SUTTON PRIMARY CARE NETWORKS ANNUAL REPORT 2021

SUTTON
PRIMARY CARE
NETWORKS
INTEGRATING
& INNOVATING

SUTTON PRIMARY CARE NETWORKS
INTEGRATING & INNOVATING

Contents

Introduction from our Chair

Our year

Our work this year has been in collaboration and partnership with a number of people and organisations including the clinical directors of each of our member Primary Care Networks (PCNs); Sutton GP Services; South West London CCG (and the local Sutton Team); Sutton Health and Care; Epsom and St Helier Hospital; Sutton Council; local Sutton charities and our Sutton Health Team.

We want to particularly thank all our practices and their staff, primary care networks, healthcare providers and those in the public, community and voluntary sectors for their endeavours over the past 12 months. Without them we would not have achieved the highest vaccination rates in London while still providing the best care we can to local people. It truly has been a team effort.

During the Covid 19 pandemic we have proved ourselves to be flexible and innovative. Our 'day jobs' changed significantly as we adapted to the new demands placed on primary care by the pandemic. Our practices underwent years of change in a matter of weeks with remote working and consultations being embedded as new ways of working. We quickly deployed 'hot' services, enabling primary care to treat patients in their homes, in care homes, and at dedicated sites. We helped set up and staff our first vaccination site at Nonsuch, moved to deliver vaccinations in our practices and then to deliver flu and covid booster vaccinations in two dedicated centres in Wallington Old Town Hall and the Thomas Wall Centre.

We needed to set up services not just for individual GP practices, but borough and ICS wide. Our local call and recall team, who were inviting patients for vaccination, expanded almost overnight to become the South West London Call and Recall Team, contacting over 200,000 hard to reach people about their missing vaccination. Despite the pandemic, we continued to provide access to primary care outside of general practice through our extended access hubs at Robin Hood Lane and Wrythe Green; developed and delivered MDTs and the Virtual Ward; expanded our Home Visiting Service to cover all house bound patients and brought in over 40 new staff under the ARRs programme.

We are pleased with the integral part we played in the Sutton and South West London approach to dealing with the pandemic; of how we collaborated, supported and innovated.

However, we also know that we need to reflect on the lessons we have learnt during the outbreak and consider how we can support primary care and our practices going forward. As a result we have hosted Sutton's first Population Heath Summit at which we shared with our partners and communities our ambitious plans to move to deliver truly preventative care using population health approaches.

We have also developed and shared our strategic plan which places a neighbourhood health service wrapped around each PCN and its member practices at the heart of our work.

During the year Sutton GP Services saw a change in its Directors with the PCN Directors becoming the Directors of Sutton GP services. In view of the centrality of the PCNs to all of our work we decided after consultation with PCNs and Practices to adopt the trading name of 'The Sutton PCNs'.

Since the annual accounts presented in this report we have experienced a significant increase in turnover, largely as a result of the close working between our four PCNs. We will be reviewing how we can deliver our continuing commitment and founding principle of investing back into general practice through support and service delivery. This year we have invested in acquiring Ardens for all our practices; hosting the population health summit; and sourcing the software and other tools needed by our practices to be as effective and efficient as they can be.

We are extremely proud of the role we play as both an advocate for GP practices, primary care networks and primary care, but also for population health as part of the broader vision for health in Sutton.

Dino Pardhanani
Chair, Sutton Primary Care Networks

Who are we and what do we do?

At Sutton PCNs we are a growing team of clinicians and non-clinicians with significant experience working in healthcare across the borough of Sutton. We help practices and primary care networks to work at scale across Sutton, provide leadership at a borough (Place) level and provide targeted and effective patient care. We also support services and projects as part of an alliance, enabling us to offer a broad range of support to general practice.

We contribute to the health agenda for Sutton and are driving population health initiatives across the borough, working with many partners and providers who include:

- **Epsom and St Helier Hospital**
- **Sutton Health and Care** – our local community services provider alliance
- **South West London CCG** and the local Sutton Team
- **VOCARE** (around 111 services) and **SELDOC** (Out of Hours Services)
- **London Ambulance Service** (LAS)
- **Sutton Council**
- **The charity and voluntary sector**

Collaboration with these organisations became ever more important in 2020/21 during the Covid-19 pandemic. We are very proud of our role this year working on the Sutton and South West London programmes to tackle Covid-19 and the impact it has had on our borough. The pressures and challenges experienced in primary care are something we have a real understanding of. We have qualified and seasoned clinicians in our organisation. Some of our team have been working on the front-line during the pandemic. We know the support that is needed for general practice and we also appreciate what needs to be done to provide high standards of patient care. We're committed to doing just that.

