed within a similar timescale.

- **Health & Wellbeing Coaches** – The PCNs are intending to employ two Health & Wellbeing Coaches that will work alongside the Social Prescribing Link Workers, available for GP Practices to refer to and will be closely aligned to the work of Rossendale Leisure Trust and in particular the Up and Active Team. In making this decision the PCNs are keen to learn from a similar model in BwD around a Health Trainer initiative. The Rossendale Health Coaches will be hosted employment wise by Rossendale Leisure Trust.

- **Dietician** – Linked to the work of the Health Coaches and SPLWs we will be employing a dietician to form an SPLW / Health & Wellbeing Coach / Dietician team that will support people emerging from lockdown and needing dietary advice that may complement any increased activity regimes. It is anticipated that these roles will support any work taking place in conjunction with the national obesity strategy.

- **Occupational Therapist** – The Rossendale PCNs will jointly employ an Occupational Therapist. This will help to provide a local OT presence for GP Practices and maybe even be of benefit to the wider Rossendale Community where it has already been recognised that OT support would help accelerate Disability Funding Grant (DFG) applications.

- **Physician Associates** – PAs work under the supervision of a GP and perform many of the functions of a GP such as diagnosing illness and taking medical histories from patients. These roles have in other GP Practices been proven to reduce the workload on GPs and it may be that in future years we see more PAs being employed in Rossendale.

- **Care Co-ordinators (Nursing role focus)** – As a sort of grow your own principle the PCNs are wanting to employ two Care Co-ordinators that will have a junior nursing role with the expectation that they will progress to more senior nursing roles.

4. Rossendale Advanced Nurse Practitioner (ANP) Care Home and Housebound Service

4.1 Jointly the Rossendale PCNs employ a small team of Advanced Nurse Practitioners (ANPs) that visit the care homes across Rossendale on behalf of the GPs. They provide a through link between these homes and local GP Practices not just advising on the healthcare needs of the residents, but also offering advice to the homes themselves.

4.2 An ANP are registered nurses who have undertaken additional training and qualifications who are able to examine, assess, make diagnosis, treat, describe and make referrals for patients who present with undiagnosed problems within their own clearly defined remit.

4.3 The benefits for residents is that the ANP service allows them to be regularly in contact with a trained professional who are able to spot signs of possible deterioration and put it right before the need for a visit is needed. For the local population they take the pressure off GP services, freeing it up for general use. They are also able to offer support, training and education to carers and nurses assisting in establishing best practice for residents.

4.4 A part of the ANP Programme, training is given to carers employed in each of the homes within Rossendale for vital observations. This gives carers the skills to be able to recognise signs of health deterioration and possible sepsis. Following this training there was an 82% increase in carers knowledge base of vital observations. Overall this initiative is improving the care given, as there is a dedicated nurse who can be called out as and when needed, with the ability to relay any information back to the GP practices.

4.5 This service has been appreciated by the local GPs and in particular the observation of Dr John O'Malley GP at Irwell Medical Practice and Clinical Director for

Rossendale East PCN – ''Their valuable position within the Primary Care Network ensures the often complex needs of a previously under-represented patient group gets the input they deserve''

4.6 Future plans for the service are to improve and expand the home visiting service with more ANPs and a better, more effective way of delivering care to local residents in nursing and residential homes. This service will play a major role in the fulfilment of the Enhanced Health in Care Homes PCN Direct Enhanced Service.

5. Extended Hours Scheme

5.1 The provision of extended hours access appointments was a requirement of the PCN Network contract DES from 1st July 2019. Rossendale have so far been able to fulfil this requirement.

5.2 The requirements of the two Rossendale PCNs are to offer the following:-

a) Additional clinical sessions (routine appointments including emergency or same day appointments), outside of PCN member practices core contracted hours, to all registered patients within the PCN.

b) Extended hours access appointments in opening hours which are held at times that take into account patients expressed preferences, based on available data at practice or PCN level and evidenced by patient engagement:

c) An additional period appointments that equate to a minimum of 30 minutes per 1,000 registered patients per week, calculated using the following formula:-

Additional minutes = A networks aggregate CRP / 1,000 x 30

This equates to a PCN with a 50,000 registered patients to a minimum of 25 hours per week.

d) Extended hours access appointments by the PCNs member practices, or subcontracted appropriately, in continuous periods of at least 30 minutes on a regular basis in full each week, including providing sickness and leave cover and

e) A reasonable number of these appointments face to face, with the rest provided by telephone, video or online consultations or a mixture of these methods.

