Hertfordshire and West Essex Sustainability and Transformation Partnership

Primary Care Networks

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Overview of the presentation:

1. NHS Policy Background to Primary Care Networks (PCNs)

2. Geographical spread & number of Primary Care Networks

3. Achievements to date

4. What the art of the possible is & forward looking

5. Questions

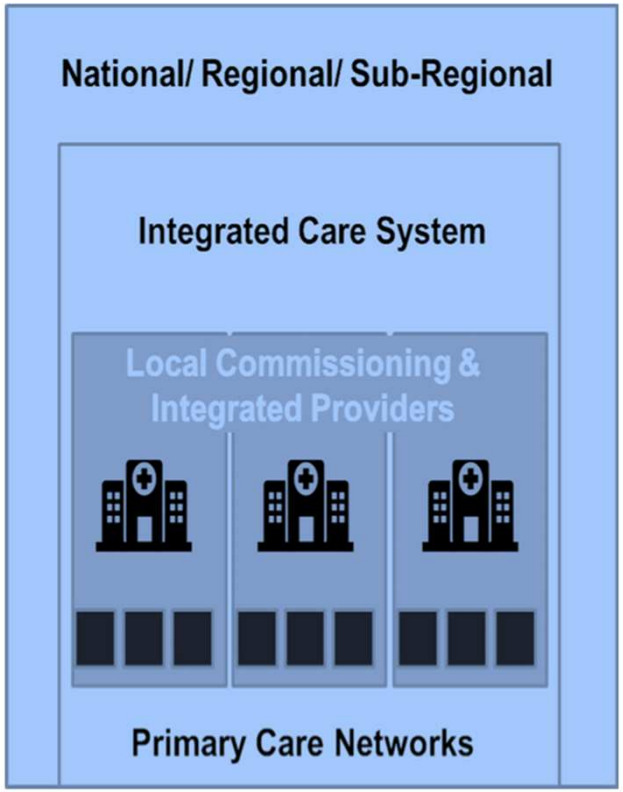
Primary Care Networks

In 2018/19 the NHS England Operational Planning Guidance:
CCGs to actively encourage every practice to be part of a Primary Care Network (PCN) covering a population of at least 30,000-50,000 and that are geographically contiguous

2019/20 national contract negotiations with the British Medical Association: built on the planning guidance with the implementation of the new PCN Directed Enhanced Service for PCNs from 1 July 2019.

PCN provided with additional funding including: new staffing models e.g. Clinical Pharmacists, Social Prescribers, Physicians Associates

PCNs are encouraged to work more closely with other primary, community care and acute health care organisations providing integrated services to their populations.



The NHS Long Term Plan

- Targeted and personalised support (risk stratification)
- Increase focus on population health
- Lead to fully integrated community healthcare
- Working as a member of an Integrated Care Partnership
- Most CCGs have local contracts for enhanced services, and these will normally be added to the network contract

Primary care vision:

To establish a strong general practice foundation, through the development of primary care networks and wider place-based care neighbourhoods

The key pillars of our system are:

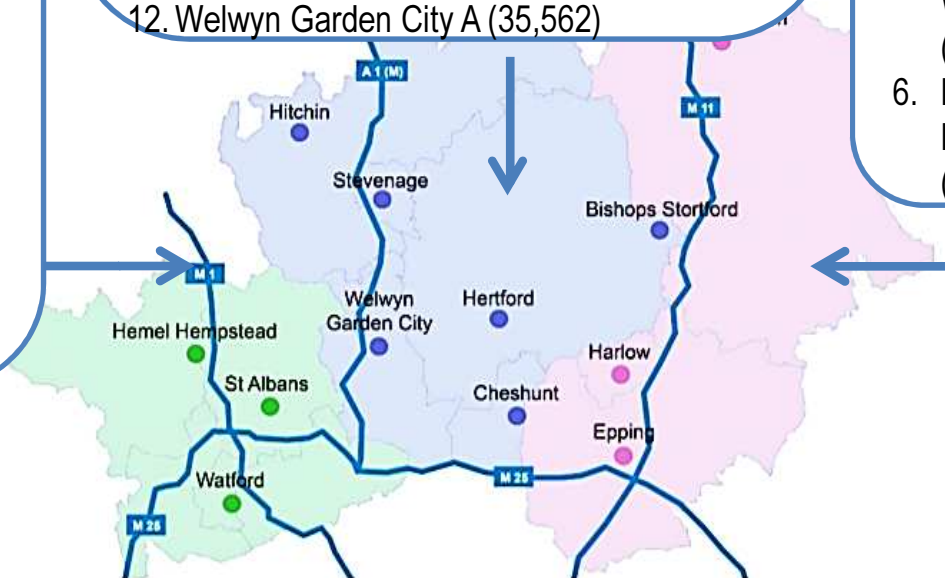
- Supporting general practice - working together and in partnership with community and care-providing organisations
- Growing, developing and retaining our primary care workforce
- Creating modern, digital solutions to enable primary care delivery
- Creating a modern, fit-for-purpose infrastructure to deliver high quality services
- Sustaining and improve the quality of care for our patients