Our Vison, Mission and Values

OUR VISION

'Strengthen General Practice to become a leading provider of equitable, high-quality integrated health and care services that allows the people of Sutton to live the best quality of life'.

OUR MISSION

To deliver our vision we will:

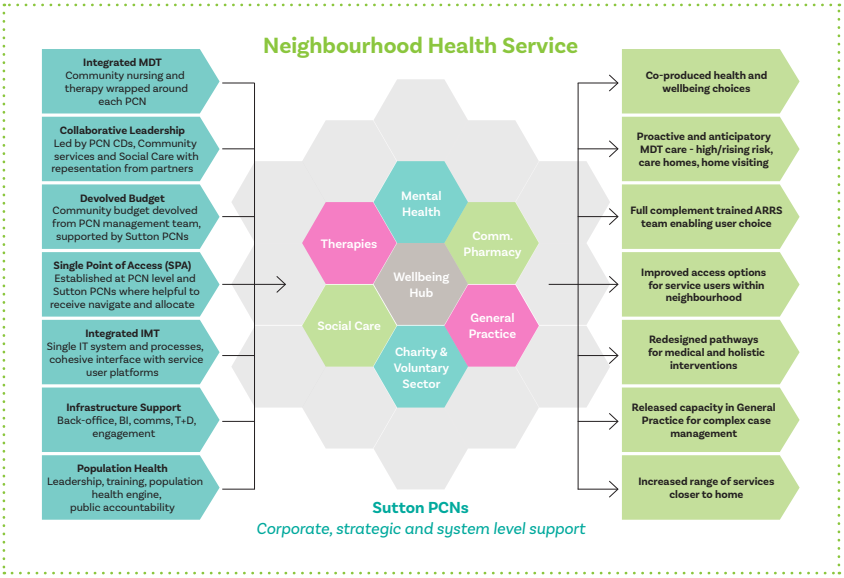
- **Co-produce** services with our neighbourhoods and partners
- **Build and support** a diverse, engaged, and highly skilled workforce
- **Reduce health inequalities** and develop person-centred care through a population health approach
- **Collaborate and lead** the development of a resilient and sustainable local health and care ecosystem

OUR VALUES ARE

- **People:** the delivery of people centred care is our top priority.
- **Enable:** we will work collaboratively to enable people focused change.
- **Open:** openness and respect will be the foundation of how we work.
- **Professional:** we will provide an environment where learning, education and development drive the quality of our work – fostering a no blame culture.
- **Leadership:** we will lead by example.
- **Equity, Integrity, Fairness,** and **Professionalism** matter to us.

OUR STRATEGY

We have revised a simple 'strategy on a page' setting our our vision and ambition to shape care in Sutton around PCNs to deliver the 'better, more local and easily accessed care' that our patients and partners say they want:



Our Board

Dino Pardhanani

Central Sutton

Chair of PCNs Board

As Chair of the PCNs Board, I ensure that the most important points for consideration are covered and conduct the business of the meeting in an orderly manner, ensuring that the agenda is adhered to and facilitating discussion from Directors, whilst keeping to the time.

Jonathan Cockbain

Carshalton PCN

Chair of Clinical Governance Quality and Safety Committee

As Chair of the CGQS Committee, I assist the Board in its duty of oversight by focusing on the areas that are within the scope of the CGQS:

- Patient experience and safety
- Service performance and improvement
- Qualitative business risks
- CQC registration and action plans

Phil Jacob

Cheam and South Sutton

Chair of Finance Risk and Audit Committee

As Chair of the FRAC Committee, I assist the Board in its duty of oversight by providing additional assurance to the Board. The FRAC Committee is authorised by the Board to act and review any activity within these Terms of Reference and to seek any information required from any employee or director.

