NHS Rotherham Clinical Commissioning Group

Primary Care Sub-group - 27 April 2022

Primary Care Network Dashboard

Lead Executive:	Ian Atkinson, Executive Place Director
Lead Officer:	Sara Hartley, Contract and Service Improvement Manager (Primary Care)
Lead GP:	Dr Avanthi Gunasekera, SCE Lead GP for Primary Care

Purpose:

To brief the committee on Primary Care performance, as measured by the metrics of the new National Primary Care Network Dashboard.

Background:

NHS England and NHS Improvement has developed a new national dashboard that provides information at Regional, STP, CCG, PCN and practice levels. It has now been published and is available to use.

The dashboard is accessed via an online platform which can be interrogated to provide information on a range of indicators. There are 124 indicators in total which fall into the following categories:

- Additional Roles Reimbursement Scheme
- Early Cancer Diagnosis
- Immunisations
- Impact and Investment Fund
- Mental Health
- Personalised Care
- Structured Medication Reviews
- Workforce
- Data Quality
- Other

The dashboard allows the user to look at the information at individual PCN level but also review the practices within that PCN. PCNs can also be reviewed against other PCNs in a similar position as well as where they sit from a national perspective. The indicators also identify whether a PCN's performance has improved or declined in comparison to the same period the previous year. The national team has indicated that a refresh is imminent.

However, the national dashboard does not currently report on information relating to A&E attendances, outpatient attendances, emergency admissions or 2 week wait Did Not Attends (DNAs). Therefore, it is proposed that a hybrid dashboard is produced until such time as this information is available on the national dashboard.

Delegation responsibility:

Does this paper relate to Rotherham CCG or delegated business?

Rotherham CCG	✓
Delegated	
Both Rotherham CCG and delegated	

Please tick which area of delegated responsibility this paper covers:

Commissioning, procurement and management of GMS,PMS and APMS contracts including taking contractual action	✓
Newly designed enhanced services (including DES)	
Local incentive schemes	
Discretionary payments	
Commissioning urgent care for out of area registered patients	
Planning Primary medical care services (PMCS)	
Managing practices with CQC concerns	
Decisions on premise cost directions	
Planning the commissioning of PMCS	
Manage the delegated allocation for commissioning of PMCS	
Assurance to the governing body on the quality and safety of PMCS	

Please indicate which of the Delegated Duties Decisions this paper requires:-

• Delegated Duties – iii – Decisions in relation to the establishment of new GP practices (including branch surgeries) and closures of GP practices.	N/A
• Delegated Duties – iv – Decisions about 'discretionary payments'.	N/A
• Delegated Duties – v – Decisions about commissioning urgent care (including home visits as required) for out of area registered patients.	N/A
• Delegated Duties – b – The approval of practice mergers.	N/A

Analysis of key issues and of risks

The dashboard (Appendix 1) provides information on 31 indicators. Each indicator has been compared with the CCG average, with outliers identified as either being higher or lower than the CCG average dependant on the indicator requirements, as indicated on the dashboard.

On reviewing the information the PCNs are currently outliers against the Rotherham averages in the following number of indicators:

	PCN	Number of Outliers
1	**Rotherham Central North**	**22**
2	**Health Village/Dearne Valley**	**22**
3	**Wentworth 1**	**18**
4	**Maltby/Wickersley**	**17**
5	**Raven**	**15**

6	Rother Valley South	12

When reviewed further, it has been possible to identify which indicators each individual practice is an outlier in against the Rotherham average (Appendix 2). This places the practices in the following order:

New Placing on PCN Dashboard	Outliers New PCN Dashboard	Practice	PCN	Previous Placing on January 2022 PCN Dashboard	Outliers January 2022 PCN Dashboard
1	24	Greasbrough	RCN	2	22
2	23	Clifton	HV/DV	1	22
3	22	Queens	MW	5	21
4	21	Rawmarsh	W1	6	20
5	21	St Anns	HV/DV	8	19
6	20	Gateway	R	4	21
7	20	Woodstock	RCN	3	22
8	19	Broom Lane	RCN	11	18
9	19	Shakespeare Rd	W1	14	18
10	19	Wickersley	MW	7	20
11	18	Parkgate	W1	13	18
12	18	Village	RVS	15	18
13	18	York Rd	W1	16	18
14	17	Blyth	MW	17	17
15	17	Greenside	RCN	18	17
16	17	High St	W1	19	17
17	17	Morthen Road	MW	20	17
18	17	Treeton	R	9	19
19	16	Braithwell	MW	10	18
20	16	Crown St	W1	22	16
21	16	Thorpe	R	21	17
22	15	Kiveton	RVS	23	15
23	15	Magna	W1	12	18
24	15	Market	HV/DV	25	14
25	14	Manor Field	MW	27	13
26	14	Swallownest	RVS	24	15
27	13	Brinsworth	R	26	13
28	10	Dinnington	RVS	29	9
29	10	Stag	R	28	10

