Lincolnshire
Primary Care Network Alliance

Annual Report 2019-20

Contents

Introduction

Welcome to the 2019-2020 Annual Report for the Lincolnshire Primary Care Network Alliance. This report gives us the opportunity to provide you with some insight as to the work of the Alliance and what we have done over the past 12 months, including a number of areas we are particularly keen to highlight.

The Alliance is about clinical leadership from working GPs with links into every GP practice in Lincolnshire. **Our focus is on population health management.** The Alliance is general practice's unified voice at a system level, ready to fully integrate with the local health and care system and be a core member of a future Integrated Care System (ICS).

" With over 90% of care delivered in general practice, this level of integration will be vital to the future success of our system and to improve the health and wellbeing of our population."

By working as a Lincolnshire-wide Alliance we have a stronger voice to influence new pathways, service delivery and workforce development that will bring investment in to general practice and integration between existing larger organisations and the newly formed primary care networks (PCNs).

Dr Sunil Hindocha

Dr Sadie Aubrey

General Practice in Lincolnshire

90% **of all NHS patient contacts are in general practice**

84 practices organised into

14 networks

434 FTE GPs currently

an expected 20% gap if no action is taken by 2021

Approximately 15,000 patient contacts per day

10%

of NHS budget in Lincolnshire spent on General Practice

Who we are

- Established in July 2019.
- Membership consists of all of the PCN Clinical Directors in Lincolnshire.
- All Clinical Directors are GPs who work directly with patients in GP practices in Lincolnshire.
- A combined and cohesive voice for general practice in Lincolnshire with reach into every practice.
- Engaged with other health and care providers, local government and Clinical Commissioning Groups (CCGs) to work at the forefront of the Lincolnshire health and care system.
- Provide clinical leadership for co-design and innovation in developing new models of care.

How we can help

- We work with commissioners and local health and care providers to meet our population's needs.
- We do this by co-designing services with a focus on population health management and integration between organisations.
- For CCGs and health and care providers in Lincolnshire, it means dealing with one Alliance rather than 14 PCNs or 84 GP practices - a frustration we have heard repeatedly in the past.

Why work with us

- We aim to work with system partners on the co-design of services.
- Involve us in any new pathways or services that affect our populations.
- No one is closer to knowing patients than their GPs as over 90% of care is delivered in general practice.
- Opportunity to build integrated person centred care rather than silo working.
- We are the voice of primary care, already working closely with the Lincolnshire Medical Committee (LMC) and NHS Lincolnshire Clinical Commissioning Group (CCG).

Example of how it might work:

The mental health needs of the population are not always being met by existing services, and low level mental health presents overwhelmingly to general practice.

Because GPs have to refer to a different organisation with a waiting list, patients are at risk of deterioration, where some immediate mental health expertise within general practice could have provided the support they needed and prevented deterioration.

The PCN Alliance can work with commissioners and mental health providers to redesign the mental health pathway/provision so that population health needs are met.

Population Health Management

Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap is increasing.

As set out in the NHS Long Term Plan, local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through Integrated Care Systems (ICS).

Therefore Population Health Management (PHM) is the critical building block for ICS's and enables PCNs to deliver with their local partners true Personalised Care (PC). Together, the three Ps (PHM, PCNs, PC) form a core offer for local people which ensures care is tailored to their personal needs and delivered as close to home as possible.

PHM enables systems and local teams to understand and look for the best solutions to people's needs – not just medically but also socially – including the wider determinants of people's health.

Many people need support with issues such as housing, employment, or social isolation – all of which can affect their physical and mental health – these solutions are often already available through, or better designed with, local people, the local council or a voluntary organisation.

Better partnership working using PHM to join up the right person with the right care solution helps us to improve outcomes, reduce duplication and use our resources more effectively. Health and care services are more proactive in helping people to manage their health and wellbeing, provide more personalised care when it's needed and that local services are working together to offer a wider range of support closer to people's homes.

Primary Care Networks

PCNs are groups of GP practices working together with other local organisations, such as community, mental health, social care, pharmacy, hospital and voluntary services. They will support the needs of a population that has grown, is living longer, and may need to access local health services more often.

Our GP practices have been working together for a number of years, through federations, networks, clusters and partnerships. The NHS Long Term Plan and the five-year framework for the GP contract, make this more formal without creating new statutory bodies.

In practice, PCNs will build on the work already undertaken and the current services offered by GP practices. It will mean greater provision of proactive, personalised and coordinated care, as well as more integration between health and social care. This will provide clear benefits for patients and GPs.

In Lincolnshire, PCNs are based on GP registered lists and serve communities between 29,000 to 77,000. They are designed to still provide the personalised care valued by patients, but be big enough to have impact and economies of scale through closer working.

Case Studies

Development of Clinical Pharmacists

Clinical Pharmacists (CPs) focus on patient medication and prescribing to help improve quality of care for people in Lincolnshire. CPs are a valuable asset to the primary care system in the county, working in General Practice, Care Homes and Urgent Care Centres.

There are currently 30 employed in primary care, carrying out a number of tasks, including refining prescribing policy, conducting patient medicine reviews and assisting GPs in extended access provision and out of hours surgeries.

As independent prescribers, CPs can also support some patients with long term conditions such as diabetes or coronary heart disease and provide independent clinics and appointments.

CPs ensure patients are seen quicker by clinicians with the right skill set to provide the right care and at the same time free up GP time to see patients with the most acute needs. It can also help reduce medicine waste, producing millions of pounds of savings for the NHS in Lincolnshire.

Supporting our care home residents

We are working with Lincolnshire CCGs and health and care partners on designing a framework to meet the needs of the Lincolnshire care home population.

An example of this already happening can be found in the south of Lincoln.

South Lincoln Healthcare PCN have been working in partnership with Lincolnshire Community Health Services NHS Trust (LCHS) and NHS Lincolnshire Clinical Commissioning Group (CCG) since December 2017 to provide the HomeHealth Care Home service.

The service ensures a dedicated team of Advanced Nurse Practitioners and an Occupational Therapist are providing care for the majority of their care home residents, with the support of the registered GP.

Key positive outcomes include closer working with care home staff and other community staff to provide joined up personalised care, advance care plans in place for more residents, 98% of residents achieving their first or second choice preferred place of death, 73% reduction in GP visits, 23% reduction in A&E attendances and 21% reduction in emergency admissions.*

** These figures are for the whole PCN care home population with 13 out of 17 care homes now covered by the HomeHealth service.*

Case Studies

Social Prescribing initiatives

With an estimated 1 in 5 GP visits not needing a clinical intervention Social Prescribing is available across our PCN's.

The service is delivered in partnership with Voluntary Centre Services and Lincolnshire Community Voluntary Service.

The county now hosts a team of 31 Link Workers employed to offer 1:1 support and advice to individuals that helps them to connect with their community, reducing social isolation and improving their health and wellbeing.

Over the Covid-19 lockdown period, Social Prescribing Link Workers carried out almost 11,000 support activities ranging from telephone calls, liaison with services, online MDTs, on ward signposting to services as the NHS GoodSam befriending service.

