Phoenix PCN Luton

TRANSCEND | TRANSFORM | TRIUMPH

About us

Primary Care Networks (PCNs) were formed to enable GP practices in a local area to collaborate and work more closely together, delivering care that is proactive and accessible, as well as addressing gaps in service. With Additional Roles that have not been generally seen in practices before, and more importantly, the flexibility to provide more patient centred personalised care with this additional support structure to your practices.

Mission Statement

We at Phoenix, aim to be at the forefront of the transcending model of health care from that old reactive Primary Care, GP Practice Model to a new collaborative Primary Care Network Model.

Our Mission is to transform our teams and patients to manage their health & wellbeing, proactively & holistically. To empower GP practices in innovating ways that will ease the burden on their workforce whilst at the same time improving access for patients to the right health care professional.

This evolving model of health care has a vision to not only triumph in our mission to accomplish this transformation but to cascade this to our staff and patients, raising standards of wellbeing for all. Rising together. Better together.

How Can the PCN Support Practices?

Phoenix Sunrisers PCN has a dedicated team of staff who are here to support practices to deliver holistic care to patients. The team consists of Physician Associates, Paramedics, Health and Well-Being Coaches, Care Co-ordinators, Pharmacists, Pharmacy Technicians and Social Prescribers. The team are a valuable resource to assist practices with dealing with specific patient groups.

Some of the things we do?

- Targeted clinics i.e. FeNo, Phlebotomy, diabetes and ECG.
- Responsible for managing the health needs of the care home patients from Rosedale, Ambassador, St. Annes, Edwardian and Windermere House.
- Proactive projects such as Prostate and Dementia Screening Projects.
- Housebound and Frailty Clinics.
- Support your GP practices with staff to help them with capacity for minor illness, coaching, phlebotomy, long term condition reviews, medication reviews.
- Workshops for patients regarding self -help and long term conditions.
- Training & Health and Wellbeing service for practice staff.

Our Surgeries

Our PCN covers the following practices:

- Bramingham Park Medical Centre/ Kingsway Health Centre
- Neville Road Surgery
- Malzeard Road Medical Centre
- Conway Medical Centre
- Pastures Way Surgery

Introducing our teams

Physician Associates:

Physician associates are medically trained, generalist healthcare professionals, who work together with doctors and other clincians to provide medical care as an integral part of the multidisciplinary team. Physician associates are practitioners working alongside a dedicated GP supervisor, but are able to work autonomously with appropriate support. They are currently supporting with:

- Annual reviews, home visits and ward rounds for patients in care homes.
- Annual reviews for housebound patients.
- Minor illness clinics in practices.
- The team also support The PCN with Centrally run PCN projects.

Paramedics:

Paramedics deliver a high standard of patient care within the PCN, using advanced autonomous clinical skills and a broad, in-depth theoretical knowledge base. As a member of a varied clinical team, they manage a clinical caseload, dealing with presenting patient's needs within a primary care setting, ensuring patient choice and ease of access to services. They can support the urgent needs within the practice. They are currently supporting with:

- Annual reviews, home visits and ward rounds for patients in care homes.
- Annual reviews and frailty reviews for housebound patients.
- Minor illness clinics.
- Advanced care planning.
- End of life care plans.
- Liasing with alternative care providers to avoid hospital admissions, (Frailty team, virtual ward round, Rapid response team, palliative nursing teams, Mental health teams.)
- Referrals to onward care.
- Holistic assessment

The Pharmacy Team

The Pharmacy Team provide a wealth of supporting activities to the practices and PCN to ensure that patients are on optimal medication to help alleviate some of the clinical burden on practices associated with medication adjustments and adherence required by updates to national and regional NHS objectives, guidelines and priorities. Some of the work that they do includes:

- Structured Medication Reviews (SMRs).
- General Medication Reviews (GMRS).
- Lifestyle Counselling.
- Requesting blood tests when necessar.
- Suggesting cost-effective prescribing alternatives when necessary.
- Re-authorising medication for patients who have reached their issue limit.
- Medication synchronisation – aligning medication for patients who request multiple times during the month.
- Medicines Reconciliation – matching up medication to recent discharge letters from the hospital and actioning any requests by the hospital in relation to medication or bloods requests.
- Responding to Medication queries from patients or receptionists, for example providing relevant information to the patients or staff regarding out-of-stock medication or suggesting alternatives when the medication issued is unavailable.
- Drugs Monitoring back-office support i.e. Supporting practice with searches and up to date NHS monitoring requirements, supporting practices with actioning systems in place for regular drug monitoring like the Eclipse Alerts.

- Supporting PCN centralized projects for example being involved in the diabetes projects and initiating or switching medication when a medication has been taken off the market or has a more suitable alternative.
- Undertaking practice-based audits to support local and national guidelines, objectives and priorities.
- Care Home Support – Supporting the PCN Clinical team with managing the care home patients with regular detailed medication reviews, addressing hospital discharge letters, building and reviewing personlised care plans, medication re-authorisation and issuing of repeats.
- Supporting our practices with specific QOF indicators.
- Supporting the practices with inspections, undertaking searches requested by CQC inspectors.

Care co-ordinators:

Care co-ordinators help to co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at the right time. They can support people to become more active in their own health and care and are skilled in assessing people's changing needs.

Care co-ordinators are effective in bringing together multidisciplinary teams to support people's complex health and care needs and the administration required.

They can be an effective intervention in supporting people to stay well particularly those with long term conditions, multiple long-term conditions, and people living with or at risk of frailty.

Our care coordinators have been upskilled to provide the clinical support urgently required in the GP practices to aid in their workforce demand - they provide clinics and support to practices at the practice locations and working from the office as back office.

