An Example of Success from Liverpool

This Stage 2 case study follows up with the results and sustainability of Stage 1 of Improved Practice for Women's Reproductive Health – LARC Services in Liverpool.

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SITUATION | SOLUTION | SUCCESS

This resource has been developed with the support of a Grant from Bayer PLC and Organon Pharma (UK) Limited. Bayer PLC and Organon Pharma (UK) Limited had no editorial control or scientific input.

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LOCATION: LIVERPOOL

SERVICE: STAGE 2 OF IMPROVED PRACTICE FOR WOMEN'S REPRODUCTIVE HEALTH – LARC SERVICES: LOCAL PROGRESS COMMISSIONER-LED CASE STUDY

This case study focuses on the results and sustainability of the project; for context, please refer to the case studies resource available on the toolkit for details of the first phase.

Overview of activity

Driving increased uptake of LARC in primary care through a Primary Care Network (PCN) model.

Latest developments since Case Study 1 – July 2021

This 2nd case study demonstrates how a 'hub and spoke' model improved access and uptake of LARC methods for women in Liverpool delivering care closer to home via GP provision.

- Local work and focus has included mobilising and connecting with remaining PCNs yet to fully move on the model, or those in need of further support.
- Liverpool City Council (LCC) Public Health commissioners have commissioned a new integrated sexual and reproductive health service, which went live on 1 November 2021. This service will provide a more holistic approach and support, GP trainee slots and upskilling to local practices, to assist with the further development of the model.
- Alongside this, LCC and Liverpool Clinical Commissioning Group (LCCG) have collaborated to ensure that the urogynae offer for extended/ wider condition management in relation to women's health can be embedded within the new integrated sexual and reproductive health offer, for improved community access.

Activity levels in relation to LARC particularly appear to have now restored, bucking the national trend.

The specification for the integrated SRH service currently includes:

Management of the following:

- Intrauterine system insertion/renewal for heavy menstrual bleeding
- Management of pelvic organ prolapse requiring pessary fitting/replacement
- Assessment and management of menopause including prescribing HRT, insertion and renewal of LNG-IUS for progestogen component of HRT.

Treatment will include:

- LNG-IUS coil fitting for heavy menstrual bleeding (HMB)
- Ring Pessary fitting and replacement for prolapsed uterus or bladder
- HRT, including LNG-IUS fitting for progestogen component of HRT
- Drug therapy in accordance with an agreed formulary.

Training: We have also continued to hold educational sessions and fitter forums – these have involved running sessions for GPs around latest evidence; guidance in relation to LARCs; menopause management.

IT (EMIS): Further work has been undertaken by GP leads on the consultation/EMIS template to improve coding and data and to have that template given the Faculty of Sexual and Reproductive Health (FSRH) stamp of approval, to then be rolled out as a consistent and endorsed national piece of work.

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Results: Demonstration of success by Primary Care Networks (PCNs)

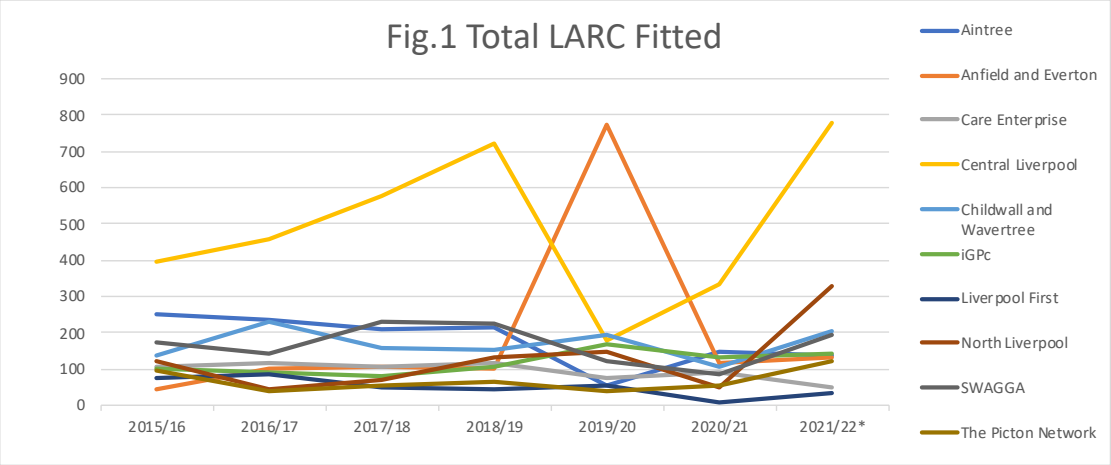
In terms of results, we have seen positive activity increases across most PCNs, with the early 'pilot PCNs' now seeing a significant upward shift (see Fig.1).