Laura Rodriquez Benito

Wallington

Population Health Lead

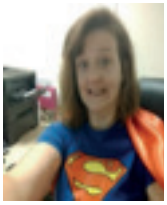
My main reason for becoming a GP was to help my patients to live healthier lives but as I gained experience as a doctor in the public healthcare system, various pressures inevitably shaped my practice in a reactive and prescriptive way. Population Health is our opportunity to CHANGE our practice and address the root causes of disease more effectively by proactively adapting our local service and individual practice to our population needs. I hope it will enable healthcare professionals to establish a more meaningful practice and relationship with the patients we serve.

Dr Anu Jacob
Carshalton PCN

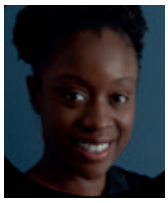
Sally Bullen
Carshalton PCN

Dr Shazma Mawani
Cheam and
South Sutton PCN
Chair of Workforce Group

Dr Michael Pambos
Central Sutton PCN
Accountable for Covid Vaccinations



Dr Ellie Barnard
Wallington PCN



Eunice Ashley
Wallington PCN

Sutton Training Hub

Sutton Training Hub provides educational and development opportunities to primary care staff with the main aims of increasing recruitment, upskilling staff and retention of staff. Covering both clinical and non-clinical staff, we offer a wide range of support ranging from key skills needed to perform an individual's role within primary care to and advanced courses to help staff reach their full potential in their primary care career.

We also support the training of future primary care placements by facilitating student placements across Sutton.

Our work involves collaborating with Clinical and Non-clinical colleagues in other South West London Training hubs, to provide training and education towards the HEE Star priorities and priorities of NHSEI to further increase recruitment and staff retention.

The Training Hub Team is made up of:

- Leah Dennis – Sutton Training Hub Lead
- Jennie Morrison – Sutton Training Hub Clinical Lead
- Taylor Fulton – Sutton Training Hub Placements coordinator and administrator

Key Achievements this year:

The Training Hub's highlight achievements this year include:

- 16 staff successfully completed Leadership and Management training Level 5 this year, taking our total to 36 over the last 3 years

- Securing £25,000 to support increasing Student Nurse Placements within Sutton. Using this money we employed a placements co-coordinator and successfully increased our placement capacity in Sutton by 20%, we aim to increase this by a further 20% this year. The students are offered a rotational basis placement, allowing them to rotate through different practices to see a variety of primary care environments and also access outreach days at specialist clinics like Diabetes, District Nursing, MSK and Amputee clinics.

- Offering a wide variety of clinical updates to allow clinical staff to keep up to date with their CPD

- Successfully enrolling 2 HCAs on the Trainee Nurse Associate Programme

- Supporting both the set-up and running of the Sutton Covid Vaccination sites, providing BLS training to staff and Volunteers and also upskilling a large number of the non-clinical workforce to be vaccinators to support the increased demand for vaccinations.

- Securing funding for Equality, Diversity and Inclusivity, with the intention of setting up staff support networks, to provide safe spaces for staff to connect and network, to promote equity, share events and experiences, inspire collaboration and create change. We are currently working closely with HEE and the ICS EDI Management team to move this project forward.

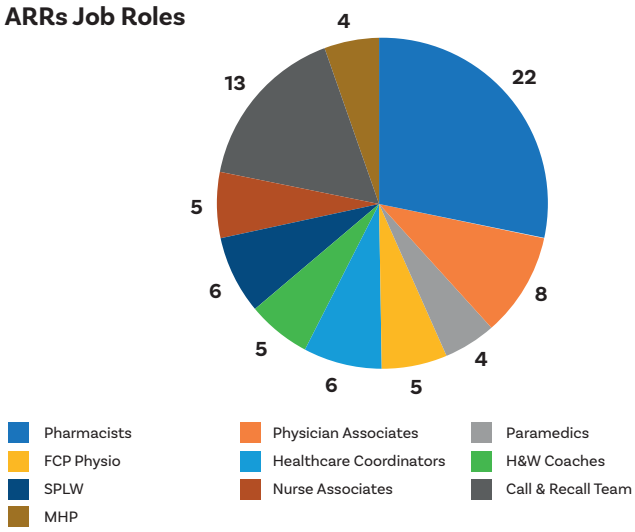
- Developing and delivering three initiatives for South West London in support of the Health Education England Primary Care Workforce Retention Project;

