

Health in Sefton

5 year strategy for improvement

2014 – 2019



together with you
Staying **local & together**

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01. About our strategy

We are NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group – the two organisations responsible for planning and buying or ‘commissioning’ nearly all of the health services needed by people living in Sefton.

This is our joint strategy for improving health and health services in Sefton from 2014 – 2019 that we have developed based on the challenges we face locally and from speaking to local people and a wide range of other partners across the borough.

Like all other public services, the NHS is facing challenging times ahead. Here in Sefton we know that we need to work differently if we are to meet the future health needs of our local population.

It makes sense for us as clinical commissioning groups (CCGs) to have a single strategy for the area. By working together we believe we can do more for everyone in Sefton, no matter which part of the borough they live in.

Having a single strategy for improving health and health services across Sefton does not constrain us, or mean we have to compromise what we want for the different communities we serve. Because we are individual CCGs, we each have responsibilities that we must meet. This provides assurance that we will commission health services that are tailored to the differing needs of people across the borough. We understand that one size often does not fit all.

This approach also makes it easier for us to work with partners like Sefton Council and better join up or ‘integrate’ our plans and services whenever we can, to work more efficiently in this challenging time. Importantly, it means we have the potential to achieve more for Sefton residents than we could do individually, as there is greater strength in working together.

Our journey in developing this strategy has taken the best part of 18 months and yet we know that this is only the beginning. We would like to thank everyone who we have worked with and spoken to for their contribution so far, and we look forward to continuing this journey with you for better health and wellbeing in Sefton in the years to come.

Dr Clive Shaw

Chair
NHS
South Sefton CCG

Dr Rob Caudwell

Chair
NHS
Southport and Formby CCG

Fiona Clark

Chief officer
NHS Southport and Formby CCG
NHS South Sefton CCG



02. About us

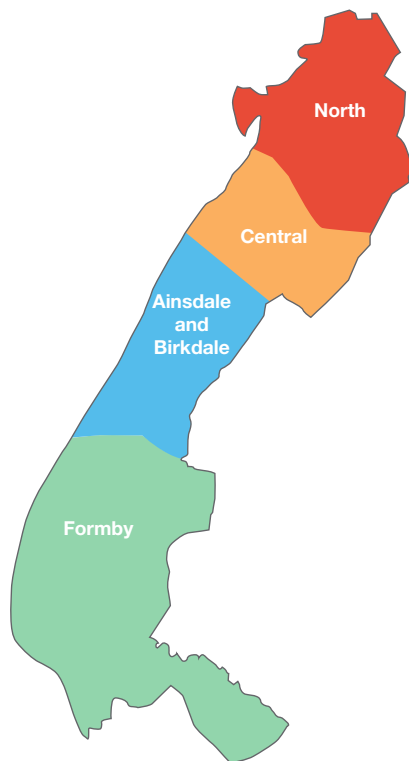
Together we have a single vision for health and wellbeing in Sefton:

“To create a sustainable healthy community based on health needs, with partners - focused on delivering high quality and integrated care services to all, to improve the health and wellbeing of our population.”

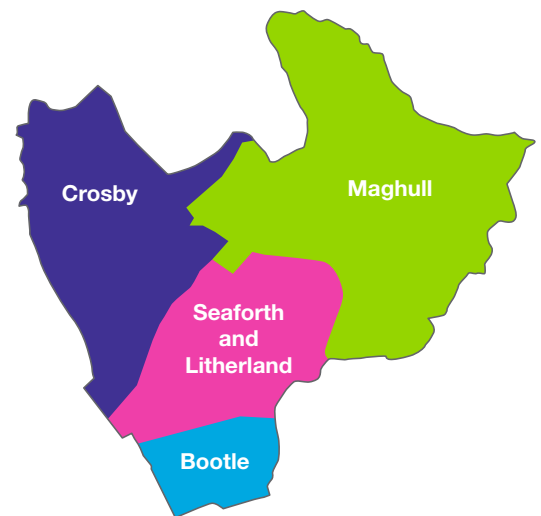
We are a clinically led membership organisations, consisting of all the local GP practices in the two areas we cover – that’s 20 practices in Southport and Formby and 33 in south Sefton.

The two areas we are responsible for planning and buying or ‘commissioning’ health services for stretch along the coast from Churchtown in the north to Bootle in the south and Maghull to the east. Each CCG is made up of four distinct geographical ‘localities’ – these bring together member GP practices in those areas to devise services tailored to the needs of their different populations.

