Welcome to Porter Valley Network's Second Patient Voice Event

- Elaine Atkin PVN manager
- Margaret Booth Patient Representative, Chair Falkland House PPG
- Hayley Harriman Care Co-Ordinator, Carterknowle and Dore surgery
- Ian Hodgson Patient Representative, Chair Hollies Patient Forum
- Adam Howard People Keeping Well
- Dr Mike Lyons PVN Clinical Director/GP Hollies Medical Centre

Agenda

Welcome to the Event and the Topic

- Elaine Atkin (PVN Manager)
- Dr Mike Lyons (PVN Clinical Director)

Patient Perspective on Care Navigation

Margaret Booth (Chair, Falkland House PPG)

Medical Perspective on Care Navigation

Dr Liam Lees (Carterknowle and Dore Medical Practice)

BREAK [and collecting the questions for group discussion]

The Role of the Pharmacist

Lucy Sharples (Clinical Pharmacist, PVN)

Care Coordination and the Health and Wellbeing Hub

Martha Jones (PVN Care Co-ordinator)

Group discussion/Q&A

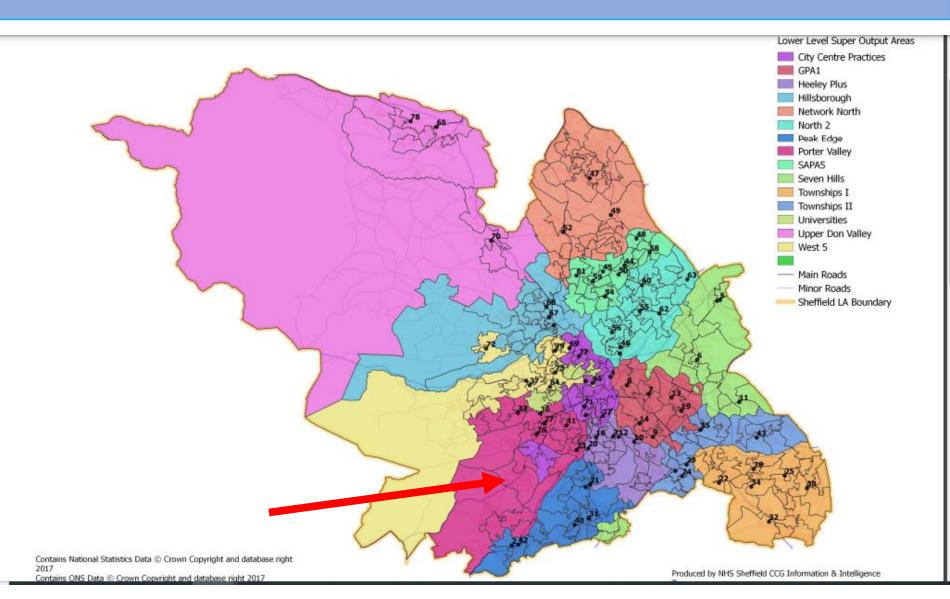
Led by Ian Hodgson (Patient Representative) and Hayley Harriman (Care Co-ordinator)

The Porter Valley Network and Care Navigation

Elaine Atkins: PVN Manager

Why were Primary Care Networks set up in 2019?

- **30-50,000** patient groupings.
- Encourages
 collaboration at
 the population
 level between your
 practices.
- Allows sharing of additional staff (ARRS).



How has the Porter Valley Network evolved?

- Progressive increased funding year on year.
- We have nearly £926,100 to fund additional roles, now including GPs.
- April 2025 awaiting the new Government's ten-year plan.
- We expect to see the Network model continuing.
- We expect there to be more requirement to work together as integrated teams in each neighbourhood.
- Need for improved interface between secondary and primary care.