Herts Valley CCG
16 PCNs

1. Alpha (53,429)
2. Beta (40,186)
3. Delta (33,713)
4. Dannais (41,830)
5. HertsFive (76,095)*
6. Potters Bar (30,137)
7. Grand Union (44,369)
8. The Rickmansworth & Chorleywood (29,145)
9. Central Watford & Oxhey (45,323)
10. Attenborough & Tudor Surgery (29,710)
11. North Watford (38,710)
12. Manor View Pathfinder (29,285)
13. Abbey Health (31,901)*
14. Harpenden (43,787)
15. HLH (38,567)
16. Alban Healthcare (44,018)

East & North Herts CCG
(12 PCNs)

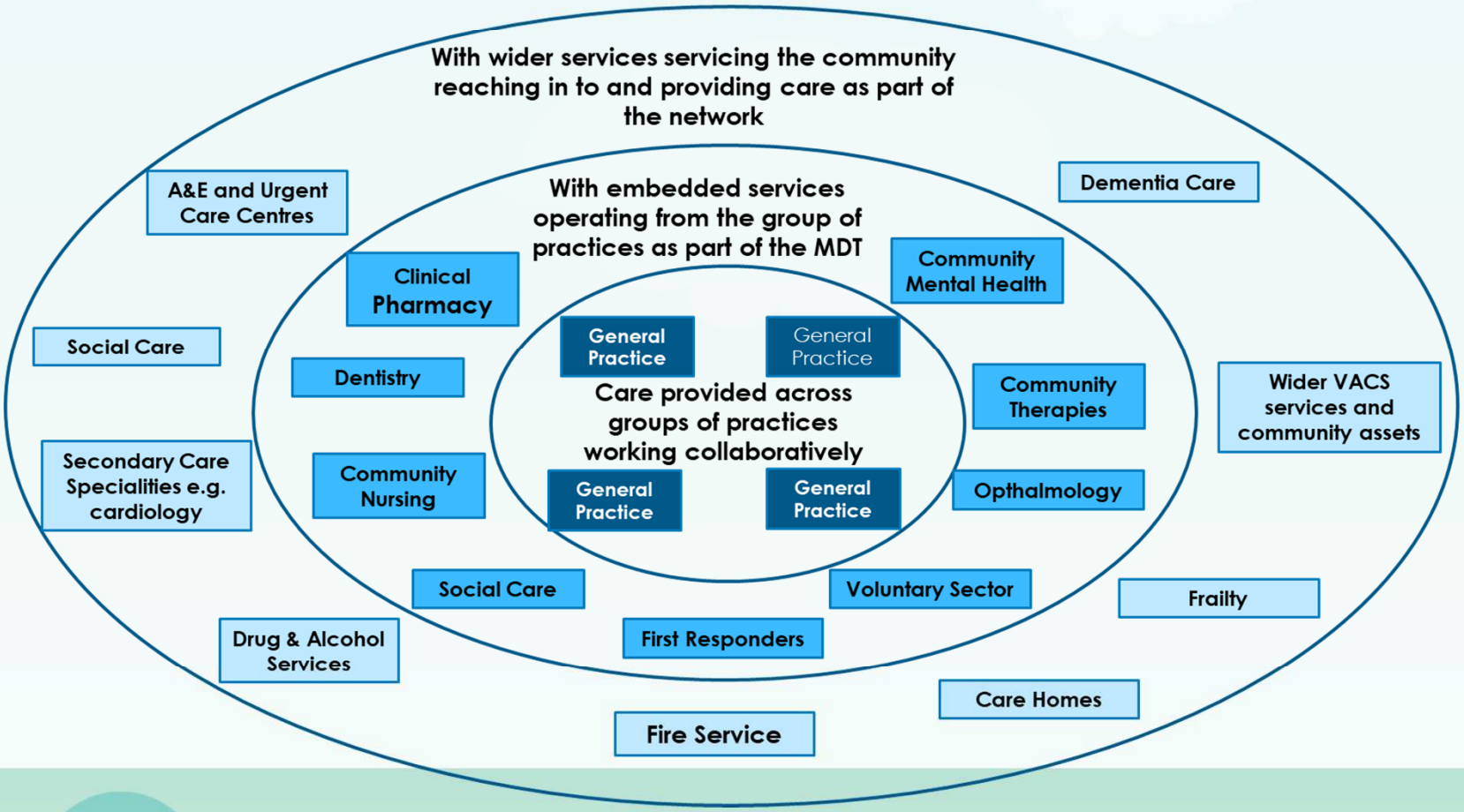
1. Icknield (57,099)
2. Hatfield (50,735)
3. Hertford & Rurals (51,770)
4. Hitchin & Whitwell (47,151)
5. Hoddesdon & Broxbourne (41,541)
6. Lea Valley Health (76,251)
7. Peartree Group & Bridge Cottage (63,763)
8. Stevenage South (48,944)
9. Stevenage North (60,770)
10. Stort Valley & Villages (61,997)
11. Ware & Rurals (32,911)
12. Welwyn Garden City A (35,562)