Southport and Formby



South Sefton



Our localities

You can see how our localities are made up below.

NHS Southport and Formby CCG

	Number of practices	Population
Ainsdale and Birkdale	5	32,000
Central Southport	5	34,000
Formby	4	25,000
North Southport	6	31,000
Total	20	122,000

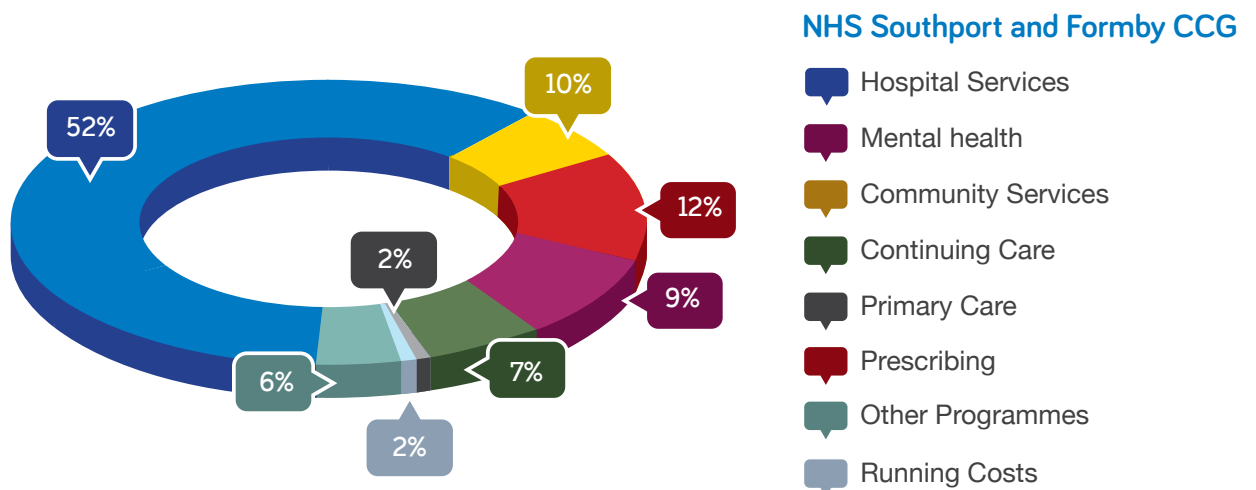
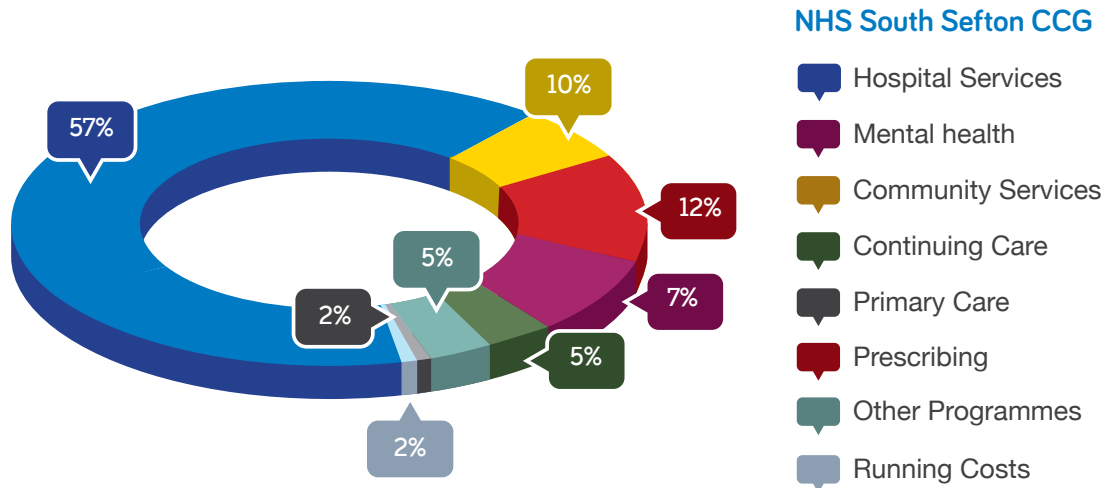
NHS South Sefton CCG

	Number of practices	Population
Bootle	7	39,250
Crosby	10	47,000
Maghull	6	28,500
Seaforth and Litherland	10	40,700
Total	33	155,540



What we commission

In 2014- 2015 our budgets when added together totalled just under £400 million and individually we each spent around 75% of this on hospital services. The following charts give a breakdown of what we spend on the different types of services we commission.