To learn more about Social Prescribing and service available, please visit:

https://www.voluntarycentreservices.org.uk/social-prescribing/
http://www.lincolnshirecvs.org.uk/

Embracing digital technology

Prior to the Coronavirus pandemic, Lincolnshire was already leading the way with embracing digital techology within general practice. However, the pandemic has enabled our PCNs to accelerate the use of technology to provide safer and more effecient ways of delivering primary care.

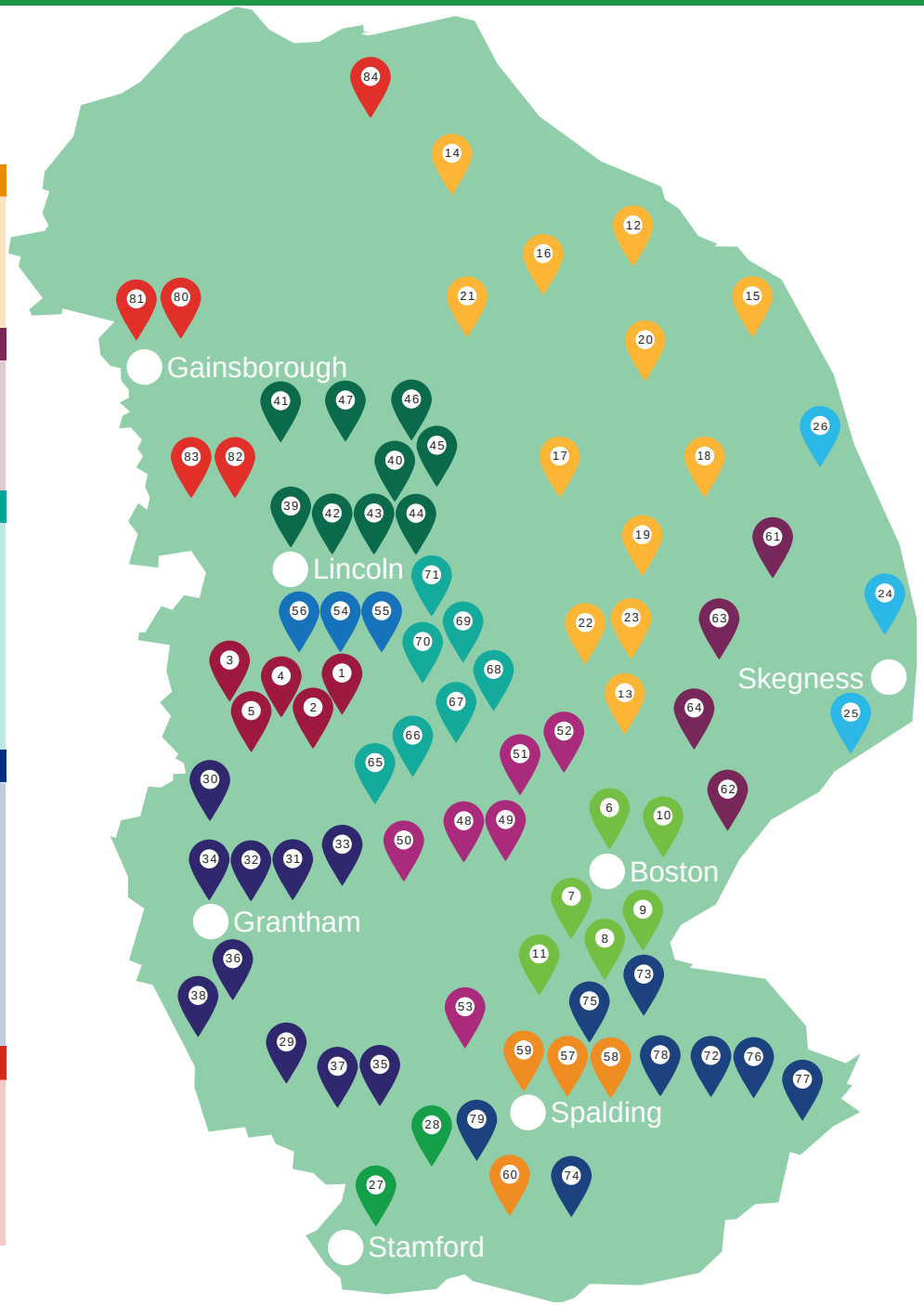
With internet, telephone, and video consultations up and running in all of our PCNs, some of our GP practices are reporting that they have been able to deal with about 80-90% of all patient contacts remotely without patients having to attend a face to face assessment.

Behind the scenes, technology is evolving also, with all our GP practices recently upgrading onto a more robust HSCN (Health & Social Care Network) connection. This has provided greater network availability, increased security, and faster internet speeds.

Perhaps the most recognised technology advancement in Lincolnshire is The Care Portal, which has given staff working in primary care greater access to patient information contained in different health and care systems. This is already proving a success with staff being able to access information in a more timely manner, providing patients with quicker access to diagnosis and treatment.

Lincolnshire PCNs

APEX	
1	Newark Road Surgery
2	Richmond Medical Centre
3	Birchwood Medical Practice
4	Boultham Park Medical Practice
5	Woodland Medical Practice
Boston	
6	Liquorpond Surgery
7	The Sidings Medical Centre
8	Greyfriars Surgery
9	Kirton Medical Centre
10	Parkside Surgery
11	Swineshead Medical Group
East Lindsey	
12	North Thoresby Practice
13	The New Coningsby Surgery
14	Caistor Health Centre
15	Marsh Medical Practice
16	Binbrook Surgery
17	The Wrabgy Surgery
18	East Lindsey Medical Group
19	Horncastle Medical Group
20	James Street Family Practice
21	Market Rasen Surgery
22	Tasburgh Lodge Surgery
23	Woodhall Spa New Surgery
First Coastal	
24	Beacon Medical Practice
25	Marisco Medical Practice
26	Hawthorn Medical Practice
Four Counties	
27	Lakeside HealthCare Surgery
28	Hereward Practice (Lakeside)
Grantham and Rural	
29	Colsterworth Surgery
30	Long Bennington Surgery
31	St Johns Medical Centre
32	St Peters Hill Surgery
33	The Harrowby Lane Practice
34	The Vine Street Surgery
35	Market Cross Surgery
36	Swingbridge Surgery
37	The Glenside Country Practice
38	The Welby Practice
IMP	
39	Abbey Medical Practice
40	Glebe Park Surgery
41	Willingham-by-Stow Surgery
42	Cliff House Medical Practice
43	Lindum Practice
44	Minster Practice
45	Nettleham Medical Practice
46	Welton Family Health Centre
47	Ingham Surgery
Sleaford	
48	Millview Medical Practice
49	Sleaford Medical Group
50	Ancaster & Caythorpe Surgery
51	Ruskington Surgery
52	Billinghay Medical Practice
53	The New Springwells Practice
Marina	
54	Brayford Medical Practice
55	Portland Medical Practice
56	University Health Centre
Market Deeping & Spalding	
57	Munro Medical Centre
58	Beechfield Medical Centre
59	Deepings Practice
60	Spalding GP Surgery
SOLAS	
61	Merton Lodge Surgery
62	Old Leake Medical Centre
63	The Spilsby Surgery
64	Stickney Surgery
South Lincoln Health Care	
65	Church Walk Surgery
66	Cliff Villages Medical Practice
67	Bassingham Surgery
68	Branston & Heighington FP
69	The Heath Surgery
70	Brant Road & Springcliffe Surgery
71	Washingborough Surgery
South Lincs & Rural	
72	Holbeach Medical Centre
73	Sutterton Surgery
74	Abbeyview Surgery
75	Gosberton Medical Centre
76	Littlebury Medical Centre
77	Long Sutton Medical Centre
78	Moulton Medical Centre
79	Bourne Galletly Practice Team
Trent Care Network	
80	Caskgate Street
81	Cleveland Surgery
82	Glebe Practice
83	Trent Valley Surgery
84	Hibaldstow Medical Practice



Lincolnshire PCNs: Profiles

APEX

Location: West Lincoln
No. of GP Practices: 5 (Birchwood Medical Practice; Boultham Park Medical Centre; Newark Road Surgery; Richmond Medical Centre and Woodland Medical Practice)
Population Coverage: 52,710
Population Profile: Apex's population and deprivation profiles are very similar to the Lincolnshire average.