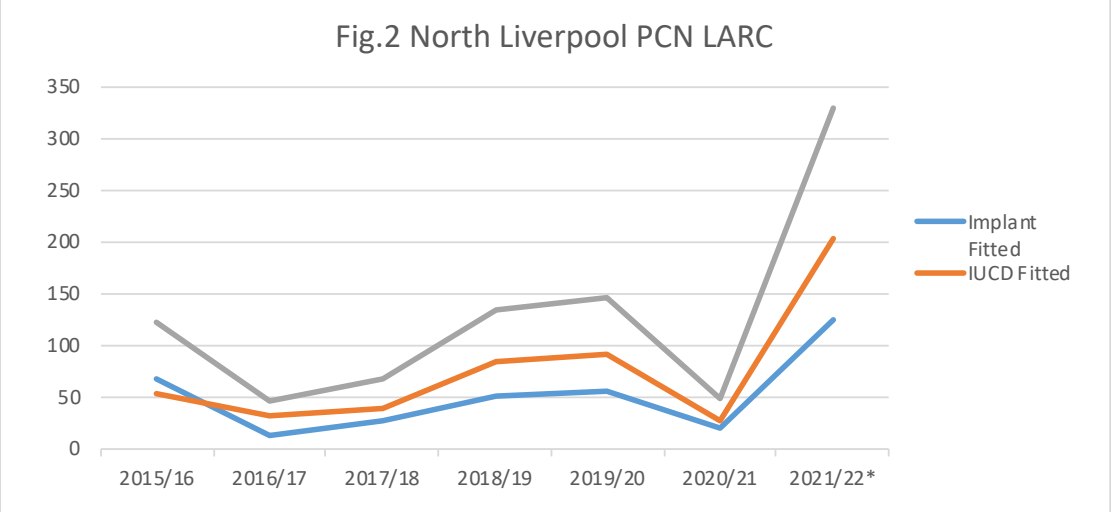
Activity levels in relation to LARC particularly appear to have now restored (see Fig.1 'Total LARC Fitted'), bucking the national trend. Indeed in some PCNs this will see us fitting more LARCs this year than we have ever previously recorded in Liverpool. View Fig.2,3,4,5 to see the implant fitting and IUCD fitting rates in North Liverpool, Central Liverpool, iGPc (the innovative General Practice collaborative) and Picton.

The projections for the overall activity across all networks appears to highlight restoration of fitting levels surpassing pre-COVID performance (see Fig.6).

It is worth noting that coding and auditing will soon be even better and allow us to provide more detailed analysis on which conditions are being managed and the direct impact the service is having on reducing the need for women to attend acute/secondary care for routine conditions.

Adapted from internal data produced by, and for, Liverpool City Council and Public Health Liverpool. The author expresses thanks for their permission to use.





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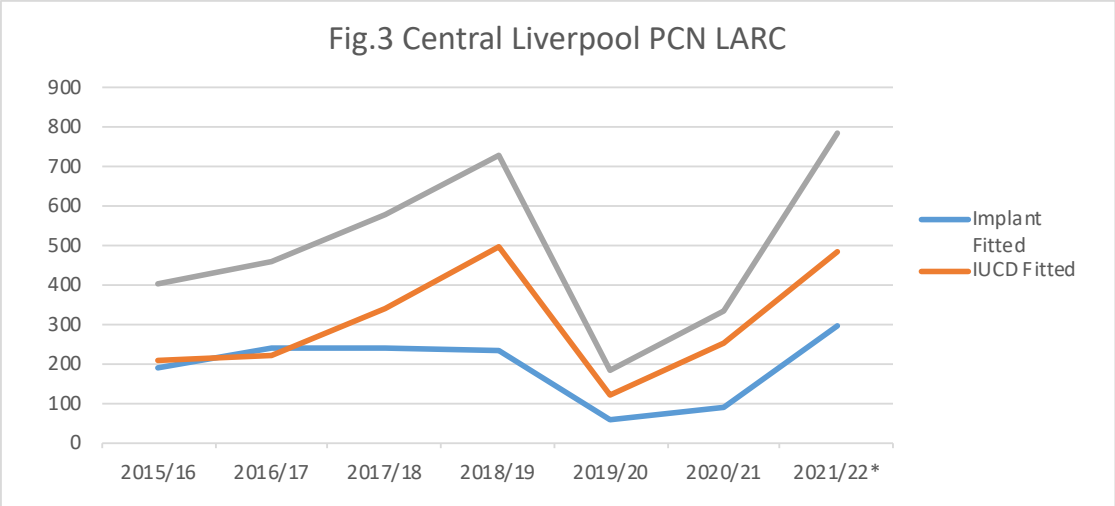