03. Who we work with

The Local NHS

The local healthcare system is complex – with multiple organisations providing services and a range of CCGs and bodies like NHS England who are responsible for commissioning some of the other services that our local patients will need to use.

Here are some of the main organisations that provide health services to Sefton residents:

Aintree University Hospital
NHS Foundation Trust

Royal Liverpool and Broadgreen University
Hospitals NHS Trust

Southport & Ormskirk Hospital NHS Trust

Walton Centre NHS Foundation Trust

Mersey Care NHS Trust

Clatterbridge Cancer Centre
NHS Foundation Trust

Liverpool Community Health NHS Trust

Liverpool Heart and Chest Hospital
NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

We work collaboratively with other commissioners to ensure services are sustainable across a wider area because plans elsewhere will often affect services or patients here in Sefton – such as workforce challenges, issues around service quality or changes to specialist services. These are some of the other NHS commissioners we work closely with:

NHS England Merseyside Area Team

NHS Knowsley CCG

NHS England Specialised Commissioning

NHS Halton CCG

NHS West Lancashire CCG

NHS St Helens CCG

NHS Liverpool CCG



Sefton Health and Wellbeing Board

This committee of Sefton Council brings us together with the local authority and other partners like Healthwatch Sefton to ensure that whenever possible all our strategies and plans are consistent. By working together, our aim is to do more for Sefton residents.

Together we have produced the Sefton Health and Wellbeing Strategy, which sets out our joint commitments to improving health, wellbeing and social care. We have ensured that our five year strategy contributes to meeting the following objectives in the Health and Wellbeing Strategy.

- Ensure all children have a positive start in life
- Support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- Support older people and those with long term conditions and disabilities to remain independent and in their own homes
- Promote positive mental health and wellbeing
- Seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- Build capacity and resilience to empower and strengthen communities

For the first time health and social care have been required to pool a proportion of their budgets together through the Better Care Fund and we believe this presents us with great opportunities to meet our shared objectives.

In 2015-2016 our joint Better Care Fund will total around £24 million that we have agreed with Sefton Council to use towards reducing unplanned admissions to hospital.

Voluntary, community and faith sector organisations are important partners in this work and we recognise their valuable role in creating a more innovative and effective local health and social care system now and in the future.



04. Why things need to change

We know that demands on health services are increasing, whilst at the same time the public sector is being required to work within tighter financial boundaries. The approach we set out in this strategy not only responds to these challenges but it goes further - committing us to make much needed improvements to the health and wellbeing of all Sefton residents.

Whilst the performance of local health services has been good since we became responsible for commissioning in April 2013, we know we have to change the way we currently do things if we are to achieve our vision and make a real difference in the future.

Central to this is ensuring that the health needs of Sefton residents are at the heart of everything we do.

Here are some key things we know about Sefton residents, along with some projections of how we expect the population to change in the years ahead:



- Over the past decade our population has reduced but in other parts of the country it has been increasing. It is set to rise again by a small number by 2021
- Our population is getting older - we have many more residents aged over 65 than the national average and by 2021 there will be nearly half as many more people aged over 85 years than now
- Over the next decade we don't expect to see much change in the number of children and young people
- Fewer residents are of working age than nationally and births have fallen whilst death rates in our poorest communities have risen



- We have become slightly more ethnically diverse, with around 5% of our population from different backgrounds and cultures and we have seen a small number of international workers move here
- Whilst Sefton is more affluent than its neighbours across Merseyside, nearly one fifth of residents live in pockets of the borough that are amongst the 10% of most deprived communities in the country
- Child poverty is much higher than in other parts of the country
- In those areas of Sefton that are most deprived, average life expectancy is 11 years less than in the more affluent parts of the area



- Levels of long term health conditions – especially heart disease, respiratory disease, kidney disease, mental health conditions and obesity - are much higher than national averages
- The number of early deaths from heart disease and cancer have reduced over the last decade as smoking rates have declined but we want to do more to close the gap between us and the national average



05. How we developed this strategy

Our strategy has used all the information we have about health and health services to determine what we need to do over the next five years. Importantly, the views and experiences of people living locally have contributed at every stage of this strategy's development.