What is the PCN currently doing?
Apex PCN Management Board meet monthly with both clinical and non-clinical representation from each practice.

Apex is already providing Extended Hours and Improved Access (with Marina PCN) and sharing Clinical Pharmacists and a Social Prescribing Link Worker across the PCN using a Hub dashboard approach to facilitate access to the PCN's patients.

During the year, one of the Apex practices, Richmond Medical Centre, integrated the transferred patients and employees of a nearby practice which had been put into special measures by CQC to provide stability and continuity of service for those patients.

Apex were early adopters of Clinical Pharmacists and already have a team of three, who have demonstrated their value by taking on a range of duties to save GP time and improve patient experience.

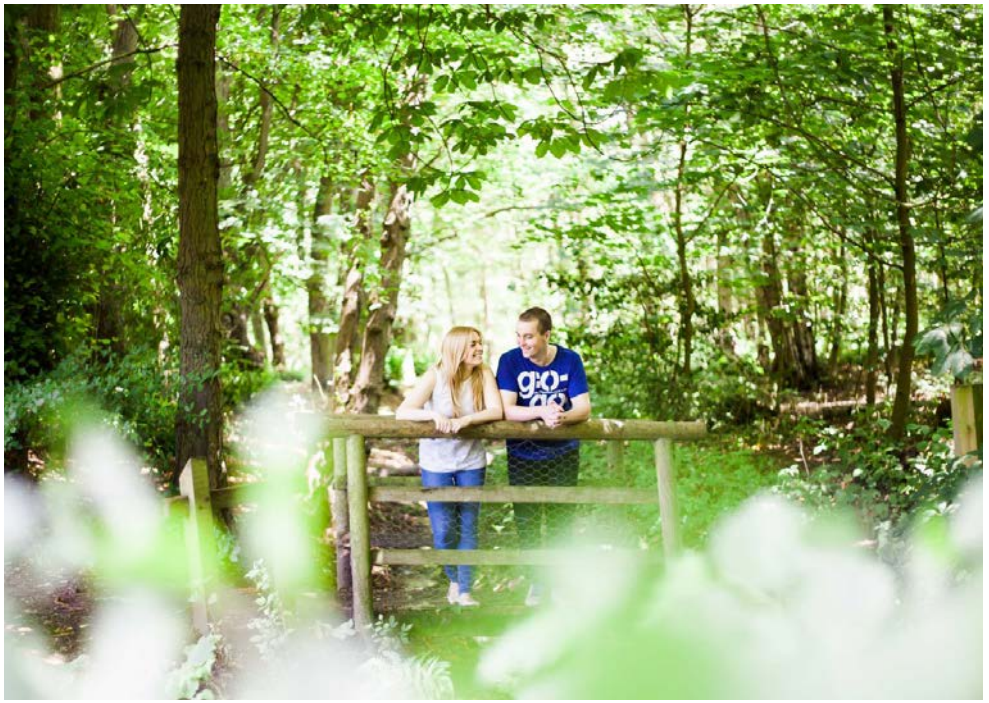
When Covid-19 struck all practices moved to a telephone triage model and adopted several on-line consultation and video consultation models across the PCN which allowed them to continue to deliver primary care services remotely. They also embraced the use of MS Teams for their own continued virtual communication.

What are the PCN's future priorities?
Apex's immediate priority is to implement the service requirements of the PCN DES for this year as well as extending their team of Clinical Pharmacists and recruiting First Contact Practitioners and a Care Co-ordinator to support the Enhanced Health in Care Home service.

All Apex practices have either adopted or are in the process of adopting the same clinical templates which should facilitate shared working particularly for the CPs and FCPs and there will be a continued drive towards using digital technology to support the delivery of their services and improving communication between the practices within the PCN.

Apex will also look at opportunities to improve collaborative working with the Neighbourhood teams and the wider healthcare system particularly with regards to the management of the frail, elderly housebound patients.

Planning for Winter and a potential second Covid-19 wave will also be in sharp focus for the Apex team to ensure they can continue to deliver safe services to their patients and protect their workforce.



Lincolnshire PCNs: Profiles

Boston

Location: Boston
No. of GP Practices: 6 (Greyfriars Surgery, Liquorpond Surgery, Kirton Medical Centre, Swineshead Medical Group, The Sidings Medical Practice, and Parkside Medical Centre)
Population Coverage: 78,000
Population Profile: Overall deprivation within Boston is higher than the Lincolnshire average with 22.9% of the population in the most deprived quintile.

What is the PCN currently doing?

Boston PCN is a forward thinking organisation that understands the importance of trusted relationships to provide a platform for communication with all parties to ensure the safe, efficient and effective delivery of care to the population.

In response to the recent COVID-19 pandemic, practices within the PCN have evolved with the use of virtual patient consultations including Qdoctor, E-Consult and AccrX. Whilst the practices have established the use of virtual consultations they also realise the need to offer consulting means to support and meet the needs of all patient cohorts and continue to see patients face to face or via telephone where necessary to ensure a personalised approach and equality of access.

Whilst the need for virtual consultations has ensured all patients continue to be provided efficient care the PCN has invested time to work in partnership with providers to co-design Information Sharing Agreements, which are sustainable post the pandemic, to ensure safe, legal and timely access to information to support better outcomes for the registered population.

At present the PCN offers a Clinical Pharmacist who offers proactive and responsive support to practices with electronic repeat prescribing, medicines optimisations and prescribing governance for not only the practices but the wider network. There are also two (generic) social prescribers supporting people with their health and wellbeing by linking in with groups and activities in our local community.

Boston PCN has committed to deliver the NHS England EHCH framework with the main focus being the provision of proactive care that is based on the needs of care home residents, their families and care home staff.

What are the PCN's future priorities?

Pre COVID the PCN had initiated work on our Mission, Vision and Values to support strategic objective development. This had paused, however the PCN recognises the need to restore this work to help with the branding and marketing of the PCN to our stakeholders and particularly our local population see this as key to support the shift in culture and behaviour as we co-design, test and implement new models of integrated care delivery and the changing roles of clinical and non-clinical workforce to develop a local resilient compassionate community.

It is anticipated that our valued and trusted relationship with the Neighbourhood Team will continue to grow and will be a fundamental enabler for delivery of our key objectives and support continued improvement and population health management in collaboration.