Already there has been some movement within the top 10 of outlying practices, with Broom Lane and Shakespeare Road moving into the top 10 and Treeton and Braithwell Road moving outside of the top 10.

The Dashboard will be used by the Primary Care Team to initiate conversations with practices and/or PCNs who seem to be experiencing difficulties with specific indicators, in order to understand whether there are reasons behind it. In the meantime, those practices that have

moved to the top of the table will be prioritised for a Contract and Quality visit in the coming months.

For a number of the indicators, particularly within the Additional Roles, the CCG average is showing as less than the national average. This is could be due to a number of reasons:

- Physiotherapy appointments – these appointments are held on the GP Federation clinical system and as such are not included in any data that is uploaded by NHS Digital

- Not all PCNs have specific Additional Roles in place e.g. physician associates, podiatrists, occupational therapists

- PCNs coding appointments on the clinical systems to distinguish when Additional Roles such as dieticians, pharmacy technicians etc have seen patients

The PCNs have identified that there will be issues specifically around the reporting of the Physiotherapy and Emergency Care Practitioner appointments, as these are held on the GP Federation's appointment system and as such the data will not be extracted as part of this exercise. As such, all six PCNs are considered outliers on the Dashboard. The CCG is continuing to work with NHS England to determine what other processes can be put in place to ensure this data is captured.

PCNs are able to determine what staffing is required to support its population and as such, may prioritise the recruitment of some roles over others. Appendix 3 provides a breakdown of the roles that each PCN has in place, with an overview of what those roles can undertake.

As the PCN Dashboard data is refreshed, those indicators based around number of appointments with the Additional Roles may see a substantial change to the information. This is due to the practices continuing to undertake a mapping exercise on their clinical systems, identifying and coding appointments to the clinical roles providing them. However, the latest refresh shows that, for some of the roles, these numbers are still quite low despite the roles being in place for a substantial period of time e.g clinical pharmacists, pharmacy technicians and care co-ordinators.

Reference to NHSE Primary Medical Care Policy and Guidance Manual (PGM):
Section 2 – Assurance Framework Contract Review - Section 2.5 Using data and information effectively
Patient, Public and Stakeholder Involvement:
Not applicable
Equality Impact:
Not applicable
Financial Implications:
Not applicable
Human Resource Implications:
Not applicable
Procurement Advice:
Not applicable
Data Protection Impact Assessment:
Not applicable
Approval history:
Primary Care Sub-Group – 27 April 2022
Recommendations:
The Committee is asked to:

- Note the outcomes of the latest dashboard publication
Paper is for Noting

Appendix 1

Category	Indicator	Reporting Period	Achieving is … than Rotherham PCN average	England Avg	NHS Rotherham CCG/PCN average	NHS Rotherham CCG/Practice average	Health Village/ Dearne Valley	Maltby/ Wickersley	Raven	Rotherham Central North	Rother Valley South	Wentworth 1
ARRS	% of consultations by Dietician per registered patient	Feb-22	Higher	0.21	0.09		0.05	0.01	0.36	0.07	0.02	0.03
	% of consultations undertaken by Physiotherapist per registered patient	Feb-22	Higher	1.00	0.00		0	0.01	0	0	0	0.01
	% of consultations undertaken by Pharmacy Technician per registered patient	Feb-22	Higher	0.43	0.50		0.11	0.01	0.98	2.33	0.03	0.02
	% of consultations undertaken by Physician Associate per registered patient	Feb-22	Higher	0.06	0.00		0	0	0	0	0	0
	% of consultations undertaken by Podiatrist per registered patient	Feb-22	Higher	0.31	0.06		0.07	0.02	0.17	0.02	0.06	0.02
	% of consultations undertaken by Occupational Therapist per registered patient	Feb-22	Higher	0.08	0.05		0.09	0.04	0.05	0.03	0.05	0.03
	% of consultations undertaken by Clinical Pharmacist per registered patient	Feb-22	Higher	1.83	5.13		0.28	0.11	10.14	5.84	1.87	11.41
	% of consultations undertaken by a Care Coordinator per registered patient	Feb-22	Higher	0.14	0.00		0	0	0	0	0	0
	% of registered patients referred to social prescribing	Feb-22	Higher	0.84	0.89		0.73	1.05	0.59	0.62	1.41	0.77
	% of medication reviews undertaken by Clinical Pharmacist per registered patient	Feb-22	Higher	1.65	6.73		7.82	4.45	6.31	3.91	4.31	12.34
Early Cancer Diagnosis	% females aged 25-49 attending cervical screening within target period (3.5 years)	Sep-21	Higher	67.67	73.88		69.04	79.86	74.24	68.68	79.46	71.26
	% females aged 50-64 attending cervical screening within target period (5.5 years)	Sep-21	Higher	74.70	76.69		73.55	78.76	76.24	77.58	78.94	74.77
	% patients placed on an urgent referral pathway for suspected cancer	Feb-22	Higher	3.00	2.72		2.67	3.52	2.07	2.39	2.78	2.94
	% patients placed on urgent referral pathway for suspected cancer where safety netting was recorded	Feb-22	Higher	17.39	26.57		33.77	23.39	14.57	10.91	38.26	27.59

Appendix 1

Category	Indicator	Reporting Period	Achieving is … than Rotherham PCN average	England Avg	NHS Rotherham CCG/PCN average	NHS Rotherham CCG/Practice average	Health Village/ Dearne Valley	Maltby/ Wickersley	Raven	Rotherham Central North	Rother Valley South	Wentworth 1
Impact and Investment Fund	% patients aged 14 years and over, on the Learning Disability register who received an annual LD health check	Feb-22	Higher	59.28	56.59		49.04	60.93	48.33	54.55	57.26	68.55
	% patients aged 65 and over who received a seasonal flu vaccination between 1 Sept and 31 March	Feb-22	Higher	89.47	90.71		88.3	87.28	90.1	93.75	92.72	91.51
Mental Health	Number of patients that entered IAPT Treatment	Apr-20	Higher			12.31	63	42	50	56	71	75
Personalised Care	% of registered patients whose care has been discussed as part of a shared decision making process	Feb-22	Higher	0.37	0.10		0.25	0.02	0.01	0.39	0.01	0.01
Structured Medication Reviews	% of patients that have received a structured medication review	Feb-22	Higher	1.38	4.61		3.36	1.37	6.3	3.81	3.92	7.73
Workforce	Total PCN Workforce - Other Direct Patient Care Staff	Dec-21	Higher	-	2.15		0	0	5.1	0.8	7	0
	Total general practice workforce FTE per 1,000 registered patients	Feb-22	Higher	1.66	1.99		2.38	1.92	2.09	1.92	1.98	1.71
A&E	A&E - Left before treatment per 1k patients	Dec 20 - Nov 21	Lower		11.40		13.9	9.3	12.4	13.1	8.4	12.1
	A&E attends per 1k patients	Dec 20 - Nov 21	Lower		334.50		367	307.6	337.6	351.4	310.6	338.1
	A&E Minors per 1k patients	Dec 20 - Nov 21	Lower		109.90		122.9	99.2	118.3	121.9	85.3	118.2
	A&E High Intensity users per 1k patients	Dec 20 - Nov 21	Lower		5.70		7.3	4	5.2	6.7	5.1	6.1
Outpatients	Ambulatory Care Sensitive Emergency Admissions per 1k patients	Dec 20 - Nov 21	Lower		8.70		10	9.3	8.2	8.4	8	8.4
	1st Outpatient GP referred per 1k patients	Dec 20 - Nov 21	Lower		115.50		109	129.6	119.4	112.4	117.8	107.4
	% First Outpatient GP referred, discharged at first attendance	Dec 20 - Nov 21	Lower		33.30%		33.10%	33.30%	32.90%	33.20%	34.10%	33.10%
	% Outpatient new DNA referred from GP	Dec 20 - Nov 21	Lower		9.40%		10.70%	9.10%	9.10%	9.50%	7.90%	10.50%
Emergency Admissions	Emergency admissions per 1k patients	Dec 20 - Nov 21	Lower		122.40		132.7	117.8	121.7	135.3	112.4	119.3
2 week waits	% of Two week wait DNA	Dec 20 - Nov 21	Lower		4.40%		5.20%	3.30%	4.00%	6.60%	3.90%	4.10%