Assessing health information

Here are some of the information sources we use to assess where we are now and where we need to do more in the future:

Sefton **Strategic Needs Assessment**

A mapping exercise of existing health and social care services to identify opportunities for improvement. This is often known as the Joint Strategic Needs Assessment.

Sefton **Health and Wellbeing Strategy**

Setting out overarching joint aims and objectives for statutory health and social care bodies across the borough based on the Strategic Needs Assessment.

Director of Health's **Annual Report for Sefton**

Along with data about public health in the borough, this report makes recommendations for improving wellbeing.

Office of **National Statistics**

Provides data and analysis about Sefton's population including levels and spread of diseases.

RightCare

This data helps us to benchmark our performance against similar CCGs in other parts of the country, so we can better identify opportunities for improvement in specific areas of health.

Local health service **performance data**

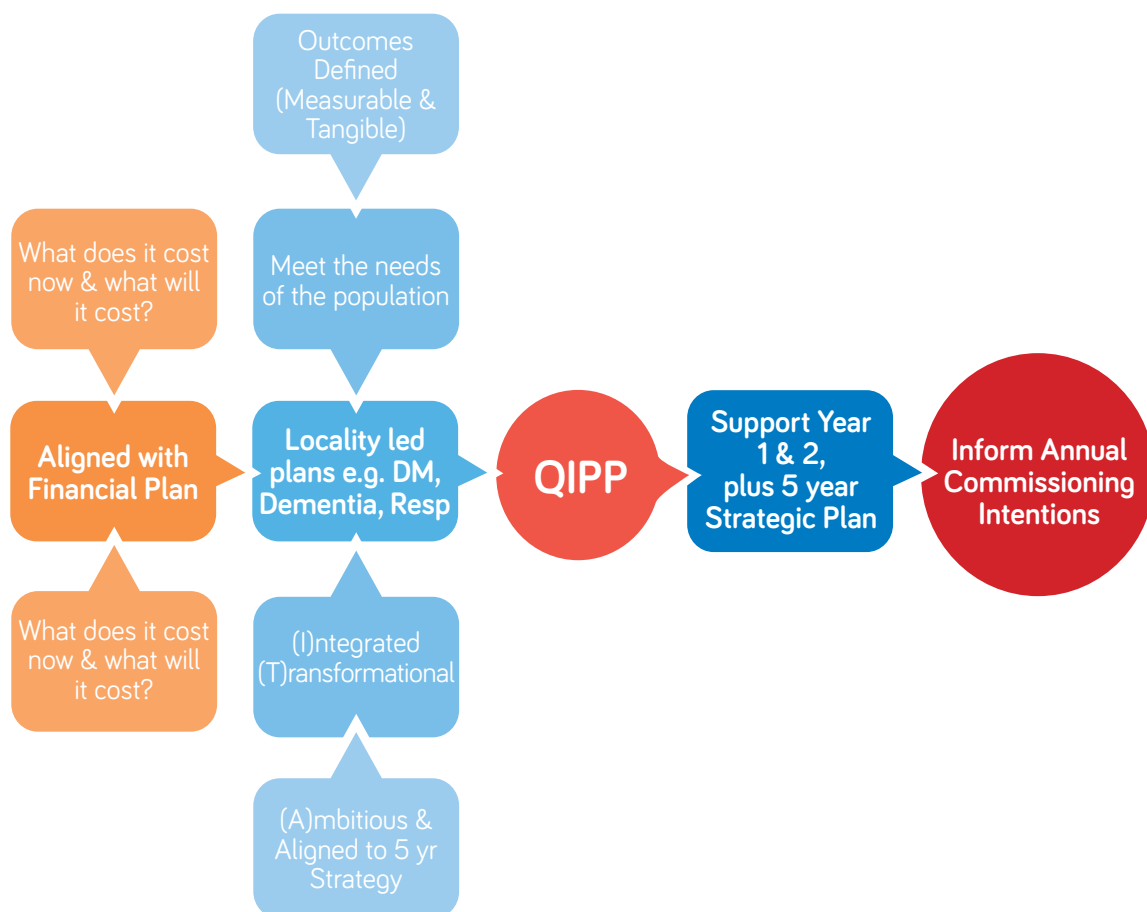
The services we commission are required to meet a range of nationally set outcomes such as reducing unplanned care by 15%, meeting targets for cancers, stroke and referral and treatment times. Alongside this we are also looking closely at what we expect from the health services we commission – so we focus on achieving better quality, longer lasting outcomes for all patients.



