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Sefton Council

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Date: 5 September 2023

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Dear Member,

HEALTH AND WELLBEING BOARD - WEDNESDAY 6TH DECEMBER, 2023

I refer to the agenda for the above meeting and now enclose the following presentation(s) which were unavailable when the agenda was published.

Agenda No.	**Item**
9	**Primary Care Network Update** (Pages 3 - 32) Presentation(s) of South Sefton Primary Care Network and Southport and Formby Primary Care Network

Yours faithfully,

Amy Dyson

Democratic Services

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Sefton Council

Report to:	Health and Wellbeing Board	**Date of Meeting**	6th December 2023
Subject:	Primary Care Network (PCN) Updates – key programme highlights		
Report of:	South Sefton PCN Southport and Formby PCN	**Wards Affected:**	(All Wards)
This Report Contains Exempt / Confidential Information	No		
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Purpose / Summary of Report:

At the previous HWBB meeting, Sefton Place leads provided an update on the wide range of innovative work being led by Sefton PCNs. It was proposed that PCN leads be asked to showcase some of these programmes in more detail at the December meeting.

Both PCNs will therefore deliver a presentation highlighting details of key programmes which demonstrate partnership working to improve health and wellbeing and reduce health inequalities for Sefton residents.

Recommendation:

That the HWBB receive the presentations.

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SOUTH SEFTON
PRIMARY CARE NETWORK

Addressing Capacity & Access

South Sefton Primary Care Network

December 2023

Introduction

- South Sefton Access Service
- Enhanced Health in Care Homes
- Mental Health Team
- Learning Disability Health Checks
- Gap analysis

South Sefton PCN Strategy on a page

Context

- NHS Long term Plan
- GP Forward View
- Network DES
- Sefton Partnership
- ICS & Place Strategy
- HWBB Strategy
- Programme Delivery Group
- Fuller Stocktake
- Health Select Committee - Future of General Practice
- Sefton PCN Collaborative

Key risks

- Clinical systems interoperability
- Workforce
- Estates
- General Practice access
- PCN 'scope creep' and continuity of the contract
- Commitment to integration across organisations
- ICB changes: placed based support is vital

PCN Vision and Objectives

South Sefton Primary Care Network aims to be at the heart of the integrated health and social care system for primary and community care

Strategic priority 1: Integrate Primary Care	Strategic priority 2: Expand the primary care workforce	Strategic priority 3: Work at scale
• Enhanced Health in Care Homes • Enhanced Health at Home • Primary Care mental health hub • Tackling health inequality • Integrated Care Teams	• Maximising benefit of Additional Roles Reimbursement Scheme • Unified Learning Environment	• Medicines Management Hub • Acute home visiting service • Admin Hub • Proactive Care team • Estates plan

Strategic Enablers

Governance arrangements
PCN Structure
Workforce Plan
Communications and engagement (via place)
Systems and digital innovation
Financial management
Risk management
Business Intelligence (via place)
Estates
Quality and performance

Impact

Improved access for patients via a wider range of services

Continuity of care for patients via integration – they tell their story once and have a joined up team approach

Quality of care increases.

Services are levelled up, reducing health inequality

Primary care staff are retained through better training, portfolio careers and increased MDT support

Primary care becomes sustainable

More effective population health management

South Sefton Access Service

- Acute Respiratory Infection Hub launched 14 February 2023
- Increased scope to include wider range of acute minor illnesses.
- Treated just over 10,000 patients
- Working with Local Pharmacy Committee to offer opportunities for community pharmacists to gain practical experience ahead of Pharmacy First launching.

Enhanced Health in Care Homes

- Framework designed to improve collaboration between health, social care, care homes and voluntary, community, faith and social enterprise (VCFSE) sector to ensure care home residents benefit from proactive care, centred on the needs of them and their families.
- Supports NHS Long term plan to ‘dissolve the divide’ between primary and community healthcare services.
- Each care home participates in weekly care home round, co-ordinated by PCN with Care Home Matron. In October 2023, 443 patients were reviewed during ward rounds. Mental Health residential home rounds due to start in New Year.
- During October the team co-ordinated Covid & Flu vaccination visits to 36 care homes in South Sefton

Care Home Networking Event

- Held first networking event to bring Care Home staff together with PCN, Local Authority and Community Services teams
- Community Matrons offered some update training to help care home staff complete ICT referral forms intended to help increase flow of referrals to the Integrated Care Team
- Future events planned to support care homes with knowledge updates eg diabetes management.