Lincolnshire PCNs: Profiles

East Lindsey

Location: Lincoln in the West, Grimsby in the North and stretching South-East towards Boston
No. of GP Practices: 11 (North Thoresby Practice, The New Coningsby Surgery, Caistor Health Centre, Marsh Medical Practice, Binbrook Surgery, The Wrabgy Surgery, East Lindsey Medical Group, Horncastle Medical Group, James Street Family Practice, Market Rasen Surgery, Tasburgh Lodge Surgery, and Woodhall Spa New Surgery)
Population Coverage: 85,215
Population Profile: We cover a mainly rural area with a sparsely spread population. We have only a few towns or sizeable communities. This presents a challenge to provide and maintain sustainable access to services for our population.

What is the PCN currently doing?

- Provision of clinical pharmacists for all practices to ensure primary care prescribing is safe, effective, and represents the best possible value for money without any compromise on quality. Achieved through implementation of Local Prescribing Schemes focused on medicine management & optimization.
- Provision of extended hours by all practices across the PCN, thus improving access for our patients.
- Creation of extended access hub for the locality to further improve access for patients outside of core working hours i.e. evenings, weekends and bank holidays.
- Provision of First Contact Physiotherapists to improve rapid access to Musculoskeletal advice and treatment.
- Provision of Social Prescribing Link Workers for the locality to help reduce health inequalities by supporting people to unpick complex issues affecting their wellbeing.
- Pilot telehealth system in Care Homes including provision of appropriate training. Implement online consultation across the locality to enhance the experience of care for patients and support general practice in managing time and workloads, as well as improving access and sustainability.
- Pilot Care Home Visiting service across the patch.
- Working at scale and collaborative to align delivery of services, bringing care closer to home for our patients (i.e. pilot One-Stop Dermatology Clinic in General Practice) and improving overall quality of care and patient experience.
- Working closely with neighbourhood teams to improve co-ordination of care so as to meet individual patient needs. Launch of project ECHO to improve end of life care for patients in East Lindsey.

What are the PCN's future priorities?

- Provision of enhanced health in care homes by multidisciplinary teams.
- Early cancer diagnosis.
- Provision of first contact paramedics.
- Provision of mental health practitioners.
- Provision of care co-ordinators.
- Forging closer relationship with neighbouring PCNs in Lincolnshire East (Skegness & Coast and Boston) to tackle the unique challenges that we face in our region.
- Working in partnership with external organizations to deliver optimal personalised care for the population that we serve.

Lincolnshire PCNs: Profiles

First Coastal

Location: East Coast of Lincolnshire
No. of GP Practices: 3 (Beacon Medical Practice, Hawthorn Medical Practice, Marisco Medical Practice)
Population Coverage: 53,000
Population Profile: Population swells during the summer months due to the tourism industry, which impacts severely on the health infrastructure in this area.

What is the PCN currently doing?

First Coastal PCN was formed on 1st July 2020, following the split of the original Skegness & Coast PCN. It is, therefore, very much in its infancy but already has key projects underway.

This includes:

- Recruitment of Clinical Pharmacist.
- Recruitment of Social Prescribing Link Worker.
- Development of a Care Home Visiting Service to incorporate the input of a Geriatrician.
- Reviewing the pathway of cancer referral within each individual practice and look at establishing a PCN process.
- Using the principles of Neighbourhood MDT working to develop anticipatory, escalation and advance care planning. This will support personalisation and the palliative care schedule requirements.
- Working closely with the Communities Team of East Lindsey District Council, who are an integral part of our PCN Board.
- Supporting the development & working with partners on the Towns Fund bids for Mablethorpe & Skegness as part of Connected Coast Board.

What are the PCN's future priorities?

The three practices in the First Coastal PCN share the same challenges of deprivation and health inequalities that have been prevalent along the East Coast for many years. Working with partners, the PCN is supporting the development of the Towns Fund bids for Mablethorpe & Skegness as part of the connected coast board.

From the health information we have, it has been noted that Mablethorpe and Skegness are ranked as the first and third most deprived towns in England and Wales respectively, and first and second as having being affected most by Covid-19 in terms of socio-economic deprivation.

Workforce, recruitment and retention is and ongoing concern. However through integration, collaborative working and system support there is a desire to use innovation and creative thinking to address the present barriers. First Coastal PCN is also working with Whole System Partnership on demand and capacity to support future workforce solutions.

As well as endeavouring to achieve the requirements of the PCN DES as part of the Five Year Plan, First Coastal PCN will be working with key stakeholders to address the challenges that our patient population face and try to raise health awareness and drive down health inequalities, whilst developing the appropriate services for our very unique population.

Lincolnshire PCNs: Profiles

Four Counties

Location: Stamford and part of Bourne
No. of GP Practices: 2 (Lakeside Hereward and Lakeside Stamford)
Population Coverage: 44,174

What is the PCN currently doing?

4Counties has grown out of the Primary Care Home in Stamford, the precursor to PCNs, through which we began our collaborative journey in 2016.

We have now joined up with Hereward in Bourne and our emphasis is to build on the model to bring the care and services around citizens in these communities.

This history gives us the benefit of close working and an advisory board whose membership includes a whole range of healthcare providers; local authorities and county councils; volunteer sector; public health; CCG; STP and GP practices. This plan is that this group will be repurposed into the 4Counties PCN Executive Board as trust and relationships continue to grow.

We are keenly focused on our communities and as locally embedded organisations are best placed to lead on the transformation around neighbourhood working. Our communities need to be trusted and encouraged to explore how to feel they can flourish. Through engagement with people, local charities and other organisations we have already begun work around how we might reshape the way we think about and care for mental health and wellbeing of our local citizens. Indeed the model developed in 4Counties has been taken on as the basis of the transformation plan for the whole County.

There are also ongoing plans to collaborate with neighbouring PCN's to develop an Extended Health in Care Homes proposition based on the model grown on our patch and extend it to a wider area.

What are the PCN's future priorities?

- The development of a workforce to support the growing health and care requirements for the local population, this will include more pharmacists, physiotherapists and expansion of our home visiting team for those who need care provided in their own home.
- Locally we have the beginnings of a model to change the culture and ways we manage mental health. The PCN in collaboration with the voluntary sector, LPFT and other stakeholder groups are keen to develop this and become an exemplar of how to best support citizens wellbeing and those suffering with mental ill health.
- We will create forum events focused on certain areas that require a 'population health' approach including frailty, mental health and children and families. We will try to get anyone who has a stake in these arenas to come, share ideas and listen to those of others to shape how the future looks.
- Working with public health to truly embed prevention in how health is approached locally. We have already become a partner of Connect Stamford an organisation promoting active travel and look forward to the development of a green wheel in the town.

Lincolnshire PCNs: Profiles

Grantham and Rural

Location: Grantham and surrounding areas
No. of GP Practices: 10 (Colsterworth, Long Bennington, Market Cross, St John's, St Peter's Hill, Swingbridge, Glenside, Harrowby Lane, The Welby practice, and Vine Street)
Population Coverage: 74,539

What is the PCN currently doing?