Taking a **systematic approach**

Because things rarely stay the same, we need to regularly review our work to make sure it is on track to meet our goals. This is why we have annual business plans or 'commissioning intentions' so we can make adjustments to our work programme if we need to.

We have adopted a systematic approach to doing this. Having a thorough and rigorous process helps us to review our progress and more easily determine our annual commissioning intentions.



Involving people

Local people are often best placed to tell us where services need to improve and where gaps exist in what is currently provided.

Involving people at every stage of our planning process is crucial and we have made a number of adjustments and additions to this strategy as a result of people's views and experiences. In each section of this document focusing on our different programmes, we have included the most important themes arising from our discussions with local people, so you can easily see the connections. Here's how we have been involving Sefton residents so far:

Talking Health and Wellbeing

These events were held jointly with Sefton Council to help us develop Sefton's Health and Wellbeing Strategy, which has laid important foundations for our five year strategy. There were five events in total, held at venues across the borough between the end of 2012 and early 2013.

Big Chats

Each CCG has held three Big Chats since June 2012. The first of these events introduced the CCGs and gave an overview of the changes to come to the wider NHS from April 2013. Big Chats 2 and 3 concentrated on the commissioning intentions of each CCG, with the second Big Chats particularly focusing on unplanned care.

Mini Chats

Held during the early part of 2014, this series of smaller public events focused specifically on our five year strategy. They allowed people to hear in more detail about the subjects that interested them the most and about how people's views from earlier events had been used to shape our strategy so far.



Community Chats

During April 2014, we asked Healthwatch Sefton to lead these more informal sessions on our behalf with a range of community groups and organisations. Community Chats enabled people who would not normally come to our Big Chats or Mini Chats to get involved in our work. The nine host organisations were Sefton OPERA, Galloway's Society for the Blind, People First, Bowersdale Centre, Alzheimer's Society, May Logan's Knit and Natter, Cambridge Rd Children's Centre, Southport Community Service Station and the Breath Easy Group.

Sefton CVS

We have worked closely with Sefton CVS to ensure that the voluntary, community and faith sector has been able to feed into our work through network, forums and individual meetings including the Health and Social Care Forum, Children's Forum and the Mental Health Service Users Group.

GP practice patient groups

We continue to support the development of these groups to enable members to influence our plans and strategies.



06. What we all want for Sefton

From all that we have learned in devising this strategy, it is clear that we need to make some fundamental changes to the way we currently do things if we are to achieve real improvements for everyone who lives in Sefton.

We will need to transform health and social care services, so they work better together and allow more flexible and personalised care for people.

It also means providing more care outside of hospitals so people can be seen closer to home and at the times to suit them. This should free up hospitals and allow them to concentrate on caring for those who are most poorly, or who need specialist treatments.

In general this is what local people have told us they want too. The reoccurring themes in all our discussions with local people have helped us to define what we all want from health and care in the future. So for everyone in Sefton, no matter what their circumstances, age or where they live we are aiming for:

- Enhanced community and primary care services – like district nursing and GP practices - so we can support more people to stay well and to remain safe and well in their own homes for as long as possible
- More access to primary care services at more convenient times, so people can be seen closer to where they live when they need help and advice
- Fewer people being admitted to hospital for urgent health problems than at present because they can be better treated closer to home
- Hospitals being able to concentrate on providing specialist care and treating those who are seriously ill because they are no longer dealing with people who can be better treated elsewhere
- Health and social care services joining together more, so people benefit from streamlined, personalised and effective care from the different organisations involved
- The right support in place for people to self-care so they can better manage their health conditions, preventing them from needing urgent hospital treatment
- Information about health and wellbeing widely available so that people can make easier choices about staying healthy, living healthier lives and where to go for help when they need it



07. Our priorities

We have identified three main strategic priority areas as the focus for all of our work:

1. **Care for our older and vulnerable residents**
2. **Unplanned care**
3. **Primary care**

To make improvements across all of these areas, we have devised a number of transformational and underpinning health programmes. You will notice there are connections between nearly all of these workstreams.

All of our programmes are led by clinicians, and this means that in general they will also be GP members of our Governing Bodies.