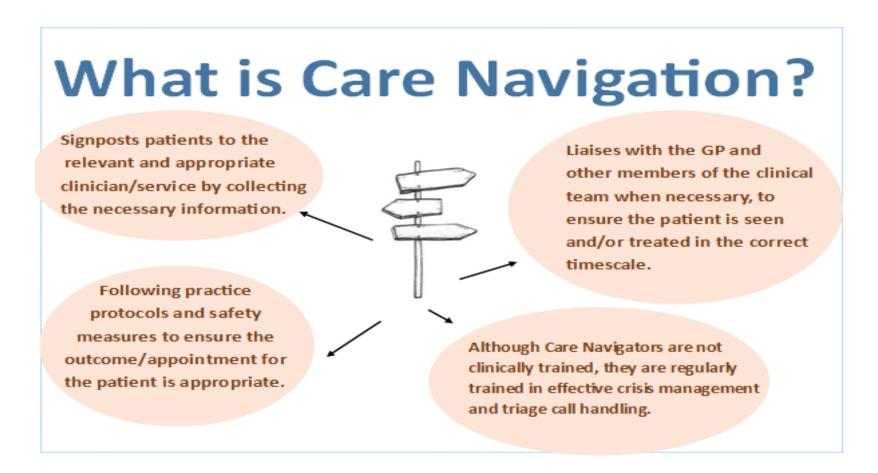
Challenges



- Increasing patient numbers.
- Lack of GPs funding for new GPs in primary care, over many years.
- Limited funding now agreed to employ newly qualified GPs in each network.
- Reliance on GPs to supervise a wider workforce, but it's difficult to supervise and train if there are decreasing numbers of GPs.



What is Care Navigation: how can this help meet patient needs?



Who makes up the Primary Care team across the practices?

- **GP**
- First Contact Practitioner Physiotherapist
- Advanced Nurse Practitioner
- Practice Nurses
- Health Care Assistants
- Nurse Assistants
- General Practitioner Assistants
- Physician Associates
- Clinical Pharmacists
- Paramedics
- Social Prescribers
- Care Co-ordinators
- Mental Health Team



Patient Perspective on Care Navigation

Margaret Booth: Chair Falkland House PPG

Falkland House Surgery PPG Results from Patient Survey

Margaret Booth: Chair Falkland House PPG

- **Key Aim:** To work with the practice to improve patient experience by:
 - Gathering patients' views on the aspects of the Practice they 'most valued' and areas that they felt 'could be improved'.
 - Producing a themed report summarising patient feedback and identifying some possible ways forward.
- 242 patients completed a survey sheet on paper or on-line
- All had visited the practice during October 2024.
- Two-thirds were women: 75% were 60+ years and 30% of those 76+ years.

Six themes emerged from patients' responses [Three most relevant to this event]

- **Theme 1**: The small, local, **welcoming nature** of the Practice over 120 comments were all 'most valued': accessible from patients' homes; continuity of care from two longstanding GPs.
- Theme 2: The Practice medical and support staff over 260 comments, 90%+ were 'most valued'; friendly and approachable; understanding and responsive; professional and efficient.
- **Theme 3: Appointments** a range of issues, including: 50+ comments were 'most valued' but 110 + were 'could be improved' (a complete turn-round since the last survey in 2019).

Theme 3: Appointments issues

- Non-urgent appointments: available more quickly.
- More face-to-face appointments.
- Greater access to GPs rather than other practitioners.
- Fewer referrals to hubs, pharmacies, and non-Practice locations.
- Patient recognition of the wider NHS context.

What are some patients telling us?

Changing NHS approaches are eroding aspects of GP provision that Falkland House patients valued most in **Themes 1 and 2.**

Possible ways forward:

- 1. How to help patients to understand how GP practice is changing and why.
- 2. How to **explain to patients** the 'care navigation' approach and how it is used by the Practice in providing care.

First steps: Practice and PPG collaboration on Patient Guides 1 and 2.

Medical Perspective on Care Navigation

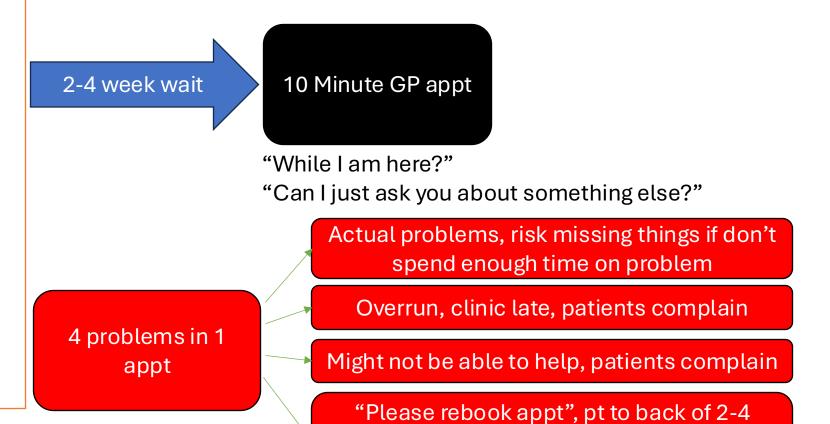
Dr Liam Lees: Partner, Carterknowle and Dore Medical Practice