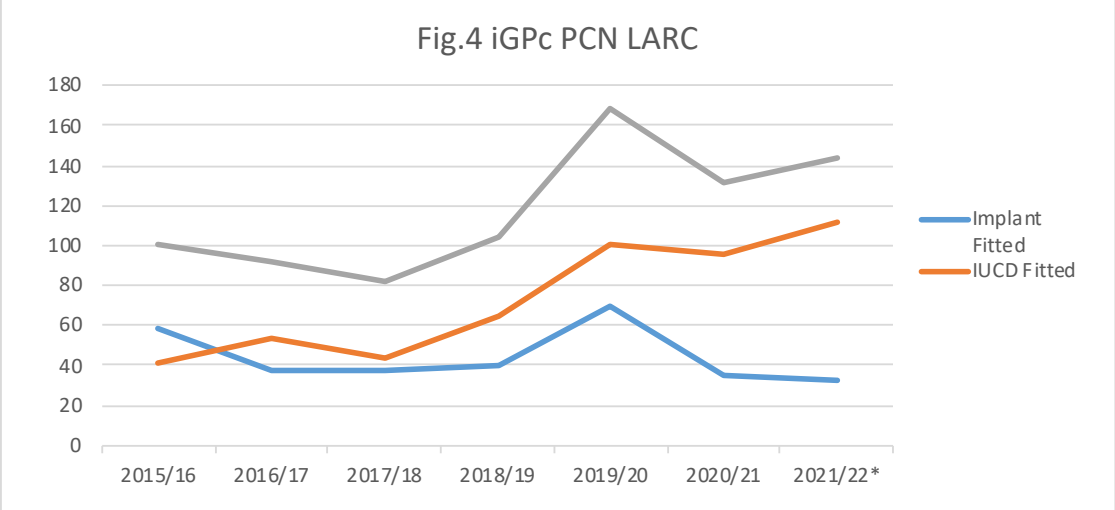

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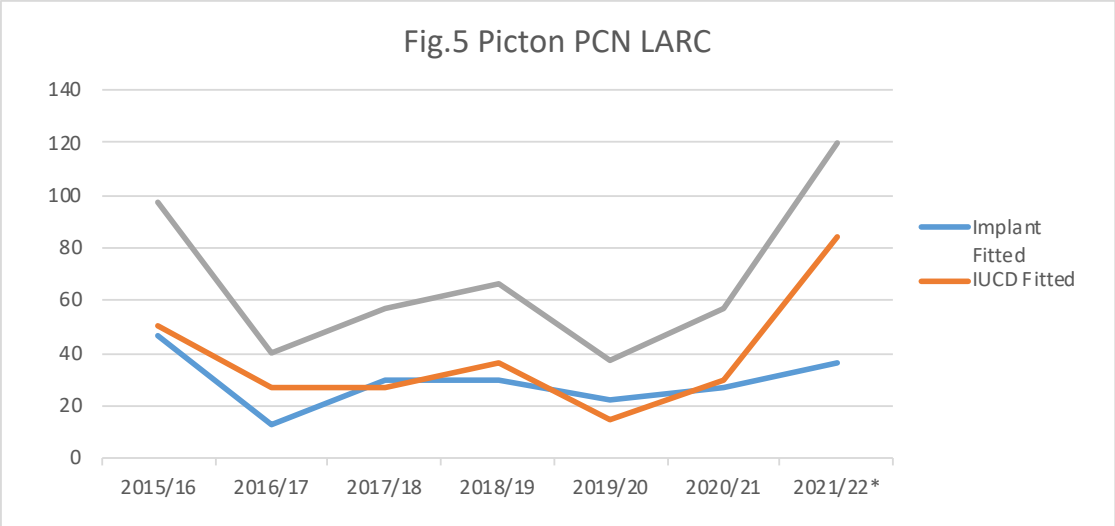