Appendix 2

		% of consultations under taken by Dietician per registered patient	% of consultations undertaken by Physiotherapist per registered patient	% of consultations undertaken by Pharmacy Technician per registered patient	% of consultations undertaken by Physician Associate per registered patient	% of consultations undertaken by Podiatrist per registered patient	% of consultations undertaken by Occupational Therapist per registered patient	% of consultations undertaken by Clinical Pharmacist per registered patient	% of consultations undertaken by a Care Coordinator per registered patient	% of registered patients referred to social prescribing	% of medication reviews undertaken by Clinical Pharmacist per registered patient	% females aged 25-49 attending cervical screening within target period (3.5 years)	% females aged 50-64 attending cervical screening within target period (5.5 years)	% patients plaed on an urgent referral pathway for suspected cancer	% patients placed on urgent referral pathway for suspected cancer where safety netting was recorded	% patients aged 14 and over on Learning Disability Register who received a Learning Disability health check	% patients aged 65 and over who received a seasonal influenza vaccination between 1 Sept and 31 March
Rotherham Practice Avg		**0.09**	**0.00**	**0.50**	**0.00**	**0.06**	**0.05**	**5.13**	**0.00**	**0.89**	**6.73**	**73.88**	**76.69**	**2.72**	**26.57**	**56.59**	**90.71**
Blyth	MW	0.02	0	0	0	0	0	0.15	0	1.22	4.38	81.87	78.95	3.97	29	89.13	89.68
Braithwell	MW	0	0	0.03	0	0.06	0.03	0.06	0	1.01	11.66	78.02	78.77	2.28	38.96	82.61	95.75
Brinsworth	Raven	0.19	0	0.77	0.02	0.03	0.06	7.95	0	0.63	5.14	71.87	77.15	2.63	3.69	22.5	93.8
Broom Lane	Central	0.08	0	2.51	0	0.01	0.03	4.61	0.01	0.46	4.17	69.29	81.06	1.53	4.85	51.35	95.09
Clifton	HV/DV	0.04	0	0.02	0	0.19	0.02	0.29	0	0.63	8.01	65.56	72.6	2.2	47.18	39.42	82.69
Crown St	WW1	0.05	0	0.01	0	0	0.08	6.52	0	0.78	14.32	72.95	77.01	3.36	42.81	66.67	99.33
Dinnington	RVS	0.01	0	0.01	0	0.15	0.11	1.48	0	1.34	3.93	77.81	79.48	3.24	30.13	56.19	90.26
Gateway	Raven	1.21	0.01	1.23	0	0.06	0.08	12.67	0	0.73	8.26	59.97	66.73	2.11	15.58	52.05	82.67
Greasbrough	Central	0.03	0	2.42	0	0.08	0.05	2.55	0	0.93	1.1	73.64	72.76	2.66	1.03	6.45	90.18
Greenside	Central	0	0	3.68	0	0.02	0	5.82	0	1.01	3.49	81.62	83.31	4.92	22.9	81.25	97.36
High St	WW1	0	0	0	0	0	0	6.81	0	0.8	14.71	79.44	80.56	3.9	45.83	50	85.07
Kiveton	RVS	0.03	0	0	0	0.03	0.03	0.51	0	2.09	1.67	83.82	83.3	1.15	59.7	82.5	91.93
Magna	WW1	0.01	0.01	0.01	0	0.05	0	20.96	0	0.86	11.94	73.36	72.89	2.8	14.1	69.05	98.58
Manor Field	MW	0.02	0	0	0	0.05	0.08	0.09	0	1.23	2.82	79.92	77.84	3.25	29.44	59.65	88.77
Market	HV/DV	0.01	0	0.07	0	0	0.03	0.33	0	1.17	11.35	78.21	77.4	2.9	12.43	70.91	99.39
Morthen Road	MW	0.02	0.02	0.02	0	0	0.04	0.11	0	1.09	4.18	81.56	82.19	4.13	24.3	73.33	86.16
Parkgate	WW1	0	0	0	0	0	0.03	3.1	0	0.91	9.95	79	75.18	3.52	13.78	86.27	92.34
Queens	MW	0	0	0	0	0	0	0	0	1.4	16.99	73.58	74.34	1.25	52.94	16.67	87.98
Rawmarsh	WW1	0	0	0.03	0	0	0	4.14	0	0.4	15.17	76.54	73.74	3.11	16.13	33.33	75.37
Shakespeare Rd	WW1	0.1	0.02	0.07	0	0.07	0.07	8.98	0	0.72	4.83	49.07	61.54	0.72	39.02	62	81.09
St Anns	HV/DV	0.08	0.01	0.21	0	0.03	0.18	0.23	0	0.51	5.38	65.04	71.71	2.86	40.43	39.74	85.44
Stag	Raven	0.23	0	1.11	0	0.56	0.07	11.83	0	0.73	5.63	82.81	80.74	2.39	8.99	74.67	96.77
Swallownest	RVS	0.01	0.01	0.08	0	0	0.02	3.4	0	1.32	5.82	79.8	77.56	3.55	36.83	56	97.87
Thorpe	Raven	0	0	0.73	0	0	0	5.66	0	0.16	4.22	79.33	77.72	1.5	10.71	27.27	81.1
Treeton	Raven	0.01	0	0.95	0	0	0.03	10.68	0	0.48	8.06	80.26	74.15	1.16	67.05	23.33	82.31
Village	RVS	0.05	0	0.02	0	0	0.02	1.75	0.01	0.76	5.99	77.01	72.78	2.38	55.67	35.9	90.38
Wickersley	MW	0	0.01	0	0	0.03	0.07	0.13	0	0.6	0.52	77.29	74.09	3.39	3	6.25	82.48
Woodstock	Central	0.1	0	1.42	0	0.01	0.04	8.59	0	0.54	4.68	60.09	70.72	2.25	7.66	66.36	90.48
York Rd	WW1	0	0.07	0.04	0	0.02	0.07	21.5	0	0.56	15.78	62.46	74.15	2.69	18.18	89.19	80.46