- Phlebotomy clinics.
- Diabetes clinics.
- Asthma review clinics.
- ECG clinics.
- FeNo clinics.
- Supporting practices with increase in bowel cancer screening uptake.
- Support practices with SMI clinics.
- Support practices with Learning disability reviews.
- PCN Proactive Dementia Screening Project.
- PCN Proactive Prostate Cancer Screening Project.
- Collating statistical evidence to support projects like running reports and evaluating outcomes.
- Training staff to referrals and read coding.
- Provide administrative support for the PCN Management, Clinical & Pharmacy Teams.

Social Prescribers:

Social Prescribing is a means of enabling health professionals to refer people to a range of non-clinical services.

Social prescribing involves helping patients to improve their health, wellbeing, and social welfare by recognising that people's health and wellbeing are determined by a range of social, economic, and environmental factors. Social prescribing seeks to address peoples needs in a holistic way by signposting and connecting to various local organisations, agencies, and community groups.

These may include:

- Providing referral into Luton Total Wellbeing for passes to exercise and gym classes for people who have a long-term condition.
- Supporting with accessing wheelchair or mobility aids to improve a patient's environment, applying for blue badges, or supporting with care needs assessments.
- Support with finances, benefits, or housing referrals- collaborating with Citizen's advice bureau.
- They can signpost patients to forums and community projects to enable social networking and connection and engagement into the community when patients have been impacted by loneliness and isolation.
- Supporting the clinical team with housebound visits and offering support to those that might be informal carers.
- Organising tailored educational sessions, connecting and collaborating with VSCE and local community networks and organisations, facilitating and providing connection to relevant patient groups.

Health and wellbeing coaches

Health and wellbeing coaches (HWBC) support people to increase their ability to self-manage motivation levels and commitment to change their lifestyle. They are experts in behaviour change and focus on improving health related outcomes by working with people to set personalised goals and change their behaviours. They work with people with physical and/or mental health conditions and those at risk of developing them.

Health and wellbeing coaches can be an effective intervention for people experiencing a range of long term conditions, including respiratory, cardiovascular (including type 2 diabetes and hypertension), and stress/low mood. They can also support people with weight management, diet and increasing activity levels.

Phoenix HWBS's

Our HWBC's are fully PCI accredited at level 3 and all have ongoing CPD. They have a vast amount of experience and skills between them and are experts in identifying any underlying issues that may be contributing to ill-health.

They are able to offer longer appointments and spend time working with patients supporting them to identify the underlying causes to their issues and identify potential resolutions to their issues.

They are particularly keen to support with:

- People with a diagnosis of depression (including carrying out the interim reviews for newly diagnosed low level and depression – where they have been highlighted).
- Coaching People; strugling with medication adherence.
- Struggling with motivation to develop or maintain healthy habits around eating, alcohol, smoking or exercise.
- With anxiety and those who need help manging stress.
- Longer term mental health.
- With difficulties achieving their goals, i.e. weight loss, behaviour change.

Health Coaching Supervision:

Our coaching supervisors can demonstrate extensive experience in application of health coaching skills within the NHS. They are Tier 3 practitioners with over 1500 health coaching hours between them just in the NHS. They have a current patient caseload and actively provide regular sessions in the PCN practices. They receive their own regular supervision as part of their practice and ongoing professional development.

The supervisors adhere to strict confidentiality, self-regulation, practise safely and effectively. They are experienced in the application of multiple approved health coaching supervision models and theoretical frameworks and are flexible in their approaches depending on the work, needs and developmental stage of the supervisee and align with core NHS values.

First Contact Practitioners Team:

The PCN has, in conjunction with Response Physio set up a service for the patients at the practices that will help alleviate the capacity problems at the surgery.

If patients have a Bone, Joint or Muscle Problem or are experiencing pain and discomfort in the Neck, Shoulder, Back, Elbow, Wrist, Hands, Hips, Knees, Ankles or Feet.

They can be booked with our First Contact Practitioners instead of your GP. They are specialists assessing, managing and diagnosing Musculoskeletal Problems.

Current events and projects:

The care-home work has now expanded to visits in the community to our housebound patients. And we have been conducting annual reviews for these patients at home to alleviate the pressures in the practices.

We run in a bid to support practices various projects. Feno and Diabetes clinics are going well with booked up Rota's and will continue in 24 /25 to help the practices with their capacity.

We have our own in-house trainers for Dementia, Basic life support, and mentoring and supervision.

We have training videos for practice staff to add onto their inductions for any new staff recruited and are building clinical training modules to upskill our PCN & member practice staff to be able to be the best diabetes holistic service in Luton.

Walk and talk

Phoenix PCN Luton

TRANSCEND | TRANSFORM | TRIUMPH

Health & Well-Being Group Sessions

****LADIES ONLY****

Time: **Every Wednesday 10am – 12pm**

Venue: **Kingsway & Conway Medical Centre, 385 Dunstable Road, LU4 8BY**

- Opportunity to discuss your Health & Wellbeing with a qualified Health & Wellbeing Coach
- Book further 1:1 sessions if you want to discuss things privately
- Group input on various topics of interest
- Peer support
- Refreshments available

Contact Us

If you would like to find out more about the PCN and how to access our service please contact us on:

07709 980161 / 07360 207899

BLMKICB.PHOENIX.HWBC@NHS.NET

PHOENIX - Pcn

@phoenix_pcn_luton

Phoenix Luton PCN

Phoenix PCN Luton

www.phoenixpcnluton.co.uk

@PHOENIX_PCN_LUTON

NHS

Phoenix PCN Luton

TRANSCEND | TRANSFORM | TRIUMPH