NHS
Warrington
Clinical Commissioning Group

Review of Primary Care Strategy 2015

Where are we now

Introduction

1. NHS Warrington Clinical Commissioning Group (CCG) is refreshing the Primary Care Strategy that has been in place since 2015. This document is aims to review the position of where we are now in terms of delivery of the priorities that were set in 2015 and will complement the refreshed strategy.

2. During the last couple of years there has been many changes at both a local and national level and therefore it is timely to refresh the strategy against the current direction of travel.

3. The Primary Care Strategy (2015) set out to build upon new opportunities provided through primary care co-commissioning. It was an ambitious programme of wide scale change, recognising the importance of primary care to our entire health system.

4. The strategy set out the idea of a 'Warrington Brand' of Primary Care, to be achieved through co-commissioning arrangements with NHS England.

5. The intention of the "Warrington Brand" was to establish that, no matter which GP practice individuals are registered with, they can expect to receive the same standard of care, this ensures any variations in the quality of service delivery will be eradicated.

6. The CCG prioritised the development of Primary Care as a key area of work due the acknowledgement that a "perfect storm" was on the horizon, mainly due to Warrington being a growing town, with some parts of the town having a rapid growth of housing and more children and families, the increased demand on services and less capacity in the system to meet the demands led the CCG to plan and implement proposed changes to transform primary care.

7. It is predicted that by the year 2020, the town will have 19,000 people aged 75+. This is 8% higher than the national average. Older people have a greater need to use healthcare services, therefore, the health services in places with a higher percentage of older people are put under added pressure and strain.

8. The Primary Care Strategy (2015) identified ten priority areas and plans for primary care along with system transformation for implementing a primary care home model of care. This document details the outcomes and deliverables that have been achieved and will detail considerations for the primary care strategy refresh for 2019.

Priority plans for Primary Care for 2015

9. The ten priorities for Primary Care are listed below.

i. Access, demand and capacity
ii. Medicines management and prescribing
iii. Care homes (nursing and residential)
iv. Primary care quality – Warrington Brand
v. Whole system/right care
vi. Complex care (including long term conditions and cancer rehab.)
vii. Promoting prevention and self-care
viii. Mental Health
ix. Workforce development and sustainability
x. Public engagement and communications in primary care.

National Direct of Travel

10. During April 2019, NHS England announced a National Direct Enhanced Service (DES) that would see the formation of Primary Care Networks across England. Since 2016, NHS Warrington CCG has worked with GP Practices in a similar way by having seven clusters across Warrington which involved Practices working in collaboration with their peers, this is described more within the progress report. The Primary Care Strategy refresh will address the directions within the DES and ensure the direction of travel for Warrington is in line with National Policy.

Local Enhanced Services (LES)

11. NHS Warrington CCG has commissioned local enhanced services with GP Practices since 2015/2016 to support delivery of the primary care strategy and to ensure equitable services for our patients across Warrington, reference will be made to this through out the progress report.

Progress report

12. The table below lists all activities identified in the Primary Care Strategy (2015) as being priorities for action, against each priority is a narrative summary of the actions taken to address the strategy. They are listed in order as they appear in the strategy.

13. It is the intention to review what has been put in place to address the priority and for those areas that still require improvements the strategy working group will consider if these are still a priority area and if deemed so, they will be continued for the Primary Care Strategy refresh for 2019.