    - **Equality, Diversity and Inclusivity:** we ran three sessions on unconscious bias for Primary care staff, this has expanded into a wider project focusing on supporting staff in marginalised groups and creating change for equity for all staff.
      In addition to her day role, Leah is leading on the Workforce Race Equality Standard for the South West London Training Hubs.
    - **Primary Care Career Pathways:** we are in the process of creating a resource that Primary care staff can use to create meaningful personal development plans for progressing their careers. The resource will detail the steps they will need to take and the training needed to progress into different roles within primary care, hopefully inspiring them to upskill themselves and retain them within primary care.
    - **Workforce and Succession:** We developed a programme for Employers on how to run an effective business, how to do succession planning for retiring staff, and talent management. We developed a programme for Employees on how to be effective within a new role, how to make the most of a personal development plan and how to plan for retirement.

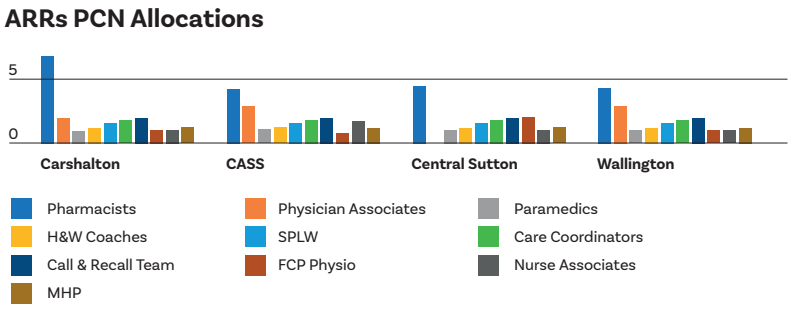
ARRS

Under the NHS 5 year Plan primary care has the opportunity to draw down funding for additional staff under the 'Additional Roles and Responsibilities Scheme'. The scheme reimburses PCNs for the costs of employing a range of staff such as Pharmacists; Paramedics; Social Prescribers; Care Coordinators; Physician Associates; Nurse Associates; First Contact Physiotherapists; Health and Wellbeing Coaches and Mental Health Support Workers.

Since April 2021 the Sutton PCNS taken on the following numbers of staff in the roles set out below:



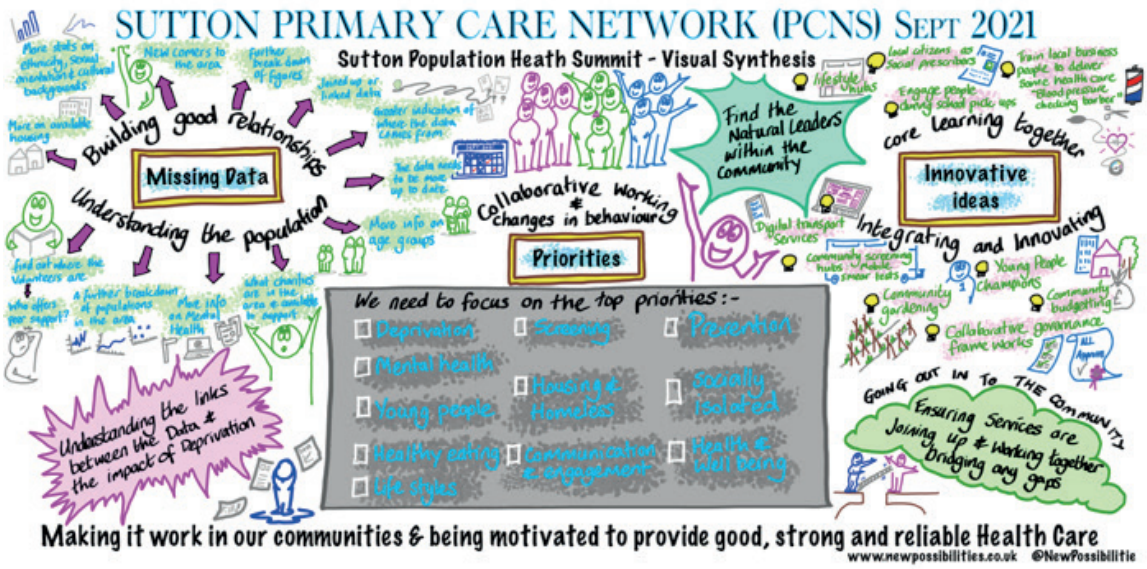
The breakdown of where those staff have been employed (by PCN shown below) shows that broadly speaking equity of benefit is being achieved across the PCNs.