In collaboration with the Sleaford PCN, we form part of the K2 Federation. We have:

- Recruited and employed a team of Community Pharmacists.
- Initiated First Contact Physio Service in partnership with LCHS and LPFT.
- Care Coordination Service supporting frail people at home and in care homes.
- Set up Red site and home visiting service to deal with patients with COVID-19 symptoms at Grantham hospital.
- Mental Health Transformation with new staff integrated into the Neighbourhood Team and a new community centre in Grantham town pending doors opening.
- Developed Community Diabetes model in partnership with LCHS and ULHT.
- Discharge to Assess development programme with the Neighbourhood Leads and responding to the changes at Grantham Hospital due to COVID-19.
- Online Consulting, implementing askmyGP service to improve patient access.
- Extended Access and Extended Hours delivered at a central hub in Grantham and supported by local delivery at every member practice.
- Adopting the use of Ardens templates to improve and standardise the quality of referrals, pathways, collecting information and reporting.
- Internal internet for sharing information, Learning Management System and records management.
- Management of the GOS-18 Ophthalmology Gateway service.

What are the PCN's future priorities?

- To further bolster our workforce by developing new services in partnership with other delivery partners and recruiting. This will include introducing a Community Paramedic scheme with EMAS following a successful pilot in Sleaford.
- A leadership programme for our board and member practices and to support the development of a population health approach to help us mature as a network.
- To roll out more services into collaborative working with secondary care and community health closer to, and more convenient for our patients, including: Community Phlebotomy Services, Community Respiratory Services, Community Dermatology Services, Community Diabetes, and Community Mental Health.
- Focus on supporting people with Learning Disabilities, starting initially with a programme to improve LD Health Checks.
- Continuing to support Neighbourhood Working with particular focus on working with community nursing and therapy solutions for frail and vulnerable people.
- Working closer with the community and voluntary sector as a fundamental part of our Neighbourhood Team. Implement Care Navigation and signposting as an integral part of our member practice and neighbourhood operating model.
- To assist practices with managerial and clinical support where required, including the potential for shared administrative services.
- We intend to develop a new Primary care site in Grantham in response to forecast population growth.

Lincolnshire PCNs: Profiles

IMP

Location: North of Lincoln
No. of GP Practices: 9 (Abbey Medical Practice, Cliff House Medical Practice, Glebe Park Surgery, Lindum Medical Practice, Minster Medical Practice, Nettleham Medical Practice, The Ingham Practice, Welton Family Health Centre, and Willingham-By-Stow Surgery)
Population Coverage: 67.000
Population Profile: Ranging from some of the least deprived areas in Lincolnshire to some of the most deprived wards (top 10) in the East Midlands.

What is the PCN currently doing?

The PCN is actively involved in a number of projects. It is currently working with a fellow PCN (Marina), LPFT, Lincoln City Council, YMCA Nomad and other organisations to support the Homeless Population of Lincoln. It is also developing an enhanced Care Home Service to better support the care home population.

The PCN has got a number of clinical pharmacists working across it's area via a sub-contract with Lincolnshire Co-Op. These pharmacists are working with GP practoces to improve medicines management. The PCN is expanding the pharmacy team further.

In addition the PCN offers a social prescribing service provided by VCS. Over the last few months these have also been used to support isolated and vulnerable individuals during the pandemic.

The PCN is currently enhancing its workforce through further recruitment of First Contact Practitioners, Pharmacy Technicians, a care co-ordinator, Occupational Therapist and in the future Paramedics and Mental Health Practitioners. In order to support this working groups have been set up with representation from the PCN, practices and LCHS. These groups are currently expanding to take in other stakeholders as required.

Practices and the PCN have worked together to successfully established a hot site to deal with Covid positive patients.

Imp is also in the process of developing an MSK service and an Asthma Review service to provide better quality of care to its patients. The PCN is also working on reducing unnecessary secondary care activity, in particular looking at utilising existing skills within the PCN area.

What are the PCN's future priorities?

- Recruiting to the additional roles
- Delivery of the elements within the Network DES
- Continuing to work with fellow PCNs on projects e.g. Homeless service
- Continue to engage with other PCN through the alliance and with the wider system
- Start building partnerships with other organisations
- Planning our approach to population health management

Lincolnshire PCNs: Profiles

Sleaford

Location: Sleaford and surrounding areas
No. of GP Practices: 6 (Ruskington, Ancaster and Caythorpe, Sleaford Medical Group, New Springwells, and Millview Medical Centre)
Population Coverage: 56,678

What is the PCN currently doing?

In collaboration with the Grantham & Rural PCN, we form part of the K2 Federation. We have:

- Recruited and employed a team of Community Pharmacists.
- Initiated First Contact Physio Service in partnership with LCHS and LPFT.
- Care Coordination Service supporting frail people at home and in care homes.
- Set up Red site and home visiting service to deal with patients with COVID-19 symptoms at Grantham hospital.
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- Extended Access and Extended Hours delivered at a central hub in Grantham and supported by local delivery at every member practice.
- Adopting the use of Ardens templatesto improve and standardise the quality of referrals, pathways, collecting information and reporting.
- Internal internet for sharing information, Learning Management System and records management.
- Management of the GOS-18 Ophthalmology Gateway service.

What are the PCN's future priorities?

- To further bolster our workforce by developing new services in partnership with other delivery partners and recruiting. This will include introducing a Community Paramedic scheme with EMAS following a successful pilot in Sleaford.
- A leadership programme for our board and member practices and to support the development of a population health approach to help us mature as a network.
- To roll out more services into collaborative working with secondary care and community health closer to, and more convenient for our patients, including: Community Phlebotomy Services, Community Respiratory Services, Community Dermatology Services, Community Diabetes, and Community Mental Health.
- Focus on supporting people with Learning Disabilities, starting initially with a programme to improve LD Health Checks.
- Continuing to support Neighbourhood Working with particular focus on working with community nursing and therapy solutions for frail and vulnerable people.
- Working closer with the community and voluntary sector as a fundamental part of our Neighbourhood Team. Implement Care Navigation and signposting as an integral part of our member practice and neighbourhood operating model.
- To assist practices with managerial and clinical support where required, including the potential for shared administrative services.
- We intend to develop a new Primary care site in Grantham in response to forecast population growth.

Lincolnshire PCNs: Profiles

Marina

Location: Central Lincoln
No. of GP Practices: 3 (Brayford Medical Practice; Portland Medical Centre and the University of Lincoln Health Service)
Population Coverage: 31,125
Population Profile: Unusually over 50% of Marina's patient population is in the age group 15 – 29 years.

What is the PCN currently doing?
Marina is already providing Extended Hours and Improved Access in conjunction with Apex PCN and sharing First Contact Physiotherapist; Social Prescribing Link Worker & Mental Health Practitioner resources across the PCN using a Hub Dashboard approach to facilitate access to the PCN's patients.

Marina is also actively collaborating with the wider healthcare system on a number of projects, one of which is the Holistic Health for the Homeless Team which is designed to improve the health of Lincoln's homeless population by offering enhanced primary care services with the support of other agencies such as LPFT, Lincoln City Council, CCG, Imp PCN and the Neighbourhood team.

Marina PCN Exec Board meet monthly and are participating in an Organisational Development programme.

The Practice Managers meet weekly to improve communication and develop joint working initiatives, which proved invaluable when they needed to work as a single team to adapt and change to maintain patient services when Covid-19 struck. They were able to work together to quickly introduce a telephone triage model utilising the Hub as well as adopting on-line consultation models and improved internal communication with the use of MS Teams.