Transformational programmes

The following two transformational areas of work are aimed at ensuring health services adapt so they can meet the healthcare challenges of the future.

Community centred **care programmes**

These programmes are currently known as Care Closer to Home in Southport and Formby and Virtual Ward in south Sefton. They involve a wide range of partners from across health and social care to provide more joined up or 'integrated', locally focused and personalised services.

Primary care **transformation programme**

Whilst NHS England is the commissioner of GP practices, CCGs have a role in improving quality in primary care. We have a strategy for primary care which works alongside our wider five year strategy for all services.

Health programmes

The following specific health programmes underpin our transformational programmes:

Cancer

Cardiovascular or heart disease
and stroke

Children's health

Diabetes

End of life care

Mental health and dementia

Respiratory or lung disease

We have added three more programmes to the list as a result of our discussions with local people:

Liver disease

Kidney disease

Neurology – including conditions
like Parkinson's and Motor Neurone
diseases and epilepsy



08. Our objectives

We have set some objectives for the next five years based on local and national requirements, which our transformational and health programmes will help us to meet.

By 2019 we want to:

- Reduce unplanned or emergency admissions to hospital by 15% over the next five years
- Reduce the length of time people spend in hospital by improving the quality of life for people with one or more long term conditions by 8.5%
- Reduce the number of people who need to be readmitted to hospital within 30 days because of their condition
- Prevent people from dying prematurely, significantly reducing hospital avoidable deaths by 13%
- Help people to recover from episodes of ill health or following an injury
- Ensure that people have a positive experience of care, improving experience of in-patient care by 13% and experience of GP and out of hours care by 30%
- Support and promote self-care, so people can better manage their health conditions and promote healthier lifestyles to prevent ill health
- Treat and care for people in a safe environment and protect them from avoidable harm

09. Our strategy... in summary

We have brought together our priorities, objectives and programmes in the following diagrams, so you can see how they link together and contribute to our shared Vision:

To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and wellbeing of our population



Sefton Wide 5 Year Plan

System Objective 1

Potential rate of years of life lost from causes considered amenable to healthcare. To significantly reduce hospital avoidable deaths by 13%

Delivered through intervention Care Closer to Home & Patient Integrated Locality Care

These two programmes represent the locality delivery model for Southport & Formby and South Sefton respectively. They focus on delivering enhanced primary and community care with improved access and management of individuals' needs with Long Term Conditions to prevent unnecessary admission to hospital

Overseen through the following governance arrangements

Sefton Health & Wellbeing Board
 Southport & Ormskirk Strategic Partnership Board
 Aintree Strategic Partnership Board
 Care Closer to Home Programme Board
 Health & Wellbeing Board Provider Forum
 CCG Service Improvement & Re-design committee.
 Integrated approach with BCF & Sefton Council Governing Body

System Objective 2

To improve the health related quality of life for people with one or more LTC by 8.5%

Delivered through Mental Health & Dementia Strategic Programme

This programme is focused on delivering mental health care based on the needs of the Sefton population, delivered through localities and integrated with healthcare to enable admission avoidance and improved recovery outcomes

Measured using the following success criteria

All organisations within the health economy report a financial balance in 2018/2019
 Reduction in Unplanned activity by 15%
 No provider under enhanced regulatory scrutiny due to performance concerns
 Achievement of the 5 defined system objectives

System Objective 3

Reducing the amount of time people spend avoidably in hospital. Reduce emergency admissions by 20%

Delivered through Quality Strategy

The Quality strategy is integral to the CCG Strategic Plan and is focused on delivering high quality care and experience, ensuring no harm is done to patients and addressing areas of any concern promptly and effectively

System values and principles

We will maintain a local focus, working in partnership.
 We will be transparent, open and honest.
 We will be approachable and listen to our public.
 We will enable action and prioritise effort to optimum effect.
 We will act with integrity, act fairly and with respect.
 We will be accountable for what we do.
 We will be caring and compassionate.