West Essex CCG
6 PCNs

1. North Uttlesford (39,090)
2. South Uttlesford (51,508)
3. Harlow North (58,705)
4. Harlow South (40,189)
5. Epping, Ongar, Waltham Abbey (64,588)
6. Buckhurst Hill, Loughton & Chigwell (59,836)

Primary Care Networks & System Partners



A Healthier Future

Improving health and care in Herts and west Essex

Hertfordshire and West Essex
Sustainability and Transformation Plan

Essex County Council

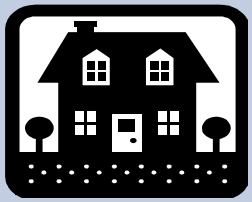
Hertfordshire

NHS

A Healthier Future

Improving health and care in Herts and west Essex

Primary Care Networks



Care Homes : building on Vanguard Initiatives

MDT supporting GP Ward Rounds

Care Home Pharmacist

Social Prescribers, Pharmacists

First Contact Physiotherapists

Physicians Associates

Primary Care Hubs: On the day demand

Direct Access Physiotherapy

PCN SPOC: Call/Recall Hub

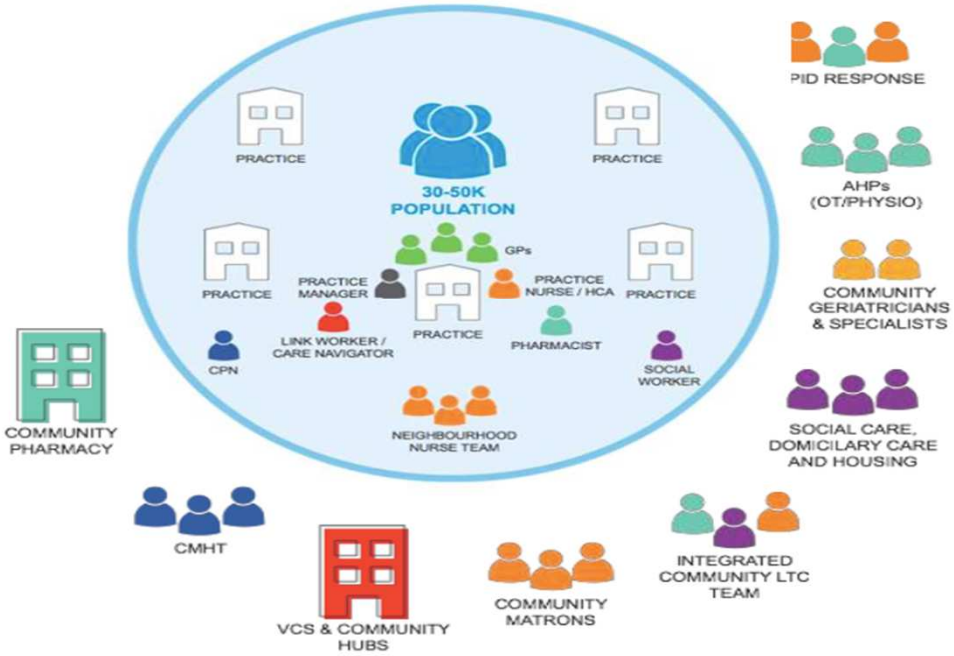
Emerging Picture for PCNs in preparation for transition to Integrated Care Partnerships