5.3 The overall network additional clinical sessions for EHA in terms of Rossendale West PCN is as follows:-

Network aggregate contractor	Formula for calculation of EHA requirement	Total weekly network additional clinical sessions for EHA

registered population (CRP)		
42,918	30 minutes per 1,000 registered patients per week	(CRP/1000*30) = 1,287 min = 21.5 hours

The Network will allocate the provision of the EHA requirement as follows:-

Network member or other provider	Number of patients as at 1st Jan 2020	Amount of EHA to be provided per week (hours)	Proportion of network EHA requirement provided:
Dr Mackenzie and Partners	10,708	5.25 : 5.354 : 5.25	26.92% : 24.42%
The Surgery (Drs Moujaes & Mannan)	4,888	2.50 : 2.44 : 2.50	12.82% : 11.63%
Ilex View Medical Practice	8,415	4.00 : 4.2075 : 4.25	20.52% : 19.77%
Rossendale Valley Medical Practice	2,634	1.25 : 1.317 : 1.25	6.41% : 5.81%
St James Medical Practice	10,066	5.25 : 5.033 : 5.00	26.92% : 23.26%
Fairmore Medical Practice	6,207	1.25 : 3.1035 : 3.25	6.41% : 15.11%
Total hours and coverage	**42,918**	**19.50 : xxx : 21.5**	**100.00% : 100%**

5.4 The overall network additional clinical sessions for EHA in terms of Rossendale East PCN is as follows:-

Network aggregate contractor registered population (CRP)	Formula for calculation of EHA requirement	Total weekly network additional clinical sessions for EHA
31,202	30 minutes per 1,000 registered patients per week	(CRP/1000*30) = 936 min = 15.5 hours (rounded to 15 min appt's) *Equates to 15 hours & 30 minutes*

The Network will allocate the provision of the EHA requirement as follows:-

Network member or other provider	Number of patients as at 1st Jan 2020	Amount of EHA to be provided per week (hours)	Proportion of network EHA requirement provided:
Waterfoot Medical Practice	9,094	4.50	29% *(4 hours & 30 mins)*
Irwell Medical Practice	14,750	7.25	47% *(7 hours & 15 mins)*
Whitworth Medical Practice	7,358	3.75	24% *(3 hours & 45 mins)*
Total hours and coverage	**31,202**	**15.5**	**100%**

6. Direct Enhanced Services 2020-21:-

6.1 Enhanced Healthcare in Care Homes (EHCH)

In response to this enhanced service each of the Rossendale PCNs have appointed a Clinical Lead both of whom are experienced GP Partners of their respective practices and share a passion for leading the local improvement of healthcare in care homes across Rossendale. In addition an experienced Rossendale Practice Manager will lead this service from a management perspective and this service is further supported from an administrative basis.

The service requirements are aimed towards a multi-disciplinary team approach (MDT) where a cluster of healthcare professionals work together to determine the best care for each individual patient.

Along with this service specification comes a need to create an MDT to support our care homes, elderly and frail population which is high across Rossendale.

The aim of this specification is to ensure care homes have the right access to the right care in the first instance rather than being referred to their own GP and routed to different pathways. This new approach will build in different service offers under a more collaborative approach.

The PCN EHCH team will work closely with the Rossendale Care Homes, East Lancashire Hospitals NHS Trust, Lancashire and Cumbria Foundation Trust and other key stakeholders.

6.2 Early Detection of Cancer

Jointly the Rossendale PCNs have appointed a GP Clinical Lead for this service together with a management lead and a member of the PCN administrative support team.

The aim of this service is to provide patients with a clinical pathway at a much earlier stage and provide more advanced services to help determine the issue and outcome.

6.3 Structured Medication Reviews (SMR) / Medicines Optimisation
This is a Pharmacy focused service requirement which is aimed at providing patients with a clear structured medication review when their medications exceed a total.

The Clinical Pharmacists jointly appointed by the PCNs will provide the main clinical input to the execution of this service. One of the Rossendale Practice Managers will be providing a management lead role together with a member of the PCN administrative support team.

6.4 Anticipatory Care, including Population Health Management – From April 2021
Through this service, PCNs will be required to develop a population health approach for the identification of specified key segments of the PCN's registered practice populations. These patient cohorts will have complex needs and are at high risk of unwarranted health outcomes (for example people living with multi morbidity and/or frailty) identified using validated tools (such as the electronic frailty index) supplemented by professional judgement.

Maintenance of a comprehensive and dynamic list of identified individuals who would benefit from anticipatory care, based on the outcome of the population segmentation approach above.

The delivery of a comprehensive set of support for those individuals identified as eligible through the anticipatory care list, through an MDT based across PCNs and community service providers.

It is anticipated a Clinical Lead for this area of work will be appointed however a Management Lead from one of the group of Rossendale Practice Managers has come forward to lead from a management perspective.