In 2022-23 we will be seeking to reinforce the numbers of staff working on Population Health and Health and Wellbeing initiatives across the PCNs meaning that we will focus on the recruitment of Health Coaches; Nurse Associates; and other supporting staff.

Population Health

Population Health can be very broadly defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within a group". While access to traditional care services plays an important part in determining the health and wellbeing of a population, evidence suggests that this is not as important as the social determinants of health – that is, the conditions in which people are born, live and work including the influence of local environment and lifestyle. It is suggested that at least 70% of the determinants of health are social and not medical in origin meaning that improving population health requires efforts to change living and working conditions across communities and that accountability for population health should be spread widely and not concentrated within the boundaries of traditional health and social care.



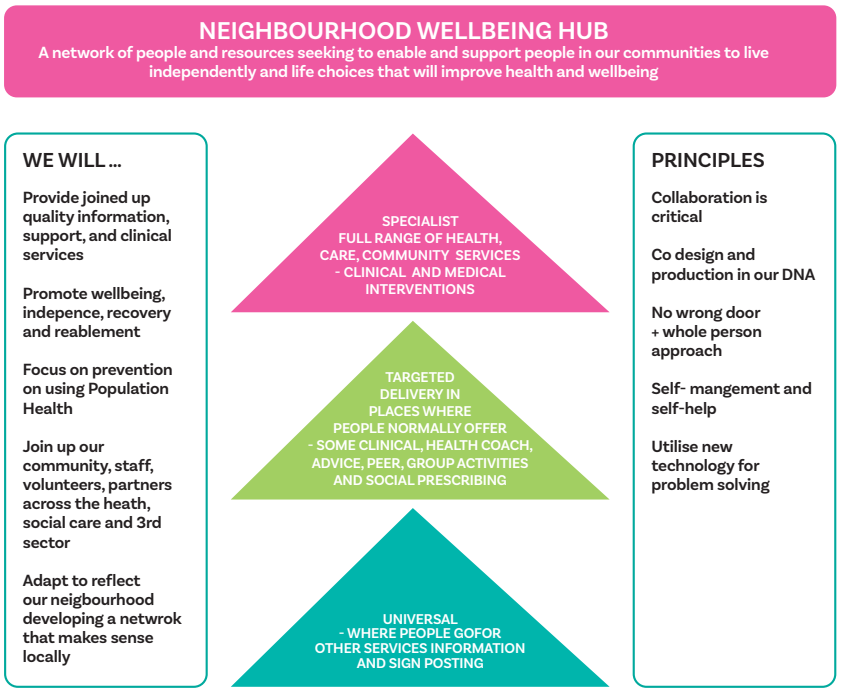
In September we hosted a Population Health Summit attended by all of our key partners as well as community groups or organisations.

The Population Health Summit was our first public step on our Population Health journey and was warmly welcomed. We now need to drive the Population Heath Agenda in line with the ten basic principles that sit behind successful Population Health initiatives. These are that we:

1. Are aware of relevant national and local strategic drivers for the population
2. Are working towards the outcomes that residents want
3. Have the data, including community insight, we need to make decisions and plan for our population, and, we have identified different groups we need to consider and target, including people at high risk of poor health and wellbeing
4. Generate sufficient community involvement in our work

5. Secure the right partners around the table
6. Ensure sufficient front-line staff involvement in our work
7. Make sure our activities sufficiently take into account residents' social determinants of health
8. Ensure parity around physical and mental health and wellbeing
9. Ensure our activities support healthy living
10. Ensure our activities support self care/self management

We are working hard to ensure that we work to these principles and, as mentioned previously, in September we hosted a Sutton Population Health Summit for key partners and community agents at which we shared our plans and began to capture feedback and engagement.



Since then we have launched our Wellbeing Hub and begun work to address the prevalence of Diabetes in Carshalton and Wallington. The Wellbeing Hub brings together Health Coaches, Social Prescribers, Nurse associates and other disciplines such as our 'Call and Recall Team/Health Inequalities Team' to create a Multi-Disciplinary Team to identify people needing support and create plans with those individuals that will deliver the health and social outcomes they want.

There will be much more to follow in the coming months especially once our Population Health and Neighbourhood Health Service work starts to work 'in sync' and we are able to wrap around people not just health care (primary and community services) but also social care and the care or activities provided by the wider not for profit sector. This work is very ambitious in its scope but is critical to the success of our Population Health Strategy.