What are the PCN's future priorities?
Marina's immediate priorities are to implement the service requirements of this year's PCN DES and to extend their multi-disciplinary team to improve patient experience as well as saving GP time by establishing a Clinical Pharmacist team whilst they also continue to develop their collaboration with other healthcare providers across the wider system.

Develop the Marina Vision, Values and Strategy; a Population Health Model for 18 – 29 years age group; and a Workforce Plan to identify future resource requirements as well as a training needs analysis to ensure they develop and upskill their existing team to meet their future demands.

Ensure they have the appropriate resources, including digital technology, to prepare themselves for the challenges of Winter & a potential second Covid-19 wave in order to protect the safety and wellbeing of both their patients and team whilst being able to continue to deliver their services.

In the medium term, Marina wants to be an active participant within the Provider Alliance with strong foundations to provide excellent population health management.

Lincolnshire PCNs: Profiles

Market Deeping & Spalding

Location: Market Deeping & Spalding
No. of GP Practices: 3 (Munro Medical Centre, Beechfield Medical Centre, Deepings Practice. and Spalding GP Centre)
Population Coverage: 63,928

What is the PCN currently doing?

The PCN is focusing on has made significant progress against some significant population health challenges when compared national and local Lincolnshire data and the future priorities for the PCN are all aimed at supporting residents and to improve these key areas, for example:

The PCN has an older than average population spread across two main towns and surrounding villages with an overall deprivation levels higher than average across the PCN.

The PCN will focus on reducing the emergency admission rate and improving prevalence rates of cancer, asthma, rheumatoid arthritis, depression, atrial fibrillation, heart failure, CHD and stroke which are historically higher than the Lincolnshire average.

The PCN has already embedded a team of care coordinators across the PCN which has been complimented by the introduction of additional roles including Occupational Therapists, Clinical Pharmacists, first contact physiotherapists, and social prescribing link workers this year.

What are the PCN's future priorities?

As we move towards 20/21 the PCN will be focusing its delivering the requirements of the specific PCN services. This means that initially the focus will be on the delivery of:

- Medicine management and optimization.
- Enhanced Health in Care Homes.
- Early Cancer Diagnosis

The PCN will continue to deliver Extended Hours at evenings improving access to primary care.

This will be achieved through the PCN further developing its workforce and the introduction of additional:

- Clinical Pharmacists.
- First Contact Physiotherapists.
- Social Prescribing Link Workers

We will also be preparing for additional Mental Health Support from April 2021.

Lincolnshire PCNs: Profiles

South Lincoln Healthcare

Location: South side of Lincoln
No. of GP Practices: 7 (Church Walk Surgery, Cliff Villages Medical Practice, Bassingham Surgery, Branston & Heighington Family Practice, The Heath Surgery, Brant Road & Springcliffe Surgery, and Washingborough Surgery)
Population Coverage: 49,371
Population Profile: Higher percentage of older people and lower deprivation indicators than the Lincolnshire average. The leading cause of disability is musculoskeletal disorders followed by mental health.

What is the PCN currently doing?

- HomeHealth Care Home service, in partnership with LCHS and Lincolnshire CCG, has been operational since December 2017. A dedicated team of ANPs and an OT provide care for the majority of our care home residents, with the support of the registered GP.
- Primary Care Occupational Therapy – an OT and student OT working directly with two out of seven practices (a pilot scheme funded by HEE), showing benefits for practices and patients.
- Social prescriber – has been actively supporting patients in our area in response to referrals from practices, the Neighbourhood Team and other community staff. The social prescriber, along with our Neighbourhood Lead and the OT have been supporting extremely vulnerable patients during the coronavirus pandemic.
- Improved Access – working together to provide evening and weekend appointments, with any patient across the 7 practices being able to book into appointments provided by other practices.
- ECGs, ambulatory BPs and ear irrigation – allowing patients to access these services at practices rather than having to attend hospital services.
- The coronavirus pandemic saw the PCN rising to the challenge of working collaboratively to support each other and ensure our population's needs were met during this challenging time.

What are the PCN's future priorities?

- Our Therapy Team - The team will aim to provide both proactive and swift reactive care for our older frailer patients who are at risk of falls and admissions, including admission and discharge tracking and coordination of care. Identifying those at risk of frailty and providing interventions early to prevent progression will be a priority.
- Clinical Pharmacists – recruitment to this role using the ARRS to support medicines management and structured medication reviews, providing expert medicines advice to patients and freeing up GP time.
- First Contact Practitioners – recruitment to this role using the ARRS to provide expert advice to patients with musculoskeletal conditions at first presentation.
- HomeHealth Service – continue to develop the service by forming a wider MDT with other community services in line with the PCN EHCH DES.
- Collaborative working – We plan to build on the work already started with GP Resilience Funding to enhance collaborative working between practices.
- Medicspot remote consultation kit – originally obtained for use in our COVID hot clinic, this is now due to be trialled in a branch site of one of our practices. This will allow patients to attend their preferred site and have a consultation with a clinician at another site, via a video link, with basic examination kit available for the patient to use guided by the clinician. This will be used by nurses doing long term condition/contraception reviews and by ANPs and GPs for consultations.

Lincolnshire PCNs: Profiles

South Lincs & Rural

Location: South Lincolnshire
No. of GP Practices: 8 (Gosberton Medical Centre, Moulton Medical Centre, Sutterton Surgery, Galletly Practice, Abbeyview Surgery (Lincolnshire practice of the year), Holbeach Medical Centre, Littlebury Medical Centre, and The Suttons Medical Group)
Population Coverage: 77,130
Population Profile: Older than average population in a highly rural area with associated health challenges and social isolation.

What is the PCN currently doing?

The South Lincolnshire Rural PCN has made significant progress against some significant population health challenges when compared national and local Lincolnshire data and the future priorities for the PCN are all aimed at supporting residents and to improve these key areas, for example:

- The PCN has an older than average population in a highly rural area which and therefore the PCN will aim to support associated health challenges and social isolation.
- Compared to Lincolnshire as a whole overall deprivation levels are higher than average across the South Lincolnshire Rural PCN.
- The PCN will focus on reducing the emergency admission rate and improving prevalence rates of cancer, asthma, rheumatoid arthritis, depression, atrial fibrillation, heart failure, CHD and stroke which are historically higher than the Lincolnshire average.
- The PCN has embedded a team of care coordinators who are the heartbeat of the PCN activity and will be complimented over the year by further expansion of the Clinical Pharmacist team and first contact physiotherapists, social prescribing and health and wellbeing coaches.

What are the PCN's future priorities?

During 20/21 the PCN is developing its strategy to support it local population though the immediate priority is the delivery of the requirements of the PCN DES. This means that initially the focus will be on the delivery of:

- Medicine management and optimization supported by our team of Clinical Pharmacists.
- Enhanced Health in Care Homes supported by our team of Clinical Pharmacists.
- Early Cancer Diagnosis and have established an in house ultrasound service that is available to all practices.
- Extended Hours delivery and preparation for a revised "access" model to improve access to General Practice.

This will be achieved through:

- The introduction of additional workforce including Clinical Pharmacists, First Contact Physiotherapists, and Social Prescribing Link Workers. This will build on the Care Coordinator model already established in the South of Lincolnshire to form a PCN workforce that is fully integrated into primary care.
- In addition the PCN has identified the need to Mental Health support and will be looking to accelerate recruitment into these roles prior to 2020/21.
- Continued emphasis on collaborative working across practices with the manager's forum developing clear work streams for prioritisation.