6.5 Personalised Care, including Personal Health Budgets – From April 2021
The Health & Wellbeing Coaches together with the Social Prescribing Link Workers and Dietician employed jointly by the PCNs will play a major role in the execution of this service. It is intended that the PCNs will jointly identify a Clinical Lead, Management Lead and Administrative Support.

Personalised Care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual diverse strengths, needs and preferences.

Proposed Service Model:-

The Comprehensive Model for Personalised Care brings together six components, each of which is defined by a standard, replicable delivery model. The six key components are:

a. Shared decision making eg MSK: Back pain, hip pain, knee pain and shoulder pain (led by Physiotherapists)

b. Personalised care and support planning ie personalised care and support plans

c. Enabling choice, including legal rights to choose

d. Social prescribing and community-based support

e. Supported self-management eg PCNs to use the Patient Activation Measure (PAM)

f. Personal health budgets (PHBs) and integrated personal budgets.

7. Future Developments

7.1 We have a number of future development opportunities in line with the new GP contract and relevant to appropriate funding.

7.2 These opportunities may well be taken as either individual PCNs, jointly as two Rossendale PCNs or as a GP Alliance of likeminded East Lancashire Primary Care Networks.

7.3 Hopefully this information pack has given you the right guidance to the joint aims of both Rossendale PCNs, where we currently are and where we are aiming to be over the next few years.

Joint Rossendale PCNs

V1 - September 2020

Joint Rossendale PCNs – Plan on a Page – (Links both downwards and across)

APPENDIX 1

Our Vision & Values	Our Strategic Priorities	Strategic Change	Work streams to Deliver change	Enablers	Ambitions for 2021-22
To uphold highest standards of financial probity, transparency, democracy and inclusiveness To achieve the best possible health and wellbeing outcomes for people who live and work in Rossendale **To consult with, listen and to serve our patients and wider community from all backgrounds** To strengthen primary care, Primary care networks and development of staff **To help the development of community assets in Rossendale**	**Achieve & sustain recurrent financial balance** **Robust systems of governance** Maximise the benefit of the Direct Enhanced Services Develop & sustain a culture of quality Improve access & outcomes for mental health services **Support patients to make the right health choices** **Support the strengthening / development of Patient Participation Groups** Share good practice within core members Develop the PCN workforce **Work jointly with the LCC on issues of Public Health** **Work closely with key stakeholders to encourage exercise & Healthy living**	**Maintain Good Governance** Enhanced Health in Care Homes DES Early Detection of Cancer Structured Med Reviews / Meds Optimisation DES Anticipatory Care & Population Health Personalised Care DES & Consider Personal Budgets **Signposting Patients & Encouraging PPGs** Sharing best working practices to GP Practices Staff Development Reviews **Closer working with Rossendale Stakeholder organisations and wider community**	**Data Sharing and Conflict of Interest Training for core member practices** Multi-Disciplinary Reviews Shared Care Planning & Protocols Practices reviewing their cancer referrals both individually and peer to peer PCN Clinical Pharmacist Leadership Use of appropriate tools to prioritise Involve Community Pharmacies Identification of patient with complex support needs – Population segmentation MDT patient reviews **Social Prescribing link Workers & Care Navigation** **Working with patients to make decisions about their health care – Shared Decision making &** **Personalised Budgets** GP Practice Transformation / Resilience Plan Fortnightly Practice Mgr teleconference Regular best practice discussions One to one staff reviews & Staff training opportunities **Active Attendance at Rossendale Health & Wellbeing Partnership** **Engagement with Rossendale Connected** **Participate in Community activities & events**	**Governance training** **GP Clinical Leadership** MDT with Care Homes & key stakeholders GP Practice Data Review Tools ie Frailty Data Sharing ANP Care Home Service NHSE Funding for SPLWs & other additional roles **Patient Participation Groups / Health & Wellbeing Partnership** **Patient representation at PCN meetings & Patient Surveys** PCN PM leads Regular communication Practice collaboration Peer Support & Time for reflection **RBC Leadership / Chair** **Regular Meeting** **Active stakeholders** **Backfill support**	**Financial probity, Transparency, democracy and inclusiveness evident in PCN decision making** Healthier and Supported Care Homes & their residents Effective MDTs operating Improved Cancer detection rates across Rossendale Effective Medicine Reviews Medicines Optimisation Consistent assessments Complex needs identified & Supported patients **Patient involvement in their care &** **Personal Budgets operating** Spreading best practice Levelling up of expertise Staff feel valued Skilled workforce **Closer working with Rossendale Stakeholder organisations and wider community**

Draft Governance Structure

APPENDIX 2