Our Patient Services

The Sutton PCNs now run a range of services that includes:

Home Visiting Service
The growing population, demand for appointments and movement of services from hospitals to primary care continues to increase pressure on general practice. Home visits are a core requirement for general practice, especially for those people who are housebound, deemed high risk, frail or vulnerable. However, home visits take considerable time and GPs usually must fit them in and around other clinical commitments.

The Home Visiting Service (HVS) is an important service for Sutton patients and practices. This service is intended to provide practices and patients with a same day and rapid access/acute (within 2 hours) home visiting solution. During the peak of the COVID-19 pandemic it provided home visits to patients with COVID symptoms to support their care and effective management of the virus. Since its inception the service has moved from a GP led to a paramedic led model.

This service supports GPs to continue to support their acutely unwell patients, housebound patients, and those patients deemed high risk, frail or vulnerable.

GP Extended Access
The public value GP services, but in recent years patients have increasingly reported, through the GP Patient Survey, more difficulty in accessing services including a decline in good overall experience of making an appointment in general practice.

However, good access is not just about getting an appointment when patients need it. It is also about access to the right person, providing the right care, in the right place at the right time. The Extended Access Service is crucial to:

- ensure everyone has easier and more convenient access to GP services, including appointments at evening and weekends;
- get the best outcomes we possibly can.

Sutton has two extended access hubs located in Robin Hood Lane Health Centre and the Wrythe Green Surgery. The hubs are open from 18:30 to 20:00 weekday evenings and 8:00am to 20:00 at the weekends. This includes 08:00-20:00 bank holiday provision with the expectation that the service is a 365 day a year service. Patient satisfaction for the service remains. During the COVID-19 pandemic the Extended Access hubs set up ‘hot clinics’ for patients with suspected COVID-19 symptoms; this was done at short notice and demonstrates the dedication and responsiveness of our clinical team.

To support better patient access for cervical screening and improve uptake, Sutton PCNs were successful in securing additional funding from RM Partners to deliver cervical screening clinics on weekends. Furthermore, we have been administering nasal flu vaccination to young children to support busy parents to access this important service for their children.

Vaccinations
Sutton PCNs have been responsible for setting up several COVID-19 vaccination sites. For example, in November 2020 Sutton PCNs agreed to be included in the first wave of COVID-19 vaccination services, requiring collaborative working with our local practices, voluntary sector, CCG, Council and other partners. We were pleased that the site at Nonsuch Mansion was one of the best performing in South West London. In addition, we have supported practices to deliver COVID-19 vaccinations from their own premises. More recently we have set up two sites in Sutton to provide COVID[1]19 booster jabs. We have taken a unique approach to provide health checks, links to social prescribing and links to local voluntary sector activities to help support the care and wellbeing of our local people.

Blood Pressure Monitoring at Home Project
This national programme is being funded by NHSE/I for people diagnosed with hypertension to allow treatment to be optimised where necessary. Home blood pressure monitoring has been identified as a priority for CVD management during the COVID-19 pandemic and beyond. To ensure that patients who are vulnerable to becoming seriously ill with COVID, can manage their hypertension well and remotely, without the need to attend GP appointments.

We are pleased that all 23 of our practices have agreed to support this project and that patients can receive their own BP machine and become experts in monitoring and managing their hypertension with effective support from clinicians.

Community Skin Lesion Clinics
The Skin Lesion Service commenced in April 2019 and since its inception has seen approximately 1000 patients and prevented more than 5% urgent referrals to the hospital. This is a service which is valued by our GPs and patients alike - who appreciate its rapid response and high quality care. It also provides opportunities for GPs with a special interest to practice and develop their dermatology skills.

We are hoping to develop this service in the future to support patients and practices with a wider range of dermatological and minor surgery needs.

Enhanced Care Homes Service

This year we have introduced the Enhanced Care Homes Service as part of the Care Homes DES. Supporting this work we have the Rapid Response Team, Virtual Ward Team and the MDT Team. The work has seen much deeper cooperation and collaboration between Older Peoples and Learning Disability Care Homes; Social Care staff; Sutton Health and Care teams; and Hospital staff.