RAG status

Red	**Little or no progression has been taken place in this area.**
Amber	**Some progression in this area has taken place.**
Green	**Lots of work has been undertaken and projects have been successful**

Progress table report

Priority No	Priority Identified in the Primary Care Strategy 2015	Activity undertaken (completed, current, or planned,	RAG Status on achievements from the strategy	Agree to continue in plan refresh Yes / No
1	Access Demand and Capacity	The former Primary Care Development Group developed an access service specification that set out to improve overall access to General Practice in core hours, to improve quality and consistency of primary care across Warrington, unfortunately the specification never commenced which was due to a number of contributing factors, however this has now been addressed through a Local Enhanced Service (LES) for 2019/20, a LES will be in operation that aims to increase access for patients and offering a range of consultations types. **Extended Access Service** The CCG currently commissions an extended access service through Bridgewater Community Health Trust. This service delivers additional appointments above core and is available during the evenings and weekend. The service is required to deliver seven national core requirements; however the CCG are not yet achieving all of these, therefore the primary care strategy refresh will address how we aim the deliver this. **Recommendation -** There is more work to do in this area, the CCG are to deliver the seven core requirements. In addition, a new Direct Enhanced Service from 1st July includes a directive that nationally all Primary Care Networks (PCNs) will deliver this service from April 2020. The CCG will support local PCN's to deliver this service.		YES
2	Medicines Management and prescribing	Medicines Management Team (MMT) supports the CCG to develop and implement medicines QIPP programmes. In 2018/19, the Medicines Management QIPP target was set at £1,469,000. To support this QIPP programme, the CCG has commissioned medicines management quality indicators for GP practices through the LES for 18/19 and again for 19/20 The quality indicators include the following: -		YES

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		1) Integration of medicines management GP Practices are commissioned to engage with the MMT to ensure cost effective prescribing across the health economy • Practices are to hold two meetings a year with the MMT to focus on the areas highlighted below: • Prescribing tends- cost growth and top 20 drugs • Prescribing indicators (benchmarking) • Antibiotic prescribing – broad spectrum antibiotics, trimethoprim /nitrofurantoin prescribing and overall prescribing • Prescribing in-line within Pan Mersey Area Prescribing Committee (APC) recommendations Practices are to engage with MMT projects, including timely signing of protocols, to enable the team to maximise CCG QIPP opportunities. Practices are to have Medicines Co-ordinators working in the practice to help maximise QIPP delivery. Cross site working could be considered if this is desirable. Practices are to continue to implement the CCG self-care policy (which is now supported by NHSE guidance on which over the counter items should not routinely be prescribed in Primary Care). **2) Stomas and Catheters** General Practice will ensure all patients with a stoma or catheter are recorded on a register General Practices will ensure all patients on the stoma / catheter register have a product use review completed annually. **3) Shared Care** General Practice will prescribe medicines considered suitable for shared care, within the framework of a locally agreed shared care agreement, unless there is a clinical reason not to do so.		

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		19/20 Specifications – includes medicines optimisation for 85+ **Progress (April to November 2018)** The Medicines Management Team is currently on target with implementing the QIPP programme and has so far delivered £965,485 of identifiable in-year savings. **Recommendation –** medicines management to be a key feature in Network developments to reduce activity, this shouldn't be a standalone priority, but MM should run through all projects.		
3	Care Homes	A series of workshops were held with primary care following the service pilot with Warrington Health Plus and an Enhanced Care Home Service (ECHS) was formally commissioned by Warrington CCG from Bridgewater Community Healthcare NHS FT during 2016/17. This service offer included reactive and proactive care components, with a strong focus on advanced care planning for the care home population, with a view to reducing the need for secondary care admissions. An educator role has been built into the service model and has provided a programme of education for care home staff to upskill staff in care homes. Care pathways have been developed with the homes, WHHFT, NWAS and community teams. Clinical pharmacists have become virtual team members and work collaboratively with the ECHS. The original model included GP input at a cluster level which has been difficult to maintain in several areas and the model has evolved to include an increased level of ANP input as a result. Data shows that admissions to secondary care remain amongst the lowest in Cheshire and Merseyside. The ECHS now has direct access to the Frailty Hub at Warrington Hospital for geriatric assessment and rapid diagnostics **Recommendation -** review of model of care in light of PCN implementation. Alignment of care homes to practices has been discussed and a conclusion on this needs to be reached		
4	Primary Care Quality	The strategy referred to the Warrington Brand which was a defined quality of provision enabling every citizen to get a common offer of care irrespective of their registered practice (incorporating the 10 priorities for primary care defined by the GP membership of the CCG)		YES