Appendix 2

		% of registered patients whose care has been discussed as part of a shared decision making process	Number of patients that entered IAPT Treatment	% of patients that have receiv ed a structured medication review	Total PCN Workforce - Other Direct Patient Care Staff	Total general practice workforce FTE per 1,000 registered patients	A&E - Left before treatment per 1k patients	A&E attends per 1k patients	A&E Minors per 1k patients	A&E High Intensity users per 1k patients	Ambulatory Care Sensitive Emergency Admissions per 1k patients	1st Outpatient GP referred per 1k patients	% First Outpatient GP referred, discharged at first attendance	% Outpatient new DNA referred from GP	Emergency admissions per 1k patients	% of Two week wait DNA
Rotherham Practice Avg		**0.10**	**12.31**	**4.61**		**1.99**	**11.40**	**334.50**	**109.90**	**5.70**	**8.70**	**115.50**	**33.30%**	**9.40%**	**122.40**	**4.40%**
Blyth	MW	0.02	6	1.89		2.1	9.7	313.4	96.1	3.9	9.4	143.4	34.68%	9.83%	120.5	4.57%
Braithwell	MW	0	7	0.33		1.97	8.2	237.5	71	1.5	9.7	123.8	30.93%	13.39%	102.9	6.76%
Brinsworth	Raven	0	15	5.74		1.78	8.9	333.7	122.8	4.2	7.1	123	31.92%	7.68%	113.9	2.65%
Broom Lane	Central	0.01	26	2.48		1.81	11.1	331.9	111.2	5.2	7.5	124.8	31.99%	8.22%	134.1	5.57%
Clifton	HV/DV	0.03	13	0.61		2.36	16.5	360.6	126.7	8.5	9	107	32.94%	10.02%	126.7	5.41%
Crown St	WW1	0	7	8.88		1.84	7.9	339.4	104.4	6.8	9.5	118.6	33.80%	7.70%	117.3	3.77%
Dinnington	RVS	0	30	5.1		2.1	8.1	320.5	74.2	5.3	8.1	114.1	32.33%	8.82%	106	3.51%
Gateway	Raven	0.02	9	8.34		2.15	32.3	511.9	195.7	10.9	12	113.5	33.41%	16.89%	170.4	11.61%
Greasbrough	Central	0.08	6	0.55		2	15.2	410.6	140.7	11	11	117.7	32.27%	10.20%	167.4	11.11%
Greenside	Central	0.04	11	2.95		1.72	10	328.7	106.6	6.4	10.8	130.9	35.05%	7.59%	137.5	3.90%
High St	WW1	0.01	14	9.02		1.98	9.2	320.4	106.1	6.5	8.8	121.1	34.82%	8.33%	124.7	1.07%
Kiveton	RVS	0	8	1.3		2.27	6.7	292.8	73.9	4.4	6.2	112.6	35.42%	7.07%	95.5	5.63%
Magna	WW1	0	27	6.13		1.89	12.6	334.4	116.1	5.9	8.4	98.5	32.52%	11.00%	116.2	4.11%
Manor Field	MW	0.03	9	2		2.21	9.6	307.4	103.6	3.8	7.8	105.1	30.53%	10.45%	111.1	5.56%
Market	HV/DV	0.01	22	3.74		2.17	9.9	355.7	101.7	4.8	9.8	109.6	32.09%	9.80%	121.6	5.20%
