Health and Wellbeing Board

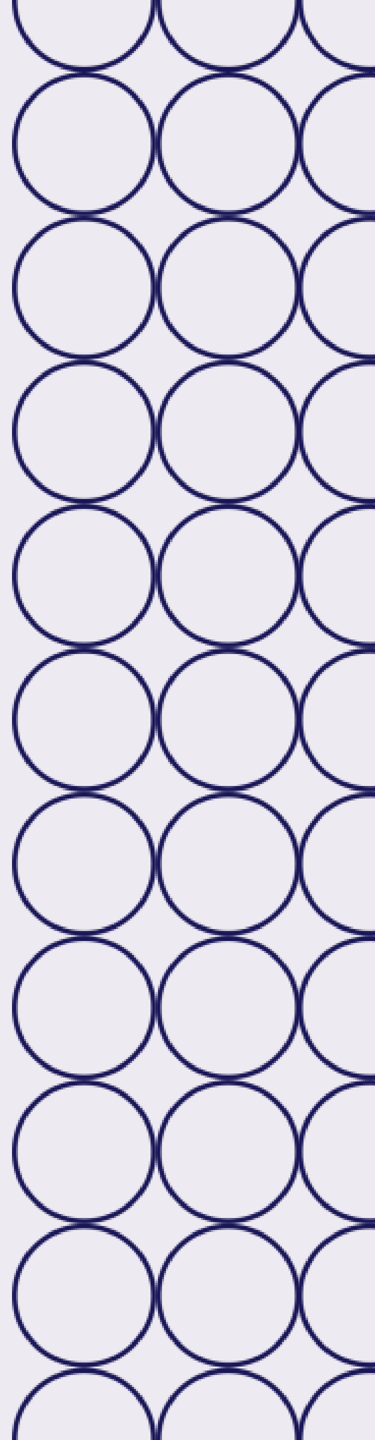
Wednesday 6th December 2023

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 → Outcomes

Delivery of Network DES

Workstream	Outcome
Enhanced Care in Care Homes Team	Improve patient outcomes and flow – frail /elderly
Early Diagnosis of Cancer	Improve patient outcomes – cancer pathway
Enhanced / Extended Access	Release/Increase GP time
SPLW | HWB coach | Cancer Navigators	MDT approach to manage HI
ARRS Maximise all roles	Release GP time | create resilient practices
MH Practitioners	Improved access to MH | Release GP time
Pharmacy | Medicines Management Team	Improve patient outcomes | Quality care

Service Development/ Improvement

Workstream	Outcome
Clinical / Coding Support Hub	Increase capacity: New patient management process & Clinical correspondence coding
Primary & Secondary Care interface	Reduce pressure on general practice | Improve outcomes for patients
Acute Visiting Service	Release GP Time/Reduce acute admissions/Improve patient outcomes
Pharmacy Hub	Reduce pressure on general practice | Improve outcomes for patients
Complex Live Complete Care Communities programme III	Improve outcomes for patients experiencing Complex lives
Enhanced Health at Home Team	Improve care, reduce HI & deliver Personalised care plans
Sefton Training Hub: PAs, job planning, supervision, training	Increase workforce. PSN approach to host students/ salaried staff. Improve recruitment & retention
ICT Development	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

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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.

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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.

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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

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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.

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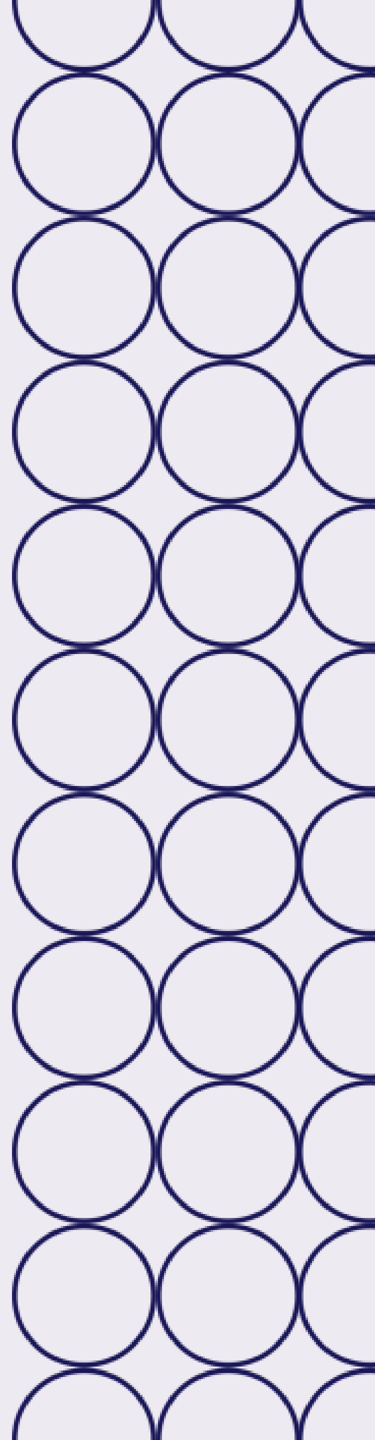