Why patients contact a GP

- Medical Problems acute
- Medical Problems ongoing
- Advice
- Crisis
- Referrals
- Admin/Sick notes
- Test results
- Prescriptions
- A chat
- Complaints
- More...

Pre-care navigation (pre-COVID)

- Medical Problems acute
- Medical Problems ongoing
- Advice
- Crisis
- Referrals
- Admin/Sick notes
- Test results
- Prescriptions
- A chat
- Complaints
- More...



week wait, patients complain ("... I can't

ever get an appointment...")

Principles

Total Triage and Care Navigation

Total Triage

All patient requests, regardless of how they are made (phone, online, in person) are initially assessed and categorised by a HCP through a digital system to determine the most appropriate course of action

Care Navigation

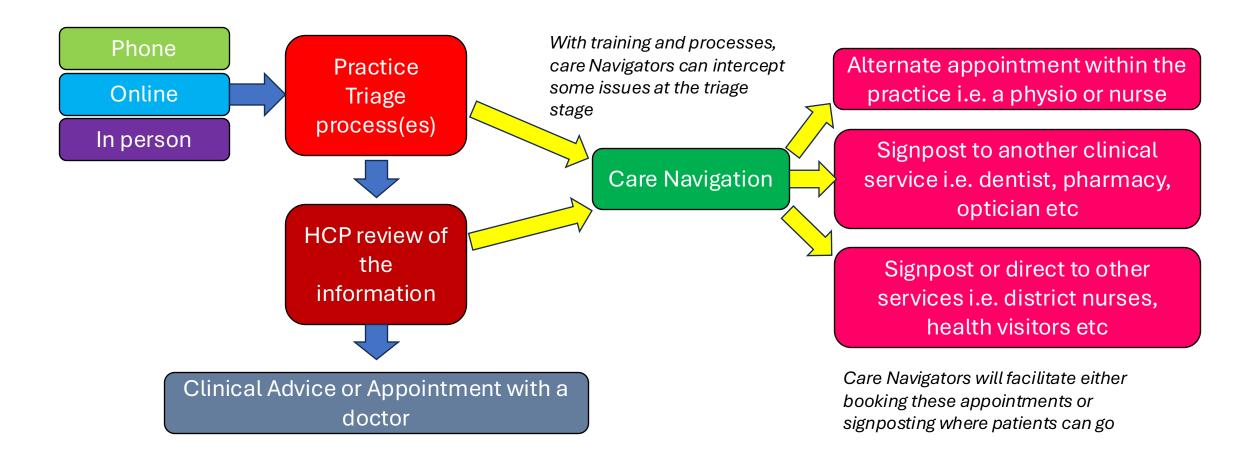
A system within healthcare where trained staff "care navigators" assess a patients needs and direct them to the most appropriate healthcare provider or service, either within the practice or in the wider community

Other factors

GP surgery capacity is finite for that day and factors may change this further i.e. illness or short notice absence of clinical staff or ½ days due to citywide/mandatory training

Not all GP surgeries have the same service provision, somewhat depends on size and other factors

Care Navigation in action



Advantages of Care Navigation

- Get patient to right appointment/service first time for their symptoms/problems.
- Means those who need to see a GP can see a GP (GPs can focus on the more complex patients where a GP input is needed), those who can see other members of team see those members.

Examples:

- Advising patients on self management or seeing community pharmacy under pharmacy 1st scheme.
- Minor illness seeing a Nurse Practitioner or Physician Associate.
- Chronic disease reviews such as asthma or COPD can be seen by specialist nurse.
- MSK and joint issues can see FCP (First contact practitioner, a trained physio).
- Medication issues can speak w/ a pharmacist.
- Other services may have paramedics doing the minor illness or mental health practitioners.