Bridget's story – PCN role

What Matters to Bridget?

- Bridget has Parkinson's Disease resulting in gradually reducing mobility and reducing ability to manage activities of daily living, leading to her care home admission. Interspersed with the physical deterioration there has been a gradual deterioration in mood and overall mental health. The Parkinson's Disease clinical team suggested Bridget's GP should refer her to mental health services

Who worked with Bridget?

- The Care Home Manager included Bridget in the weekly check-in so that she could be discussed with the PCN Care Co-ordinator. It seemed Bridget was suffering with increasing depression and they wanted to query next steps with the GP regarding mental health referral. The GP had stated that this was still outstanding, but that they would chase an outcome. Care coordinator offered to review Bridget's clinical record to establish current position. Upon review it transpired the mental health referral had rejected with advice to increase sleeping medication and introduce an anti-depressant. Subsequently the care home was able to contact the GP and request the new medication

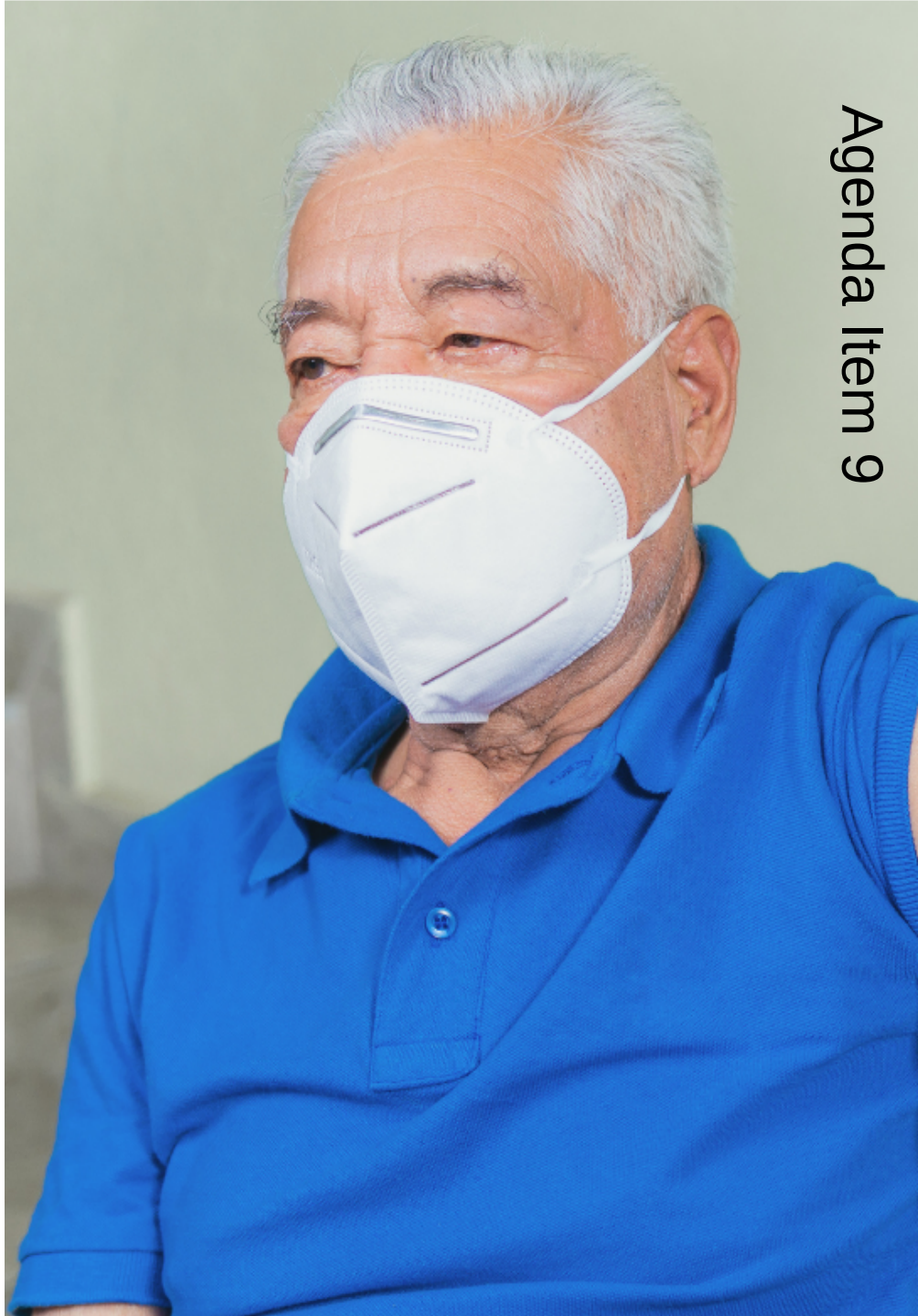
What Difference did EHCH make for Bridget?