Complex Lives – Complete Community Care programme

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)

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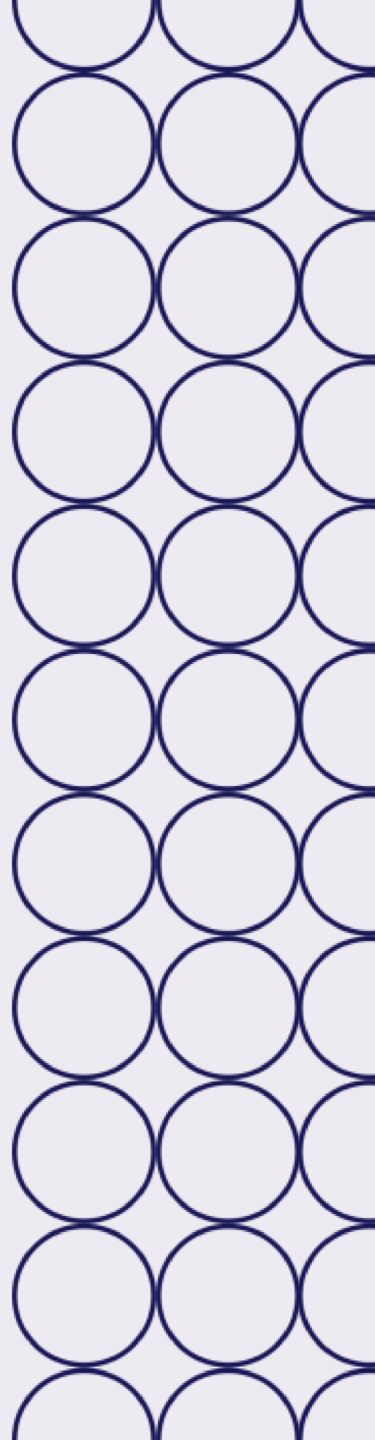

A common purpose

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.

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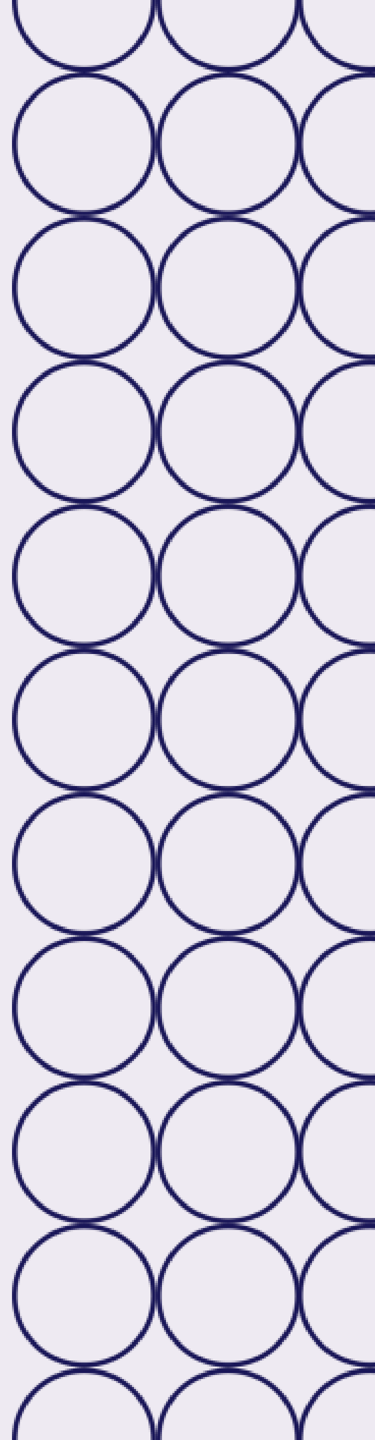