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		A former primary care development group was set up and chaired by a Practice Manager. The group developed the first set of quality indicators for the Warrington Brand and these were initially referred to as a BES (Brand Enhanced Services and later changed to general local enhanced services, (LES). In the first year of development seven quality indicators were set, with each of them having sub indicators within each area, the overarching indicators are captured below with further information described in each of the 10 priority sub headings:- **Year 1** 1. Medicines Management • Reduce inappropriate antibiotic prescribing • Ensure cost effective evidence-based prescribing for the residents of Warrington • Reduce prescribing costs for drugs prescribed for minor short-term health problems in Warrington. 1.1 Shared Care 1.2 Register of people with stomas/catheters 2. Dedicated care (using Aristotle to identify top 0.5% of patients) 3. Ambulatory Care (DVT and NPT) 4. Effective Referrals (WRAG and mandated CCG pathways) 5. Membership Engagement 6. Mental Health 7. Workforce Development All of the above quality indicators were commissioned by the CCG to ensure equitable services across Warrington Primary Care. **Year 2** The LES is now in the second year of commissioning and the quality indicators for this year are as follows: 1. Pathways (DVT, NPT, Sepsis and medicines management) 2. Bank Holiday opening 3. Dedicated Care (1 in 500 of registered population to have care plans)		

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		4. Long term conditions (Dementia, Cancer, Diabetes) 5. Workforce development (patient advisers, MECC, Apex demand and capacity tool) 6. Maturity Model **Year 3** The CCG are about to launch year 3 of the LES, the schemes include:- **Pathways** ✓ Medicines Management ✓ DVT & NPT **Long Term Conditions** ✓ Mental Health ✓ Frailty and end of life ✓ Hypertension, detection and management ✓ A/F **GP Access** ✓ Enhancing appointments, Apex, data collection **Recommendation** – this priority has been achieved; however the Warrington Brand and the ethos should remain throughout all we strive to achieve for Primary care and the residents we serve.		
5	Whole system/right care	During the creation of the strategy this was known as the “Primary Care home model. During 2014 GP Federations in Warrington submitted a bid against the prime minister’s challenge to support the cluster model of change. The bid was successful, and Warrington received £4.4m investment to further develop the cluster concept. During 2016 the prime ministers challenge fund ended.		YES

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		The CCG then took on the responsibility for the commissioning of seven clusters, to support this collaboration a maturity model was created which is a five stepped systematic model for practices to mobilise and work towards integration. During 2016-2019, there were seven clusters across Warrington. Since the publication of the recent *five-year framework for GP contract reform (January 2019)* the clusters have changed, we now refer to the clusters as Primary Care Networks (PCN's) as this is in line with nationally policy and GP Practices have recently aligned into five networks. PCN's are responsible for delivering primary care provision at scale, bringing together system integration and care co-ordination for a their populations. From 1st July 2019, PCN's will be commissioned through a Direct Enhanced Service (DES) the direction of travel will be described fully in the primary care strategy for 2019. In addition, since the inception of Warrington Together primary care are involved in delivering place-based care and Networks will develop multi-disciplinary teams (MDTs) processes with other health care professionals. There is still lots of work to do for Networks as they mature overs the coming years, but during the last few years Practices have been introduced to working in this way and have developed work plans and relationships with their colleagues. **Recommendation -** the strategy should address the direction of travel for the DES and Warrington Together work. Both these areas should feature as a new priority within the primary care refresh plan, and focus should be on "placed based care"		
6	Complex care (including long term conditions and cancer rehab.)	For the previous two years the CCG has aimed to address this priority by commissioning a dedicated care LES.		YES