- Bridget commenced the new medication, and her sleep and mood are improving. Over time it is hoped that the resident will return to previous baseline and enjoy life more.

Integrating Care - Enhanced Health at Home

Enhanced Health at Home supports the aims of the Sefton strategy by establishing a team focused on integration of services with the Sefton partnership to enable older patients who want to live at home to remain to do so, maintaining high quality of life, and appropriate support to retain independence.

1. Patients have a regular named team that operate a ‘no wrong door’ policy
2. Patients are contacted proactively and regularly by Care Co-ordinators and Social Prescribing Link Workers
3. Patients remain well, and avoid in-patient admissions or re-admission through proactive medication reviews, acute visiting service, etc.



Ida's story – PCN role

Ida has recently attended A&E for hip and abdominal pain. She was keen to meet with a Care Co-ordinator to discuss home adaptations and to see if she is entitled to any benefits.

The PCN care co-ordinator referred to a Social Prescribing Link worker, who supported Ida to access all benefits she was entitled to. Additionally, referrals were made to the local authority Occupational Therapist and Community Physiotherapy for equipment. The PCN Care Co-Ordinator is a trusted assessor and was able to order some equipment while Ida was waiting for a full Occupational Therapy assessment, which has helped Ida to manage more effectively at home. Ida and her daughter were delighted the equipment arrived so quickly, and can't wait for Ida' to attend the walking aid clinic to test drive a 4-wheeled walker!