Core Team

- Sustained Relationships
- Shared Values And Functions
- Proactive Population Health Management And Data Sharing
- Formal & Informal Multi-Disciplinary Working
- Co-Location where possible and appropriate

Aligned Teams

- Regular Communications With Core Team
- Mostly reacting and responding to referrals



A Healthier Future

Improving health and care in Herts and west Essex

Achievements to Date:

Bernadette Millwood (General Practice Nurse, Primary Care Nurse Tutor ENHCCG & Co-Clinical Director
Icknield Primary Care Network

Aspirations for the future

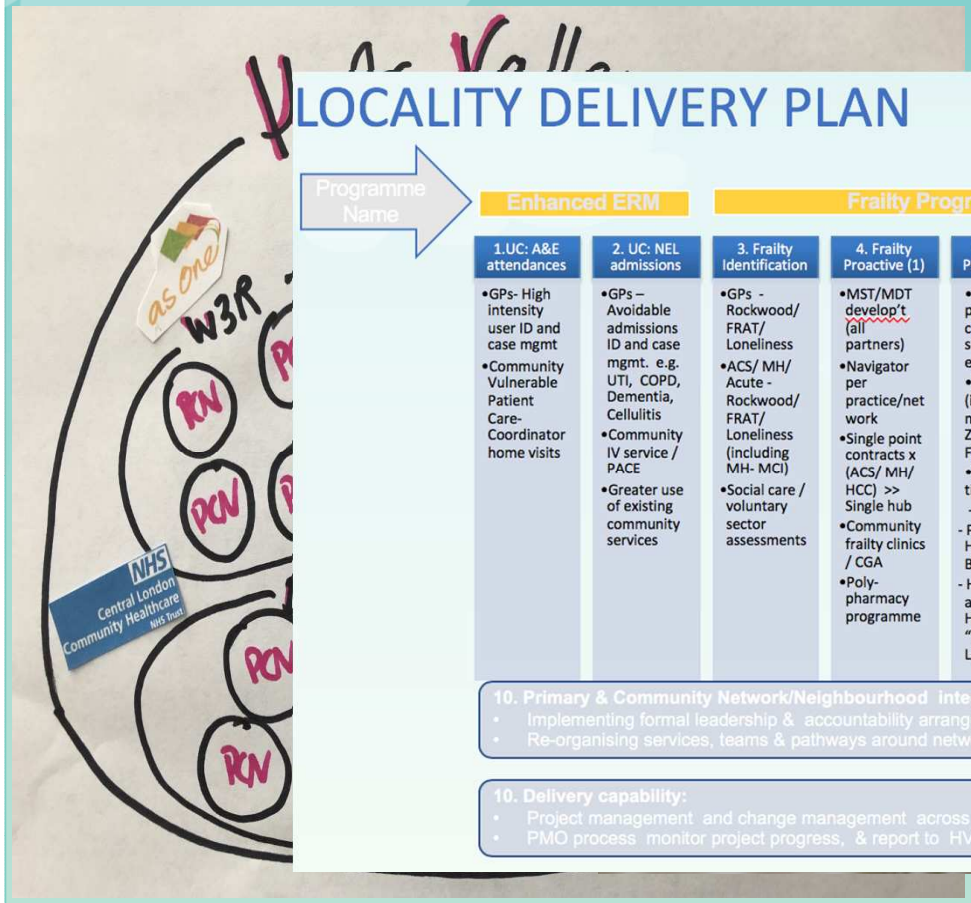
- To provide the PCN population with the **best available health & social care**
- **Sustainability** in General Practice
- **Collaborative working** e.g. Mental Health services e.g. for those under 25 years old
- To create a PCN community that **shares best practice protocols and new ways of working**
- To provide a **well-trained, stable and resilient workforce** by providing **training opportunities**.