What services can be used?

Practice:

- ANP/NP/PA
- Pharmacist
- FCP

Network:

- Extended access GP
- Extended access ANP
- Pharmacist
- FCP
- Wellbeing Hub
- Primary Care Mental Health Team

Community

- Pharmacy
- Dentists
- Opticians

Allied Health Services

- Health Visitors
- District Nurses
- Sheffield Talking Therapies (STT)
- St Lukes
- Others

Hospital services

- Specialist nurses
- Outpatient departments
- Self referral

Emergency Services

- MIU
- A+E
- Eye casualty
- 999

Barriers to Care Navigation

- Patient expectation does not always align with navigation decision.
- Not all practices have additional staff roles.
- Some practices may have additional staff accessible through Network which may mean appointments further away from the practice (patients might be more likely to decline and argue to see a GP).
- Demand on whole system, more patients, more appointments, same/less number doctors in population.
- Hospital factors, waiting lists now measured in years, so patients have more contacts with GP before seeing specialist and those patients may not be suitable for care navigation.
- Cultural/language barriers and cultural expectations.

Addressing barriers to Care Navigation

- Processes in practice to ensure good information gather (triage) so HCP / care
 navigator can make correct decision [Practice]. Adjusting message on online tools,
 bespoke messages on answerphones to communicate this.
- Patients giving us all the information we need. A shift away from "while I am here" mentality (this happens frequently, a patient tells us about a cold, gets an ANP appt, then asks the nurse "can you deal w/ this other medical problem", is told "no, I'm a nurse" and goes away unhappy) [Patient, with strict processes and signposting, can often train patients away from some of this].
- For practices with non-English speaking populations or those with available and behaviours, practices often create pathways and services for these [**Practice**].
- Use of network to increase numbers of staff roles available and training the patient that these services are acceptable [Patient and Practice].

Care Navigation: The role of the Pharmacist

Lucy Sharples: Clinical Pharmacist, PVN

The Role of the Pharmacist

Supporting Your Health & Medications

Lucy Sharples
Porter Valley PCN



What is a GP Practice Pharmacist?

- ► A highly trained healthcare professional working within a GP surgery.
- ▶ A Pharmacist is the expert in medicines.
- Helps patients with medicines, health advice, and longterm conditions.
- ▶ Works alongside GPs, nurses, and other healthcare staff.

Who are we at Porter Valley PCN?

Debbie Rasine Cam Katie Jon Sarah

So, what do we do?

- Medication Reviews
- Managing Long-Term Conditions
- Prescribing Medications
- Providing Advice
- Supporting Repeat Prescriptions
- Audit

Medication Review

- ► This makes sure the medicines you are prescribed are safe, effective and necessary.
- ► To check for interactions with over the counter (OTC) medications.
- ▶ To make sure you know why you take your medication.
- Is needed to make sure you are not having any adverse effects or problems.
- Individual to each person.

Managing Long-term Conditions

- Blood pressure
- ► Cholesterol
- Kidney Disease
- Asthma
- Diabetes
- Pain

Providing advice

Able to offer alternative medication

- Manufacturing /availability problems
- Swallowing difficulties
- Side effects

Health living and lifestyle advice

Advice on reducing medication dependence

Support self care for minor illnesses

Help with medication administration

Supporting Repeat Prescriptions

- ► Update your repeat prescription in line with a discharge summary or correspondence from a consultant.
- Align medication to make sure all your medications run out at the same time.
- Offer specialist advice about appliances and complex medications.
- ▶ Offer Repeat Dispensing.

Audit

To ensure adherence to guidelines and for safety:

- ► Hormone replacement therapy (HRT) following a significant event at one of our Practices.
- ► Review of those with lower kidney function taking anticoagulant medication.

Benefits of a Pharmacist in a GP Practice

- ▶ More convenient access to expert medicine advice.
- Shorter GP waiting times.
- ▶ Improved patient understanding of medications.
- Fewer hospital visits.
- ▶ Better health outcomes for patients.

Any Questions?

Thank You!