Morthen Road	MW	0.02	15	1.67		1.9	8.9	318.4	105.6	4.3	8.9	147.4	33.73%	6.85%	125.7	2.03%
Parkgate	WW1	0	8	7.18		1.72	11.4	326.8	114.1	5.8	7.3	111.5	33.54%	10.80%	119.3	4.73%
Queens	MW	0.07	0	0.66		2.69	10.6	334.5	92.1	6	10.6	96.7	36.30%	17.98%	130.5	7.69%
Rawmarsh	WW1	0	7	9.69		1.24	11.2	345.8	123.7	4.2	8.6	127.1	30.38%	8.93%	124.2	6.73%
Shakespeare Rd	WW1	0.09	10	4.19		1.34	22.9	411.6	178	8	7.8	84.1	32.94%	19.27%	121	12.28%
St Anns	HV/DV	0.56	28	5.1		2.53	14.6	378.7	133.6	8.1	10.8	110.1	33.93%	11.64%	143.9	5.01%
Stag	Raven	0	13	5.32		2.59	6.8	259.3	79.4	3.6	7.5	126.6	34.46%	6.79%	106.9	2.98%
Swallownest	RVS	0.03	22	3.59		1.55	9.7	311.5	100.1	5.2	8.6	135.8	35.64%	7.38%	120.3	2.29%
Thorpe	Raven	0	6	4.18		1.6	8.2	272.3	89.1	3.3	7.6	91.7	32.26%	6.69%	93.1	2.06%
Treeton	Raven	0.03	7	7.62		2	8.2	341.6	118.9	4.8	7	132.4	31.09%	8.14%	128.8	2.13%
Village	RVS	0.01	11	5.37		2.11	8.8	308.6	101.8	5.1	9.4	100.7	32.88%	7.72%	137.9	5.53%
Wickersley	MW	0.01	5	0.44		1.33	9.4	316	103	4.4	10.5	120.3	34.30%	7.64%	113.6	1.04%
Woodstock	Central	1.18	13	7.09		2.14	16.7	371.2	138.7	7.5	7.5	84.3	34.49%	13.28%	125.8	9.77%
York Rd	WW1	0	2	11.64		1.31	15.1	315.6	117	5.1	8	89.1	32.04%	13.64%	118	5.75%

Appendix 3

Breakdown of role provision across each PCN

PCN	Role	Whole Time Equivalent
Rotherham Central North	Care Co-ordinator	0.835
	Clinical Pharmacist	2.987
	Physiotherapist	1
	Paramedic	3.906
	Pharmacy Technician	3
	Social Prescribing Link Worker	2
	Nurse Associate	0
	Dietician	0
	Health and Wellbeing Coach	0
	Physician Associate	0
	Trainee Nurse Associate	0
	Mental Health Practitioner	0
	Total ARRS	**13.728**
Health Village and Dearne Valley	Care Co-ordinator	0.835
	Clinical Pharmacist	4.493
	Physiotherapist	2
	Paramedic	3.267
	Pharmacy Technician	2
	Social Prescribing Link Worker	2.6
	Nurse Associate	0
	Dietician	0
	Health and Wellbeing Coach	0
	Physician Associate	0
	Trainee Nurse Associate	0
	Mental Health Practitioner	0
	Total ARRS	**15.195**
Maltby Wickersley	Care Co-ordinator	3.055
	Clinical Pharmacist	3.427
	Physiotherapist	2
	Paramedic	2
	Pharmacy Technician	1.2
	Social Prescribing Link Worker	1
	Nurse Associate	2
	Dietician	0
	Health and Wellbeing Coach	0
	Physician Associate	0
	Trainee Nurse Associate	0
	Mental Health Practitioner	0
	Total ARRS	**12.682**