How are we doing against these ?

- Currently **integrating** the clinical pharmacists & social prescribers into general practice
- **Reviewing our care home needs** and how best to incorporate skill & expertise of frailty nurses
- Early plans and meetings held regarding **employment of first contact physiotherapists** from April 2020
- **Patient survey** being prepared by Hitchin and Whitwell PCN & Icknield PCN to gather data on the local need for a physio
- Developing a service specification with the CCG to provide a **PCN Spirometry Hub** with the aim of improving the diagnosis of COPD and asthma
- Formed clear and agreed **multi-disciplinary teams with community provider partner** including reviewing estate needs
- Plans to connect with **local voluntary organisations and the local authority** & to include the **PPG representatives** in the planning of our services.

We work well as a single team

- **Commitment** as a single team working together
- **Leadership aspirations** empowering & involving wider colleagues in the work of the PCN
- Attending Leadership conferences & courses in Primary Care NHS England **involving lead nurse colleagues from the PCN.**



LOCALITY DELIVERY PLAN

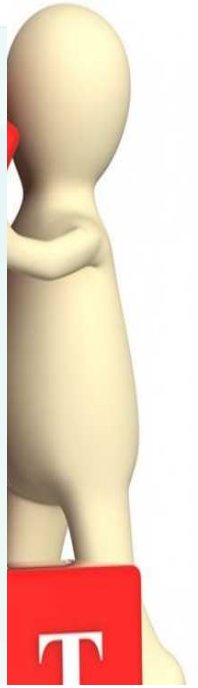
Programme Name

Enhanced ERM		Frailty Programme				Carers	Care Homes	Medicines Mgmt
1.UC: A&E attendances	2. UC: NEL admissions	3. Frailty Identification	4. Frailty Proactive (1)	5. Frailty Proactive (2)	6. Frailty Acute & Emergency	7. Carers	8. Care Homes	9. Medicines Mgmt
•GPs- High intensity user ID and case mgmt •Community Vulnerable Patient Care-Coordinator home visits	•GPs – Avoidable admissions ID and case mgmt. e.g. UTI, COPD, Dementia, Cellulitis •Community IV service / PACE •Greater use of existing community services	•GPs - Rockwood/ FRAT/ Loneliness •ACS/ MH/ Acute - Rockwood/ FRAT/ Loneliness (including MH- MCI) •Social care / voluntary sector assessments	•MST/MDT develop't (all partners) •Navigator per practice/net work •Single point contracts x (ACS/ MH/ HCC) >> Single hub •Community frailty clinics / CGA •Poly-pharmacy programme	•Social prescribing clinics/ services/ events •STP Falls (incl. Pimp my Zimmer); FLS •Personalisation - My Plan - Personal Health Budgets - Holistic adoption of HCC "Connected Lives"	•Acute Frailty units	•Increased identification •Expanded social prescribing & services for carers	•Community Pharmacy reviews in Care Homes •Basic obs by care homes; Video GP consultat'n; OPAT. •Falls prevention initiatives	•Community Pharmacy supporting Care Homes •Community Pharmacy; Domiciliary MURs to reduce stockpiling and better compliance •Medicines optimisation STP programme as applicable

Project Name

10. Primary & Community Network/Neighbourhood integration – to deliver the "place based" care model
- Implementing formal leadership & accountability arrangement between partners, including budget.
- Re-organising services, teams & pathways around networks.

10. Delivery capability:
- Project management and change management across all work streams
- PMO process monitor project progress, & report to HVDB.



What Next

What's Next

- NHSE & Improvement PCN Service Specifications
- Support for Local Delivery Board Plans
- Ongoing support in building the emerging network teams
- Integration of services with other providers e.g. Frailty services, Mental Health etc.
- Support to prevent attendances and admissions that can be managed in the community
- Increased use of technology e.g. online consultations

Thank you