Lincolnshire PCNs: Profiles

Trent Care Network

Location: Saxilby, Gainsborough and Brigg
No. of GP Practices: 5 (Caskgate Street Surgery, Cleveland Surgery, Hibaldstow Medical Practice, The Glebe Practice, and Trent Valley Surgery)
Population Coverage: 39,936
Population Profile: Overall deprivation is similar to that of Lincolnshire with 20% of the population in the least deprived quintile. Our population is very similar to the Lincolnshire average for the size of networks Our expected growth by 2025 is 3.1% and in 2035 is 6.6%.

What is the PCN currently doing?
Not having previously been a Federation, our 5 practices came together in 2019 to form Trent Care Network, and since then we have developed some really good working relationships with a variety of care providers.

With PCN colleagues in Lincoln (West), we procured a social prescribing service with Voluntary Centre Services. The social prescribers and the Neighbourhood Team have been particularly helpful during Covid-19, contacting and supporting shielding and vulnerable patients.

Through joint working with the CCG, other PCNs and LCHs, we are working on a framework model to recruit to the First Contact Practitioner role. We anticipate doing something similar for the Paramedic role for 2021/22.

Pre Covid-19, we had started to implement online consultation, during the pandemic Nationally, digital ways of working such as remote working and total triage were expedited. Our PCN practices have implemented total triage tools, such as askmyGP and eConsult.

Our Network works closely with the Neighbourhood Team Lead. During Covid-19, NHS England made a request that primary care and community health and care services enhance support for care homes. The Neighbourhood Team Leads were asked to be the designated clinical leads for care homes. Our Network's Neighbourhood Team Lead is the designated clinical lead for our care homes and also South Lincoln Healthcare PCN's care homes. We have also aligned each of our care homes to a lead practice within our Network.

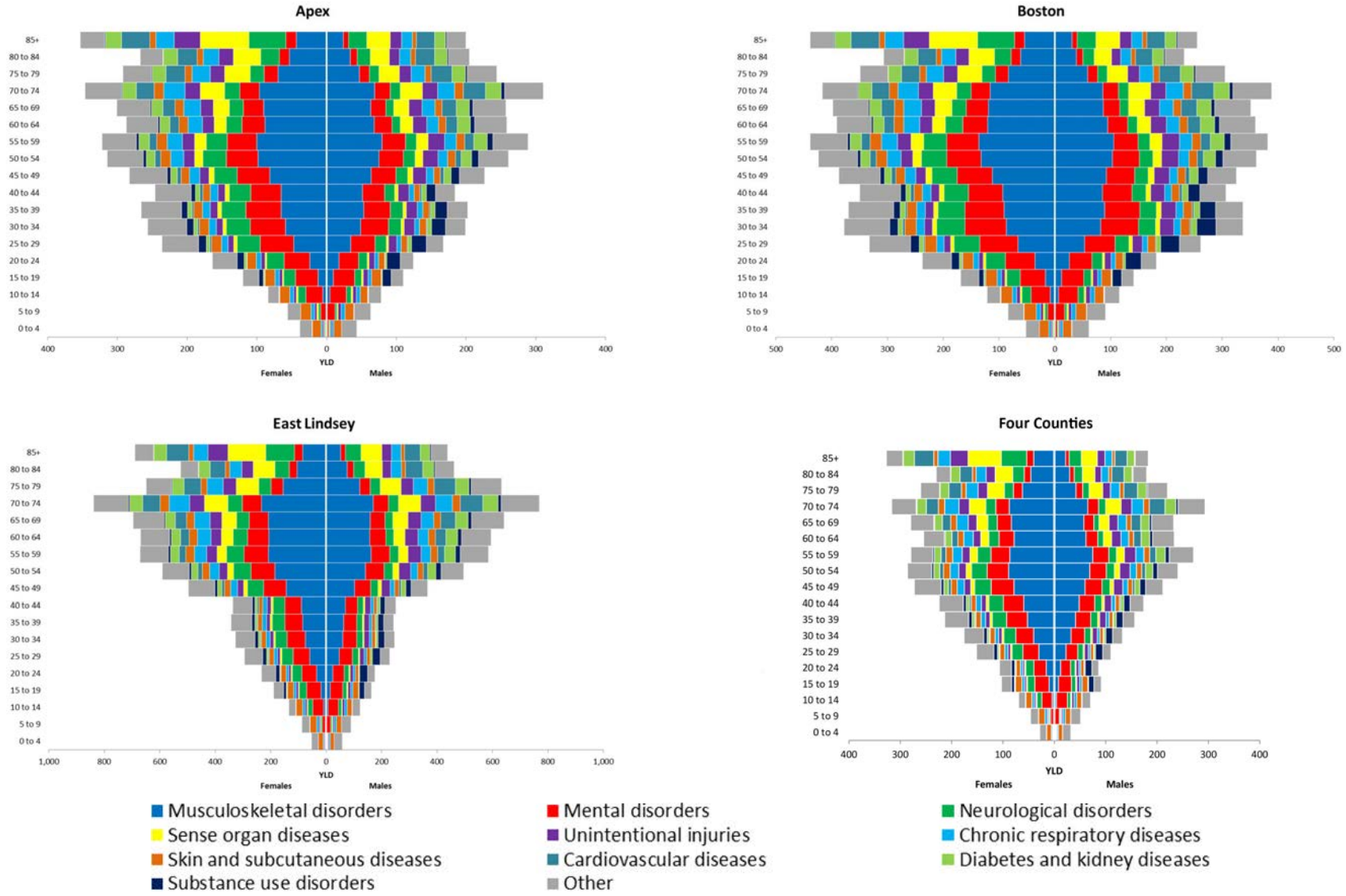
What are the PCN's future priorities?

- Working towards delivering the PCN Network DES requirements
- Recruiting to the additional roles – Clinical Pharmacists, First Contact Practitioners and Occupational Therapist (Paramedic and Mental Health Practitioners in 2021/22)
- Continuing to engage with other PCNs and the PCN Alliance Clinical Directors
- Continuing to forge stronger working relationships with our local partners and the wider system to help improve patient care
- Engaging with the Mental Health Transformation Team to begin to deliver and integrate mental health services into the PCNs community
- Utilising the population health management data to help us to provide better care and improve physical and mental health outcomes, promote wellbeing and reduce health inequalities for the population

Lincolnshire PCNs: Population breakdown

Years with lived disability*

* This is just one example of the data available. Further information can be found at: www.research-lincs.org.uk/area-profiles.aspx