Learning disability health checks

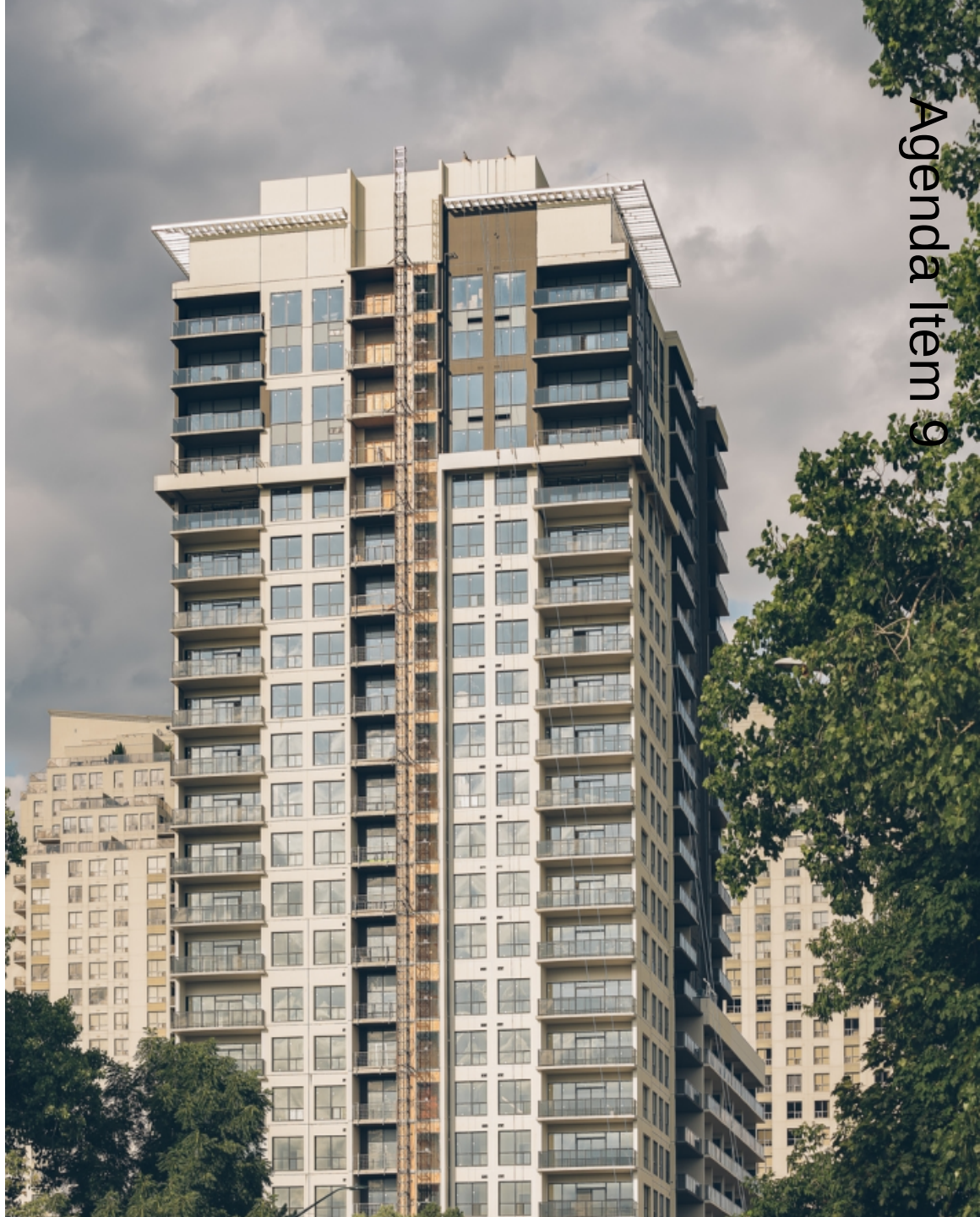
- Expanded PCN team to support practices in visiting patients at home who have not attended surgery for their annual learning disability health check.
- Having time to visit patients at home, or at day centres is improving uptake of health checks.
- Recently, a nurse associate, Sara after several attempts, made contact with a patient who not been seen for some time and discovered them living in extremely poor home conditions. The patient had not eaten a meal for days, and they were acutely unwell. Sarah went out to buy the patient a meal. She was able to liaise with the practice safeguarding lead to arrange urgent referral and made arrangements with a several other agencies to ensure appropriate intervention.

Primary Care Mental Health Team

- Team continues to grow offering one to one and group support, services include:
  - ACEs recovery programme
  - Associate Psychological Practitioners offering talking therapy and brief interventions
  - Mental Health Practitioners for assessment complex mental health needs eg bipolar disorder,
  - Social Prescribing Link Workers
  - Children & Young People Mental Health Practitioners
- Integrated offer working closely with VCF sector, Mersey Care and NHS Talking Therapies, co-ordinated through a single referral form and a new mental health forum.
- ACEs team have incorporated a health check offer in the ACEs programme to enable participants to better manage chronic diseases, access screening programmes and refer to other agencies eg smoking cessation.
- Bereavement group in development

Gap Analysis

- Repeated feedback from staff, eg Social Prescribing Link Workers that housing condition is significantly impacting patients health and wellbeing.
- Substantial time spent liaising with housing agencies
- Commissioners are meeting to look at developing an integrated ACEs offer to support local authority and PCN colleagues to ensure a co-ordinated and shared offer across Sefton.