Appendix 3

PCN	Role	Whole Time Equivalent
Raven	Care Co-ordinator	1.835
	Clinical Pharmacist	5.8
	Physiotherapist	1
	Paramedic	1
	Pharmacy Technician	0.8
	Social Prescribing Link Worker	1
	Nurse Associate	2
	Dietician	0.4
	Health and Wellbeing Coach	0
	Physician Associate	0
	Trainee Nurse Associate	0
	Mental Health Practitioner	1
	Total ARRS	**14.835**
Rother Valley South	Care Co-ordinator	4.368
	Clinical Pharmacist	4
	Physiotherapist	2
	Paramedic	2
	Pharmacy Technician	0
	Social Prescribing Link Worker	3
	Nurse Associate	0
	Dietician	0
	Health and Wellbeing Coach	1
	Physician Associate	2
	Trainee Nurse Associate	3.76
	Mental Health Practitioner	0
	Total ARRS	**22.128**
Wentworth 1	Care Co-ordinator	4.936
	Clinical Pharmacist	6.814
	Physiotherapist	1
	Paramedic	3
	Pharmacy Technician	2
	Social Prescribing Link Worker	1.2
	Nurse Associate	2
	Dietician	0
	Health and Wellbeing Coach	0
	Physician Associate	1
	Trainee Nurse Associate	0
	Mental Health Practitioner	1
	Total ARRS	**23.95**

Appendix 3
Outline of Additional Role requirements

Cross cutting – all roles

- Work with and alongside the practice team as mart of a multi-disciplinary team
- Work with partner organisation as necessary (i.e. public health, hospital team and commissioners)
- Taking up training, education, and being part of any clinical or professional networks
- Providing training to colleagues and practice staff where appropriate
- Refer people to other health professionals/services where appropriate
- Taking part in clinical audits and research as appropriate
- Holistic approach to patient; working in partnership with patient and carer (where relevant)
- Contribute to building a seamless service across the primary care network (ie dieticians, podiatrists OTs etc)

Clinical Pharmacist

- assess and treat patients for specific diseases
- manage the care of patients with chronic (long term) diseases
- carry out medication reviews for people taking a number of complex medications – especially older people and those in care homes and those with several long term conditions
- undertake structured medication reviews and support patients to make sure that medicines are used well and effectively – for example not over prescribing anti-biotics; and helping to reduce waste

Pharmacy Technicians

- work with patients to make sure that people get the best results from their medicines, and support patients in taking decisions about medication, for example
    - checking how people are using inhalers
    - supporting medicine reviews and reconciliations
- making sure that people moving care settings get their medication when they need it
- for patients with complex medication, liaise with specialist pharmacists
- providing relevant advice and information
- support work that's helps to reduce waste and promotes efficiency; for example efficient ordering and return systems; reducing waste; and sorting and streaming prescription requests – meaning that more experienced staff review the more clinically complex issues

Social Prescribing Link Workers

- take referrals from 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;
- work with patients to produce a simple personalised care and support plan, with the aim of connecting people to community groups and statutory services in the areas that matter most to the patient
- 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'. This would include making sure that the persons needs are met through meeting any needs from disabilities, or communication
- explore and support access to a personal health budget where appropriate
- the Link workers would also work with local communities, community groups and the local voluntary sector; helping to build capacity in the sector and thriving organisations

Health and Wellbeing Coach

- provide personalised support to individuals, their families, and carers to support them to be active participants in their own healthcare; empowering them to manage their own health and wellbeing and live independently. This will be through supporting patients
    - to identify their needs

    - to establish and attain goals that are important to them
    - by providing interventions such as self-management education and peer support
    - to self-manage and adopt healthy behaviours
    - by considering the whole person and what matters most to them
- working with the social prescribing service to connect patients to community-based activities
- work with patients to understand their level of knowledge, skills and confidence relevant to their health condition
- support people to develop the knowledge, skills, and confidence to manage their health and wellbeing, and access community support offers
- explore and support patient access to a personal health budget, where appropriate