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		Initially practices had to be trained on the software system called Aristotle and this was installed in each practice, so the first part of the LES related to the training of staff, the expectations of this LES in year 1 is listed below **Year 1** • Practices were required to sign a data sharing agreement to enable the Primary Care data to be shared and their risk stratification reports populated. • To enable the process to be successful practices have to upload their information and send them to the commissioning support unit (CSU) • Practices to identify their top 0.5% patients and feedback to the CCG quarterly via the performance template on the following areas: - How many patients had active care plans? - How many patients required a care plan to be put into place? - What levels of good practice are in place to review care plans? - What actions has the Practice put in place for patients not requiring a care plan but to reduce cost and time to the health system? - Details of any themes emerging from analysing the top 0.5% **Year 2** Practices have to identify at least 1 patient per 500 registered populations (which equates to approx. 20 patients / 10000, this activity is for 12 months) from either the Aristotle software system or their clinical judgement on appropriateness. The following is completed for each patient: • Communicate with the patient regarding the approach and plan and obtain written consent. • Ensure a bespoke care plan is in place tailored for the patient and their individual needs, e.g. is there an advanced care in place that includes information such as DNR (do not resuscitate), lives alone, next of kin, carer information, social etc. • If appropriate create a Special Patient Note (SPN) and ensure that Bridgewater have received the SPN for management of the patient's care during the out of hours period.		

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		During this year this work will dovetail with the work of Warrington Together ensuring MDTs and care plans are in place for each patient. This will be a phased implementation across clusters, focusing on central North first.
		
		Year 3
		Complex Care for Frailty & End of Life
		
		• To have a named clinical frailty lead
		• To **identify and code** people at risk of frailty using the electronic Frailty Index (eFI)
		• To complete a face to face **assessment** of patients recorded with Severe or Moderate frailty using Rockwood assessment tool to validate the eFI score (embedded in the named CCG Frailty Template
		• To **use standard templates** established on EMIS/TPP:
		  ○ Frailty
		  ○ End of Life – EPaCCS
		• To register where appropriate severe frailty patients on the GSF register (all life limiting illnesses including frailty, using the Proactive Identification guidance (PIG) embedded in CCG frailty template.
		• To consider registering moderate frailty patients on the GSF register, where appropriate
		
		Recommendation - this work should commence within place-based care which should remain as a key priority for the new refresh strategy		

7	**Promoting Prevention and Self-Care**	The CCG has worked closely with Pubic Health during the past 2 years and has developed the quality requirements in this area, they are as follows: - **1) Making Every Contact Count Training** Practices to identify their key front-line staff to receive training that will enable staff with the leadership, environment, training and information they need to deliver the MECC approach and give staff the competence and confidence to deliver healthy lifestyle messages, to encourage people to		YES

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		change their behaviour, and to direct them to local services that can support them. **2)** Practices to have a named public health champion who is responsible for receiving public health messages to disseminate to all staff and to also ensure 4 evidence-based campaigns are delivered within the practice per annum in partnership with public health and the CCG In addition to the above clusters have chosen projects for their step two maturity model that are aimed at self-care / social prescribing. Lots of work around this area continues across both the CCG and general practice. **Recommendation –** this work underpins all workstreams, lots of work has been done in this area to inform the public to make wise choices, continue with this as a priority for the primary care refresh.		
8	**Mental Health**	The CCG has had mental health as a priority area with the local enhanced services for three years. The quality standards that have been commissioned are as follows:- **Assign Practice Lead for Mental Health** Each GP surgery has a named 'lead GP for Mental Health' with an email address submitted to the CCG. The lead is a named contact for mental health with responsibility to disseminate information to their Practice on Mental Health provision. The named lead also attends an annual MH Symposium (or similar). **Use of low-level interventions for patients presenting mild or moderate depression or anxiety** Clinical staff offer information leaflets to patients outlining available low level interventions/services that can be used prior to referral/self-referral to IAPT. This is monitored by the CCG through read codes.		