The result has been clear ownership of Care Homes by practices; evidenced regular ward rounds and improved care planning and actual care. For example, Covid and Flu vaccinations for Care Homes have been provided by the GP Home Visiting Team and Sutton Health and Care District Nurses working together with different homes and patient groups.

A real benefit of our work this year has been to bring together primary and secondary care together with GPs forming joint holistic management plans with hospital consultants specialising in frailty. It follows that we are proud of the progress we have made with our Enhanced Care Homes Service this year.

Patient Engagement

This year we have invested a lot of time and resource in establishing an effective group of Patient Champions for Sutton. The Champions have been an invaluable resource in addressing health inequalities and, for example, in reaching hard to reach communities in the vaccination programme where the Health Champions formed our door to door vaccination awareness teams.

Our Patient Reference Group work, supported by Sutton Healthwatch, has seen us maintain our Sutton wide Patient Reference Group work through the pandemic (no mean feat) and has given us a group with whom we have been able to test our future plans around a Neighbourhood Health Service focused on PCNs and Practices.

Health Inequalities
This year we have started to get to grips in a meaningful way with our health Inequalities challenge. We have begun outreach programmes with underserved communities such as travellers, the homeless and women's refuges.

We have developed our relationship with our travelling community to the point that they have been chasing us for vaccinations rather than the other way around which is a a real sign of progress. We have also engaged with the Sutton Volunteer Centre and funded a volunteer coordinator there to help us recruit, train and retain volunteers for our various programmes. We will be developing this work further in the coming year.

Virtual Ward/MDTs
The Sutton Virtual Ward offers 'wrap-around' support to people in their homes ensuring they can receive care that meets their needs in a timely fashion with the aim of reducing the need for avoidable hospital admission. Suitable for patients with: Covid-19; Frailty; and Long-term conditions

Support is provided by a multidisciplinary team (MDT) of St Helier Hospital consultants, specialist community health and care professionals who with the patient's GP, work together to virtually to coordinate the best wrap-around care for patients that have been admitted to the virtual ward

In the first three months of the service alone we saw over 300 patients reviewed in virtual ward and pulse oximetry leading to the prevention of hospital admission or re-admission. 80% of GP practices have referred patients to the service and attended the virtual ward

Accounts snapshot

Sutton GP Services Limited (Registered Number: 09420373)

INCOME STATEMENT FOR THE YEAR ENDED MARCH 2021

	Notes	2021 £	2020 £
TURNOVER		1,638,777	1,800,675
Cost of sales		611,985	467,280
GROSS PROFIT		1,026,792	1,333,395
Administrative expenses		1,044,295	1,208,669
		(17,503)	124,726
Other operating income		-	500
OPERATING (LOSS)/PROFIT	4	**(17,503)**	**125,226**
Interest payable & similar expenses		-	1,496
(LOSS)/PROFIT BEFORE TAXATION		**(17,503)**	**123,730**
Tax on (loss)/profit		(3,326)	23,509
(LOSS)/PROFIT FOR THE FINANCIAL YEAR		**(14,177)**	**100,221**

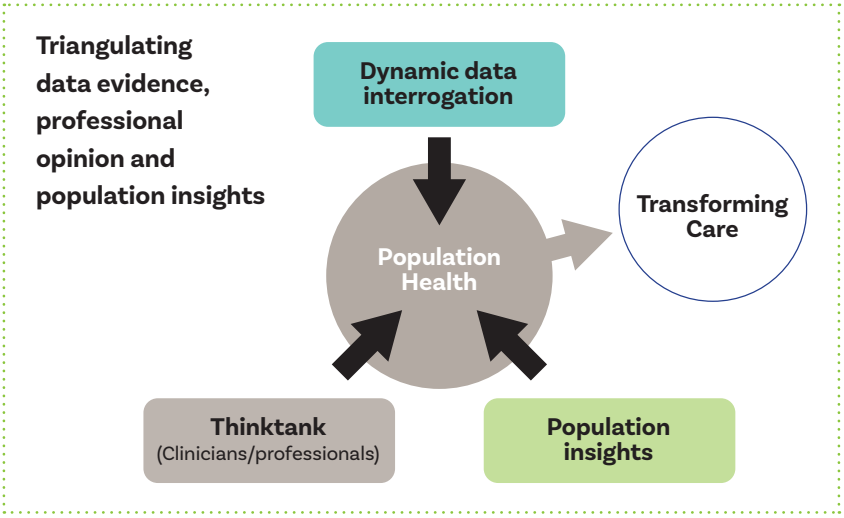
2022 and beyond

The direction for the development and growth of primary care within the NHS is laid out in the NHS Five Year Forward View, which is helping to reshape the primary care landscape in Sutton. Over the next three years, we expect to see a significant shift to primary care services currently provided out of our hospitals in line with the 'London Vision'. That development, alongside the development of our new Neighbourhood Health Service model of care, will bring together hospital, primary care and social care at a PCN level in Sutton.