A common purpose

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

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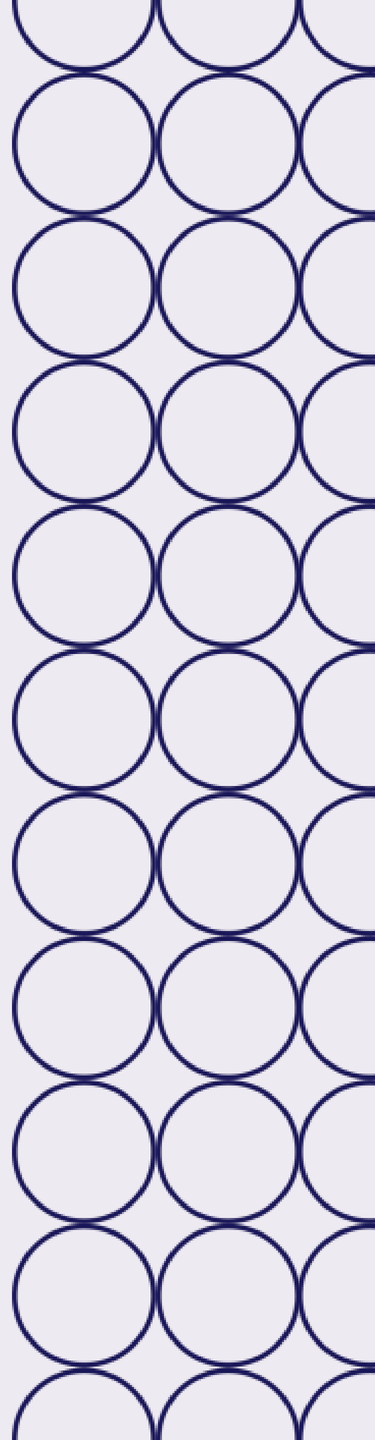

STAKEHOLDERS

- 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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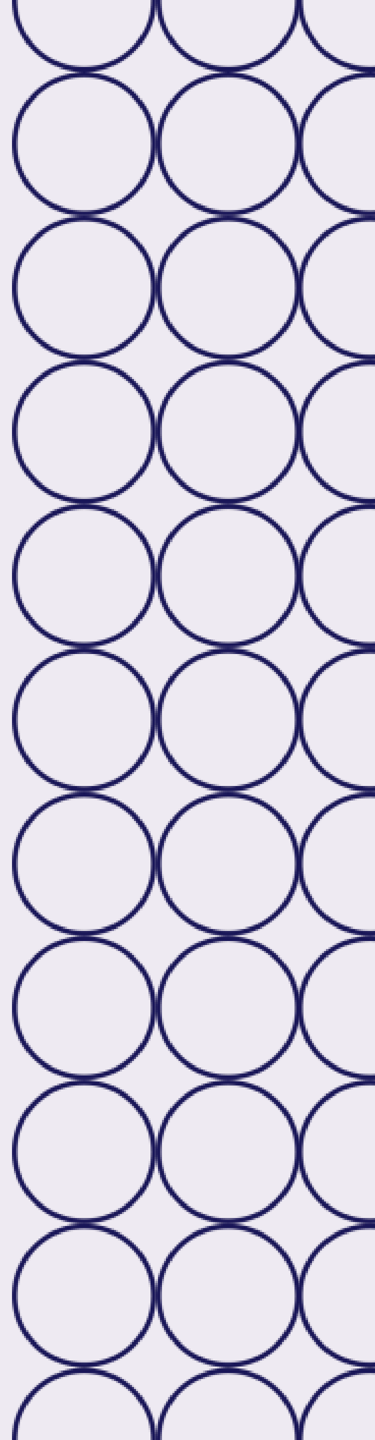

Engagement

- 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

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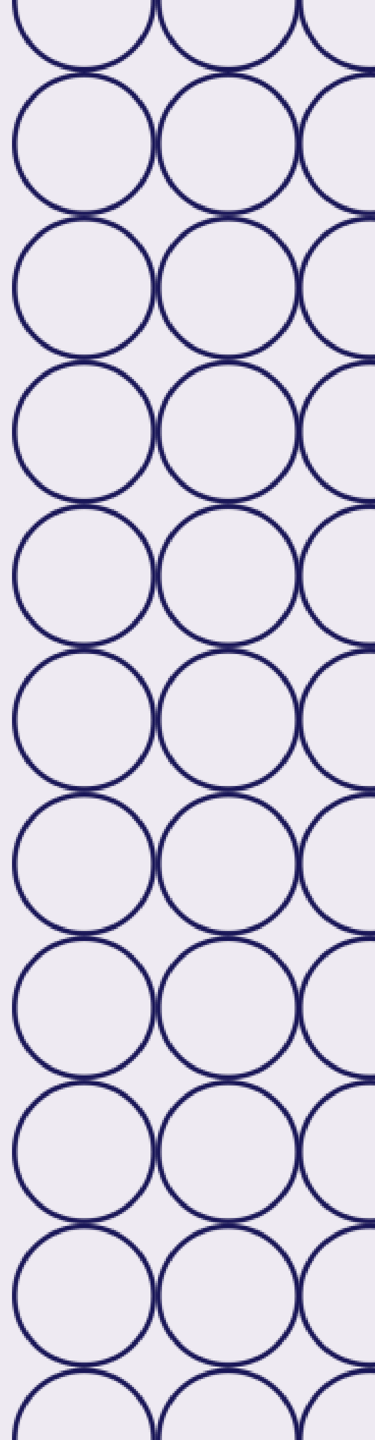

Thank you for listening.
Any questions?

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In partnership with:

Southport & Formby Health