Speak to your GP practice if you wish to discuss something with the pharmacist.

Care Coordination and the Health and Wellbeing Team

Martha Jones: PVN Care Co-ordinator

Who we are

- 2 Network Care Co-ordinators.
- Shared office space with D43, Talking Therapies, PCMHT, working win and others as they drop in.
- Referrals to us from the clinicians or reception team across all 6 practices.
- Close working relationships now with many services across Sheffield and our neighbourhood.
- Weekly huddle where we can discuss complex patient needs and how best to work together to save duplication of service.

What we do

- Receive referrals from clinicians and reception teams.
- Patients are placed on a waiting list (currently 2-4 weeks wait).
- Offer telephone calls or face to face appointments.
- Listen to your story.
- Explore your situation and what is important to you.
- Provide information and resources.
- Make referrals to other organisations.
- Follow up calls can be available as required.

Emotional

Occupational

Physical

Environmental

Health and Wellbeing

Financial

Intellectual

Social

Spiritual



Sheffield Carers Centre

Carer Advice Line: 0114 272 8362



Search here

Q

Sheffield **Talking Therapies**

About Us

Our Services

Our Carer Card

Our Events

Join our Community

For Professionals

Information Hub

Home About us How we can help

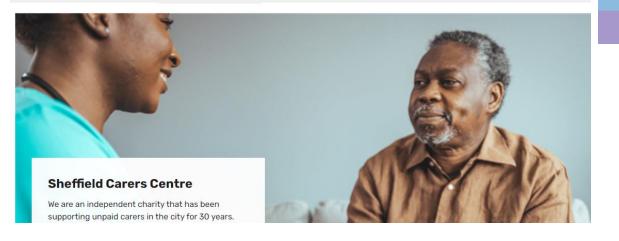
Self help

Online support

Get in touch

Urgent help

Click here to make an online referral





About us

Welcome to the Sheffield Talking Therapies for anxiety and depression service, formerly known as IAPT.

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Welcome to the Sheffield **Mental Health Guide**

A website for Sheffield people of all ages

We're here to provide information on mental health services, activities and resources that are available to you, or someone you are supporting. Our website has been co-created with the community and people who have lived experience of mental health.

I want to volunteer

- start volunteering
- ▶ Drop-in Service
- ▶ Bulletin

I want to volunteer

Thousands of people volunteer in Sheffield for a huge rar organisations. Volunteering can be great fun and you can but also to yourself. To find out how other people have b our Stories page.



Please Donate





Our services Get the support you need

Activities and events Ongoing social activities

Get involved How you can help About us

What we're doing in the community

Shops

Our charity shops

Home / Our services / Dementia services for customers

Dementia services for customers



We provide a wide range of specialist services to people living with dementia and their family carers. Each of our services is introduced below. Please contact us for further details.

Weight Management in Sheffield

Morelife are proud and excited to be working with Sheffield City Council to provide free local weight management support across Sheffield.

We have been delivering weight management and healthy lifestyle interventions for over 25 years and are now honoured to be delivering programmes through our expert level clinicians and advisors to Sheffield locals.

Not only are we well-seasoned experts at providing weight management programmes nationwide, but we have also been instrumental in some of the most important Obesity research in the UK.



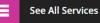




How this might look







Get a care and support assessment

You can ask us for a care and support assessment to see if we can help with your long term care needs.

You may need help to live as well as possible with illness, disability or impairments. This can include help with things like:

Self-Help v

- · washing and dressing yourself
- · preparing and eating meals
- · getting out and about and keeping in touch with friends and family

Energy Affordability Line: 0800 448 0721

Today's opening times: 10am - 4pm

Get Help v

Advice Line: 0808 278 7820

Today's opening times: 10am - 4pm



Get Involved v



Door 43

Door 43 is our mental health and well-being service for young people living in Sheffield aged 13–25.





Citizens Advice Sheffield is here to help

About Us v

We help people find a way forward

Your feedback about our service

- Invaluable help
- Cathartic
- Fantastically helpful
- Calm
- Friendly and understanding
- Really good at your job
- Reassuring
- An absolute blessing
- Useful
- I can take a breath now
- Amazing
- Really enjoyed it
- Great
- Wonderful
- Great to know you're there.