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		Promote physical health within patients with severe and enduring mental health conditions Each practices threshold is to offer as a minimum 50% of patients on the severe and enduring mental health register to sign up to access online GP services. This enables North West Boroughs to view physical health outcomes of patients to align physical and mental health to improve patient outcomes. Practices are expected to report on total patients on the SMI register alongside number signed up to online services prior to April 2018. **Annual audit of 10 practice referrals to Assessment Team from April onward** GPs had to conduct an audit of at 10 consecutive referrals made to the assessment team at NWB then share lessons learned at practice meetings and identify and themes and trends for learning. **Military Veterans** Promoting the recording of patient veterans and reservist's status within their GP practices to support the NHSE requirement for Armed Forces and the delivery of the military convent. GP practices are to increase the recording of military veterans on their clinical systems as there are 11,818 veteran population in Warrington but only 1,653 currently recorded on GP systems (data source 2016) **Improve the cervical/breast/bowel screening rates in people with a learning disability (LD)** To reduce health inequalities and improve the quality of life for patients with an LD. Working closely with the LD Nurse at NWB to increase the uptake of health chcks for this patient cohort. **Dementia** There are three quality requirements for Dementia, they are:- • Maintaining the rates of dementia diagnosis • Complete advanced care planning for all dementia patients • Each practice to work with the CCGs to support the delivery of the dementia action plan and strategy.		

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		Lots of work for Mental Health has taken place and continues to do so. The CCG are continuing to commission mental health through a Local Enhanced Service for 2019/20 to ensure that vulnerable people have physical health checks. In addition there is work continuing to ensure IAPT practitioners (improving access to psychological therapies) are available at primary care network level. **Recommendation: Ensure that the mental health strategy and the primary care strategy are aligned.**		
9	Workforce development and sustainability	Improving the work force in a primary care setting is a priority for the CCG and although pockets of this have been addressed to reduce risks, there is much more that needs to be done in this area. The CCH has commissioned a workforce local enhanced service for the previous two years which has included the following quality indicators: - • Front line staff to receive Making Every Contact Count training (ensuring people are seen by the most appropriate clinician for their needs first time) • All reception and admin staff to become Patient Advisers (trained advisers to signpost patients to the right part of the system for their needs) • Installation of Apex (once commissioned by NHSE) this software is to analysis demand and capacity at primary care level). In addition, Warrington Together also have a task and finish group for workforce, and NHSE are about to lead on the development of a workforce strategy working closely with CCGs.	YES	
10	Public engagement and communications in primary care.	A significant amount of work has been undertaken since 2015 in developing our communications and engagement with Primary Care to ensure that as our members they are fully informed. Work to date has included:	YES	

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		• Primary Care action plan for the GP Five Year Forward View – outlining the key priorities for Primary Care and how communications can support this work • Development and implementation of communications to support the roll out of Patient Advisers across Primary Care in conjunction with Practice Managers and Patient Participation Groups • Review of winter communications for GP practices for 2018/19 based on feedback from last winter, resulting in the co-development and implementation of a Winter communications toolkit for practices containing key information to help them • Creation of toolkits for practices for key pieces of change-based work the CCG is leading on, including changes to the way repeat prescriptions are ordered and the implementation of the outcome of the second consultation about more medicines that should be bought over the counter for short term, minor illnesses rather than these medicines being routinely prescribed by a healthcare professional • Review of the weekly Primary Care bulletin in 2015 and implementation of changes based on this feedback • A second review of the Primary Care weekly bulletin has been undertaken in 2018 to ensure this communications channel continues to meet the needs of its audience – the outcomes of this review will be implemented in 2019 • Developed Commissioning Protected Learning Times to engage with primary care on the CCG's priorities and upcoming work. **Recommendations** – Communications and Engagement should not be a priority on its own with the refresh strategy, but the communications strategy will be developed to reflect how we intend to engage and communicate across all priority areas of the refreshed strategy. **Communications and engagement is an enabler to all our work.**		