Addressing Capacity & Access

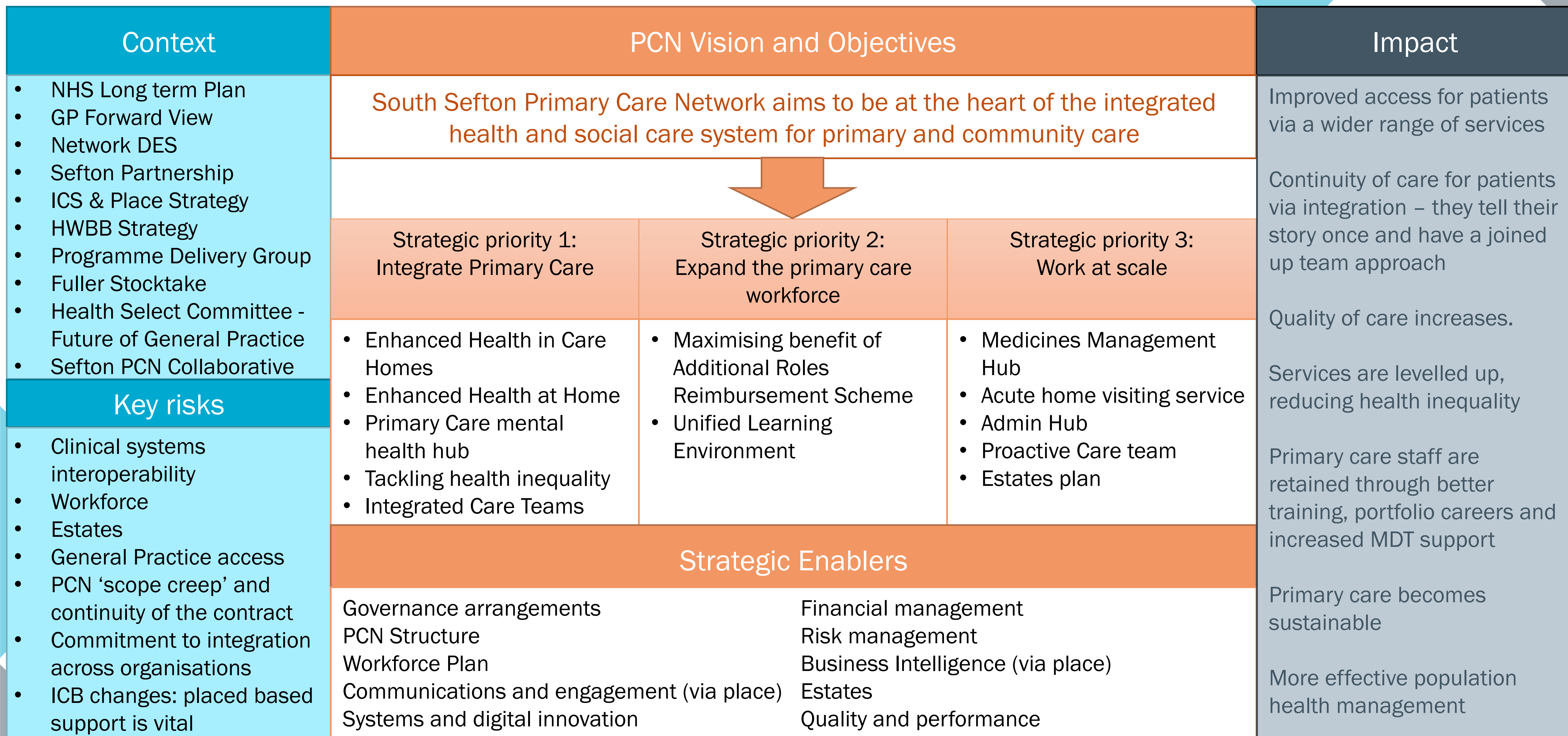
South Sefton Primary Care Network

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



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.