Care Coordinator

- use local health data to identify and work with a cohort of patients to deliver personalised care
- support patients to use decision aids in preparation for a shared decision-making conversation
- bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (based on what matters to the person
- help people to manage their needs through answering queries, making and managing appointments, and making sure that people have good quality written or verbal information to help them make choices about their care
- support people to take up
    - training and employment,
    - appropriate benefits where eligible
    - self-management education courses,
    - peer support (condition groups, for example)
    - personal health budgets where appropriate
- provide coordination for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals
- support co-ordination and delivery of MDTs within the PCN

Physician Associates

- face-to-face, telephone, and online consultations for emergency or routine problems, including management of patients with long-term conditions; including home visits when required
- provide first point of contact care for patients with undiagnosed problems; this could include taking a medical history and carrying out physical examinations. This would help to establish a working diagnosis and a care plan in partnership with the patient
- help to manage the patient's conditions through offering specialised clinics (ie diabetes, asthma)
- provide health advice
- analysing diagnostic test results and taking any actions needed

First Contact Physiotherapists

- assess, diagnose, triage, and manage patients; patients can self-refer or be referred by other health professionals
- provide first line treatment options including self-management, referral to rehabilitation and social prescribing
- work with the patients to develop tailored care programmes through
    - making decisions together
    - supporting self management
    - referrals where appropriate
    - creating plans that help the patient to be as physically active as possible; and support the patient in meeting their personal goals and reducing the need for medication
- request and progress investigations such as x-rays and blood tests, and referrals to facilitate the diagnosis

Appendix 3
Dieticians

- provide specialist nutrition and diet advice to patients, their carers, and healthcare professionals through treatment, education plans, and prescriptions
- educate patients with diet-related disorders on how they can improve their health and prevent disease by adopting healthier eating and drinking habits
- provide dietary support to patients of all ages (from early-life to end-of-life care) in a variety of settings including nurseries, patient homes and care homes
- work as part of a multi-disciplinary team to gain patient's cooperation and understanding in following recommended dietary treatments
- work with other health colleagues to ensure the smooth transition of patients discharged from hospital back into primary care, so that they can continue their diet plan

Podiatrists

- clinically assess, treat, and manage a caseload of patients of all ages with lower limb and foot conditions
- provide guidance to patients on equipment such as surgical instruments, dressings, treatment tables and orthotics
- prescribe, produce, and fit orthotics and other aids and appliances
- provide specialist treatment and support for high-risk patient groups such as the elderly and those with increased risk of amputation
- carrying out nail and soft tissue surgery using local anaesthetic
- deliver foot health education to patients

Occupational Therapists

- create treatment plans to increase patient mobility and ability to care for themselves
- work with patients to plan realistic goals with clear outcomes
- use verbal and non-verbal communication to meet the needs of patients with communication difficulties
- work with colleagues and patients' families, teachers, carers, and employers in rehabilitation planning
- where appropriate, and working with colleagues, support discharge and contingency planning for those receiving on-going care in residential, care home, hospital, and community settings
- review, evaluate and change rehabilitation programmes, helping people to rebuild lost skills and restore confidence
- as required, advise on home, school, and workplace environmental alterations, such as adjustments for wheelchair access, technological needs, and ergonomic support
- advise patients, and their families or carers, on specialist equipment and organisations that can help with daily activities
- help patients to adapt to and manage their physical and mental health long-term conditions, through the teaching of coping strategies

Nursing Associate

- work as part of the PCNs MDT to provide and monitor care
- provide support and supervision to training nursing associates, healthcare assistants and apprentices
- support registered nurses to enable them to focus on more complex clinical care
- perform and record clinical observations e.g. blood pressure, temperature, respirations and pulse
- once trained, provide flu vaccinations, ECGs and venepuncture and any other relevant clinical tasks
- care for individuals with dementia, mental health conditions and learning disabilities

Paramedics

- work as part of a MDT within the PCN
- assess and triage patients, including same day triage, and provide definitive treatment as appropriate or make referrals to other members of primary care team
- advise patients on general healthcare and promote self-management where appropriate

Appendix 3

- perform specialist health checks and reviews, including:
    - perform and interpret ECGS
    - perform investigatory procedures
    - undertake collection of pathological specimens including blood samples and swabs
- support delivery of anticipatory care plans
- provide alternative model to urgent and same day GP home visits

Mental Health Practitioners

- support shared decision-making about self-management
- facilitate onward access to treatment services
- provide brief psychological interventions