We believe that primary care should be at the forefront of these developments and that the Sutton PCNs are the means by which primary care can make this happen. We aim to be a collective voice for general practice, mandated by our members, facilitating at scale contracting and collaborative working as part of a collaborative Sutton 'Place'. The Place Board supports the delivery of the borough wide health and wellbeing strategy. We are working to ensure the voice of general practice is heard in these important strategic meetings.

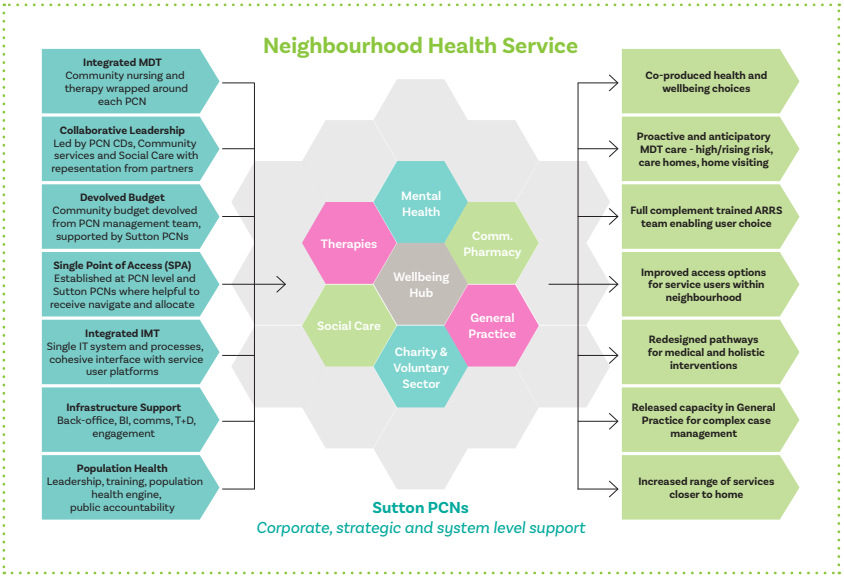
We have also known for many years that some communities suffer unnecessarily worse health and wellbeing than others. Tackling health inequalities and developing a thorough understanding of the health needs of our populations and designing services accordingly using Population Health approaches is really important. The Population Health Summit agreed that our priorities should rightly be people with long term conditions but with a real effective balancing focus on preventative actions to support our residents to avoid developing long term conditions, or working to minimise the impact of those conditions on their health.

Our simple aim is to triangulate the interrogation of data insights, the lived experience of our residents and the expertise of clinicians and professionals to create a population health engine that drives improvements to care and longer term health using largely preventative population health approaches.



As a first step we are piloting Population Health initiatives in Carshalton and Wallington, as these PCNs have the highest levels of socioeconomic deprivation in Sutton. To support our population health work we have established a Neighbourhood Wellbeing Hub which brings together under one roof all of our lifestyle interventions. Staffing for the Hub includes Associate Nurses, Nurses, Trainers, Health Coaches, Social Prescribers, Dietitians, Podiatrists and many more.

We are working towards a coming together of community services and primary care at a PCN Neighbourhood level in 2022-23 and by 2024 further aligning that with social care provision too. We aspire to create a PCN/Locality base for the delivery of health, care and wellbeing in a collaborative way between all of the key actors in the locality ecosystem. The emerging shape of how this local ecosystem could work is show in the diagram below:



Our population health work will be the force that drives our wrapping of services around PCNs. Each PCN will have access to the Neighbourhood Wellbeing Hub and a team within it that works in their PCN that provides simple but effective lifestyle interventions to motivate, encourage and support people to make changes to improve their health and wellbeing.

SUTTON
PRIMARY CARE
NETWORKS
INTEGRATING
& INNOVATING