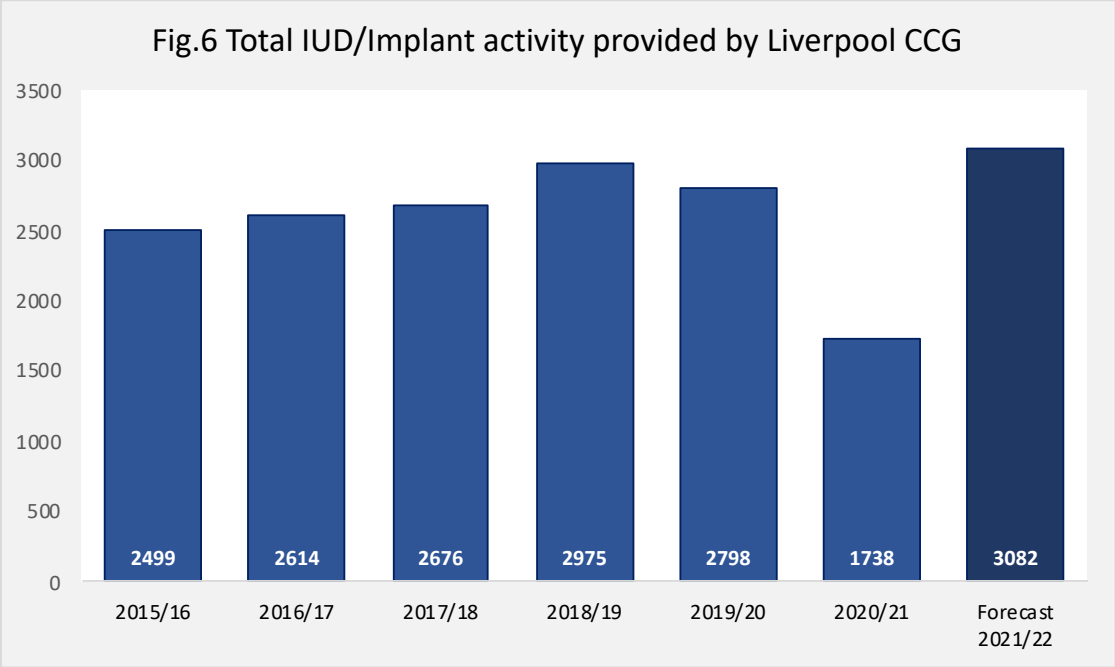

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Key learnings and challenges

PRIORITISATION AND STAKEHOLDER NETWORKS:

- Capacity to continue to drive it is challenging – there is a need to develop a robust 'steering group' of stakeholders to continue to oversee it and move forward to ensure this is delivered.
- CCGs are being disestablished and Integrated Care Systems (ICSs)/Integrated Care Boards (ICBs) are coming – this is making the decision-making landscape, the roles, accountability and assessment of next steps a little challenging at present.

FINANCIAL VIABILITY:

- This takes time to get absolutely right and to ensure that all of the templates, payments, contracts and coding are providing what we want – not only data-wise, but to ensure that payments reach the correct places/practices.
- We have engaged our CCG and NHS colleagues well in how we develop this; they back and support the model. However, the contracting arrangements related to where various parts of the system are located (for example the money for women's health/reproductive health) makes it very difficult to unravel and to shift that money into the appropriate places.
- Many agree that the model, proximity, GP approach with links to community provider (PCN model) is the right way, but clearly identifying where the budgets are is not easy.
- Coding and understanding/unravelling the data within the secondary care setting – devising business cases to have those conversations about where funding best sits (and for what care) is also challenging.

Know your local system and where to land your case – a joint commissioning group, an ICS lead, or somewhere else

SUGGESTED SOLUTIONS TO HURDLES:

- Know your local system and where to land your case – a joint commissioning group, an ICS lead, or somewhere else. We have a One Liverpool Plan and a joint commissioning board where cases have been framed to collaborate around this work.
- Engage all partners, commissioners and providers to get hold of the vital data and coding/tariffs to model the case for certain conditions to be more appropriately managed out in the community – we have engaged the consultant leads and business leads in the acute services effectively and they are now on board.
- Establish a clear task group to focus on education, support and providing the latest updates to GPs in order to give them more links, confidence and skills to drive this sort of offer forward and create the rationale for change.

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NEXT STEPS/FUTURE EXPANSION:

- The next focal point is to bring Ring Pessary fitting and further routine condition management into the equation across both community and GP providers on a longer term and more sustainable basis.
- Planned mapping – to create a business case and joint working with CCG and Liverpool Women's Hospital around the above aspect with consultant support to put appropriate pathways and training in place; specify what can be managed and where across the system, and create vital referral links for those times when support is needed (consultant support).

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