Southport & Formby Primary Care Network

Health and Wellbeing Board

Wednesday 6th December 2023

Dr Rob Caudwell, Clinical Director
Dr Lindsay McClelland, Clinical Operational Lead
Dr Mark Wigglesworth, Clinical Lead, Complex Lives
Clare Touhey, PCN Manager

Strategic Context

- Integrated working across health and social care
- Reduce pressure on Primary Care
- Workforce planning
- Population Health management: reduce health inequalities
- MDT led proactive, personalised, coordinated care
- PCN Estates Planning

Input

- Place Support & direction of due process
- Estates commitment
- Data analysis & interpretation
- PCN engagement/OD/Leadership Support expertise and capacity

Workstreams

Delivery of Network DES

- Enhanced Care in Care Homes Team
- Early Diagnosis of Cancer
- Enhanced / Extended Access
- SPLW | HWB coach | Cancer Navigators
- ARRS Maximise all roles
- MH Practitioners
- Pharmacy | Medicines Management Team

Service Development/ Improvement

- Clinical / Coding Support Hub
- Primary & Secondary Care interface
- Acute Visiting Service
- Pharmacy Hub
- Complex Live Complete Care Communities programme III
- Enhanced Health at Home Team
- Sefton Training Hub: PAs, job planning, supervision, training
- ICT Development

Outcomes

- Improve patient outcomes and flow – frail /elderly
- Improve patient outcomes – cancer pathway
- Release/Increase GP time
- MDT approach to manage HI
- Release GP time | create resilient practices
- Improved access to MH | Release GP time
- Improve patient outcomes | Quality care
- Increase capacity: New patient management process & Clinical correspondence coding
- Reduce pressure on general practice | Improve outcomes for patients
- Release GP Time/Reduce acute admissions/Improve patient outcomes
- Reduce pressure on general practice | Improve outcomes for patients
- Improve outcomes for patients experiencing Complex lives
- Improve care, reduce HI & deliver Personalised care plans
- Increase workforce. PSN approach to host students/ salaried staff. Improve recruitment & retention
- Improve patient pathways. Right care, right time, right place.

Impact

- General Practice - improve Capacity / Access and resilience
- Improve Mental Health Services
- Support proactive care for Frail, Elderly & Dementia patients
- LTC Management
  Including cancer and multimorbidity
- Prevention Services
  Obesity, alcohol, vacc/immunisations
- Reduce Health Inequalities
  Drugs & Alcohol, complex lives, homeless, ESL, LD, social isolation, travelling community

Enablers

- Project Tulip (Estate)
- H&WB utilisation (Estate)
- Digital Programme
- PCN Infrastructure (Fed)

Infrastructure to deliver increased capacity plans

Working together to support our patients better to address the health challenges in our area through multiple programmes of work.

- Social Prescribing Link Workers / Health & Wellbeing Coaches
- Mental Health Practitioners in practice
- Cancer Care / Early diagnosis of Cancer
- Complex Lives – Complete Community Care Programme

Southport & Formby Primary Care Network

Social Prescribing Link Workers

- Well established team of 6 Link Workers & our Lead Link Worker.
- Receiving over 300 referrals every quarter to support patients.
- Positive outcomes through patient feedback: 50.6% of patients felt really confident post seeing Social Prescribing service compared with 9.2% before being seen. (Quarter 2 SPLW data 2023/24)
- 100% of patients said it had a positive impact to work with a social prescriber. (Quarter 2 SPLW data 2023/24)
- Identify gaps in services such as housing, face to face advocacy.

Southport & Formby Primary Care Network

Brighter Living Partnership

Sefton CVS
Supporting Local Communities

Health & Wellbeing Coach role

- Initial pilot of 1 HWBC in our largest practices, St Marks Medical Centre (list size of 16,257, January 2023) due to significant challenges population experience.
- August 2023-September 2023 - 256 patients seen, 456 contacts.
- Supported patients with behaviour changes relating to weight management, physical activity, sleep and relaxation advice, smoking cessation.
- Recruiting for additional HWBC to align with local Community Cardiology service with plans to recruit wider in 2024/25.
- Partnership working with Brighter Living Partnership.

Southport & Formby Primary Care Network

Brighter Living Partnership

Sefton CVS
Supporting Local Communities

Mental Health Practitioners

Working in partnership with our Mental Health providers, Mersey Care to provide Mental Health practitioners at practice level:

- Successful recruited to 4 WTE in the team across our practices.
- Provided 891 appointments from May – Oct 2023.
- Supporting patients with:
    - depression,
    - PTSD,
    - trauma,
    - alcohol misuse,
    - history of self-harm,
    - carer stress,
    - bereavement,
    - agoraphobia.