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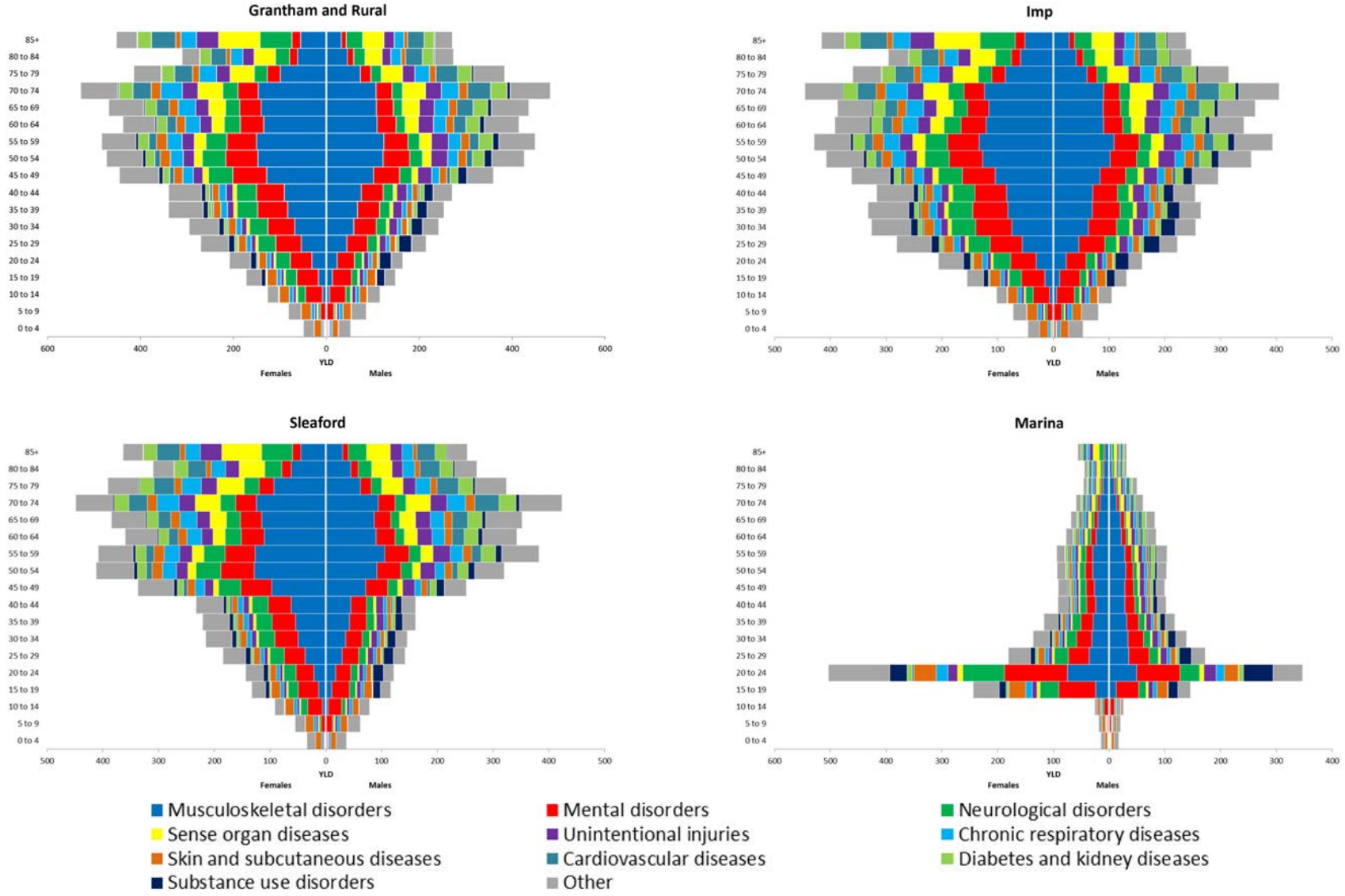

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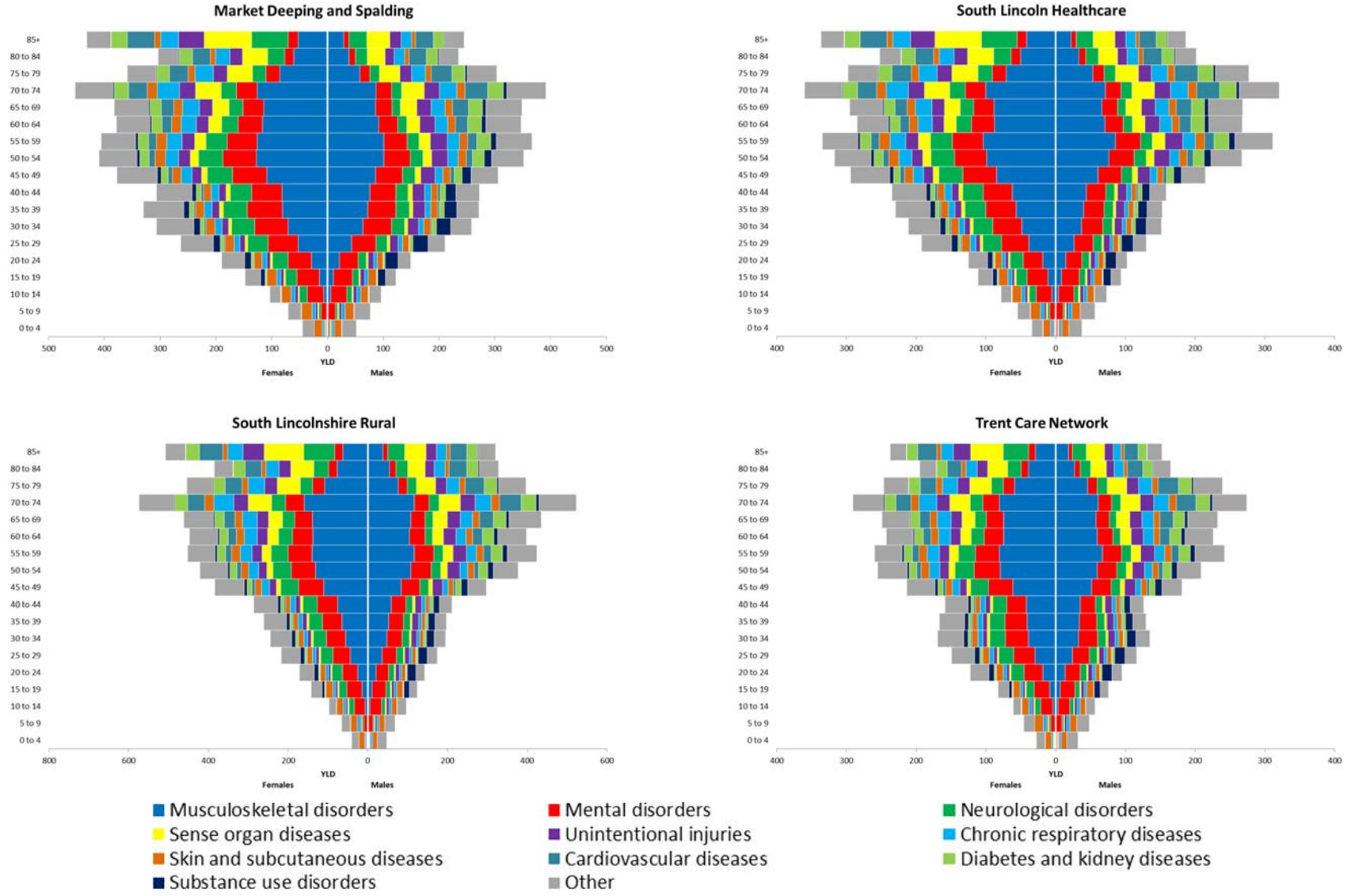

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