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NHS Mersey Care NHS Foundation Trust Community and Mental Health Services

Cancer Care

- Working in partnership with Southport Cancer Centre. Providing non-medical support to patients who have had a cancer diagnosis. Supporting with practical / emotional / financial impact of a diagnosis.
- Service has grown significantly since its inception in 2020.
- Focus on increasing physical activity through Being More Active Programme. Clear evidence to link increasing activity with improved health outcomes and reduced chance of recurrence.
- Provides additional appointments for patients – 594 in Quarters 1 and 2.

Total No of Referrals	
2020	151
2021	361
2022	456
2023 Qtr 1 & 2	288

Southport & Formby Primary Care Network

SOUTHPORT Macmillan Centre

In partnership with MACMILLAN CANCER SUPPORT

Early Diagnosis of Cancer

Appointed a Cancer Care Coordinator to:

- focus on helping practices to improve screening uptakes.
- Targeted work on our vulnerable / hard to reach groups and those experiencing health inequalities.
- Supporting practices to promote screening programmes and increase early diagnosis of cancers for our population.
- Planning and implementation of additional screening appointments.

Complex Lives – Complete Community Care programme

Complex Lives relate to a population experiencing a combination of homelessness, substance misuse, mental ill health, offending behaviour, and poor physical health.

People in these situations have often experienced childhood trauma, family breakdown, domestic abuse, and other major life changing events (Adverse Childhood Experiences)

Southport & Formby Primary Care Network

A common purpose

Aims:

- ✓To develop a collaboration of those with lived and learned experience of Complex Lives.
- ✓To test and report how stakeholders can re-calibrate their focus, language and attitudes, to improve service delivery for the Complex Lives population.

Southport & Formby Primary Care Network

A common purpose

Objectives:

1. Identify people living Complex Lives.
2. Engage with this population, listen and understand the issues that mean most to people
3. Engage with relevant stakeholders
4. Form a leadership team of key stakeholders to provide strategic oversight of the programme and to facilitate change.
5. Co-design a common framework and operational map with those who experience Complex Lives
6. Begin to Identify measurable outcomes (person centred)
7. Disseminate a model as learning progresses.

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Attitudes and behaviours

- ✓ Placing those with lived experience at the centre of change with their needs as a focus
- ✓ Addressing inequality with proportionate redirection of resource where it is apparent this is required
- ✓ Developing a common purpose and shared language and understanding amongst stakeholders
- ✓ Challenge silo working and break down organisational barriers, being disruptive and bold where necessary.
- ✓ Using the principles of Asset Based Community Development
- ✓ Incorporating a “No wrong door” approach and an aim to “Make Every Contact Count”.
- ✓ Recognise that our strength is through collaboration and co design

Southport & Formby Primary Care Network

STAKEHOLDERS

- Service users
- S and F PCN
- St Marks Medical Centre
- Light for Life
- Change Grow Live
- Crisis Café
- Brighter Living
- Mersey Care
- Mersey and West Lancs NHS
- Sefton Council
- Public Health
- Sexual Health services
- Life Rooms
- Foodbanks
- Police
- Probation
- Domestic abuse
- Suicide prevention
- HALT
- Health visitors / Midwives
- Palliative Care
- Migrant services

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Engagement

- Services users
- Front line service providers
- Stakeholders

- Complex Lives Workshop

Outputs

- Complex Lives Multidisciplinary Team meeting
- ACES programme (South Sefton PCN)
- Meaningful daytime activity and recovery
- Frontline communication training
- GP training: Inequalities rotation / teaching / placement
- Student nursing placement: Complex Lives
- Dentaid grant

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Risks & Barriers

- Ensuring a “ground up” approach
- Enhanced Service Funding
- Dental services
- Translation services for charities

Southport & Formby Primary Care Network

Thank you for listening.
Any questions?

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NHS

Southport & Formby Primary Care Network

In partnership with:

Southport & Formby Health