System Objective 4

To improve in-patient experience by 13%. The proportion of people reporting poor patient experience of inpatient care

Delivered through Primary Care Quality Strategy

To improve access to primary care and enhanced quality of service in support of a reduction of 15% in unplanned admissions

System Objective 5

Improve patient experience of GP and out of hours care by 30% (% reporting poor care to reduce)

Commissioning for Excellence

Southport and Formby 5 Year Plan

System Objective 1

Potential rate of years of life lost from causes considered amenable to healthcare. To significantly reduce hospital avoidable deaths by 14%

Delivered through Care Closer to Home

This programme represents the locality delivery model for Southport & Formby CCG. They focus on delivering enhanced primary and community care with improved access and management of individuals' needs with Long Term Conditions to prevent unnecessary admission to hospital

Overseen through the following governance arrangements

Sefton Health & Wellbeing Board
Southport & Ormskirk Strategic Partnership Board
Care Closer to Home Programme Board
Health & Wellbeing Board Provider Forum
CCG Service Improvement & Re-design committee.
Integrated approach with BCF & Sefton Council through Health & Wellbeing Board.
Governing Body

System Objective 2

To improve the health related quality of life for people with one or more LTC by 9%

Delivered through Mental Health & Dementia Strategic Programme

This programme is focused on delivering mental health care based on the needs of the Southport & Formby population, delivered through localities and integrated with healthcare to enable admission avoidance and improved recovery outcomes

Measured using the following success criteria

All organisations within the health economy report a financial balance in 2018/2019
Reduction in Unplanned activity by 15%
No provider under enhanced regulatory scrutiny due to performance concerns
Achievement of the 5 defined system objectives

System Objective 3

Reducing the amount of time people spend avoidably in hospital. Reduce emergency admissions by 21%

Delivered through Quality Strategy

The Quality strategy is integral to the CCG Strategic Plan and is focused on delivering high quality care and experience, ensuring no harm is done to patients and addressing areas of any concern promptly and effectively

System values and principles

We will maintain a local focus, working in partnership.
We will be transparent, open and honest.
We will be approachable and listen to our public.
We will enable action and prioritise effort to optimum effect.
We will act with integrity, act fairly and with respect.
We will be accountable for what we do.
We will be caring and compassionate.

System Objective 4

To improve in-patient experience by 12%. The proportion of people reporting poor patient experience of inpatient care

Delivered through Primary Care Quality Strategy

To improve access to primary care and enhanced quality of service in support of a reduction of 15% in unplanned admissions

System Objective 5

Improve patient experience of GP and out of hours care by 28% (% reporting poor care to reduce)

Commissioning for Excellence
together with you

South Sefton 5 Year Plan

System Objective 1

Potential rate of years of life lost from causes considered amenable to healthcare. To significantly reduce hospital avoidable deaths by 12%

Delivered through Care Closer to Home

This programme represent the locality delivery model for South Sefton CCG.
They focus on delivering enhanced primary and community care with improved access and management of individuals' needs with Long Term Conditions to prevent unnecessary admission to hospital

Overseen through the following governance arrangements

Sefton Health & Wellbeing Board
Aintree Strategic Partnership Board
Health & Wellbeing Board
Provider Forum
CCG Service Improvement & Re-design committee.
Integrated approach with BCF and Sefton Council through Health & Wellbeing Board.
Governing Body

System Objective 2

To improve the health related quality of life for people with one or more LTC by 8%

Delivered through Mental Health & Dementia Strategic Programme

This programme is focused on delivering mental health care based on the needs of the South Sefton population, delivered through localities and integrated with healthcare to enable admission avoidance and improved recovery outcomes

Measured using the following success criteria

All organisations within the health economy report a financial balance in 2018/2019
Reduction in Unplanned activity by 15%
No provider under enhanced regulatory scrutiny due to performance concerns
Achievement of the 5 defined system objectives

System Objective 3

Reducing the amount of time people spend avoidably in hospital. Reduce emergency admissions by 19.7%

Delivered through Quality Strategy

The Quality strategy is integral to the CCG Strategic Plan and is focused on delivering high quality care and experience, ensuring no harm is done to patients and addressing areas of any concern promptly and effectively

System values and principles

We will maintain a local focus, working in partnership.
We will be transparent, open and honest.
We will be approachable and listen to our public.
We will enable action and prioritise effort to optimum effect.
We will act with integrity, act fairly and with respect.
We will be accountable for what we do.
We will be caring and compassionate.

System Objective 4

To improve in-patient experience by 14.5%. The proportion of people reporting poor patient experience of inpatient care

Delivered through Primary Care Quality Strategy

To improve access to primary care and enhanced quality of service in support of a reduction of 15% in unplanned admissions

System Objective 5

Improve patient experience of GP and out of hours care by 32.6% (% reporting poor care to reduce)

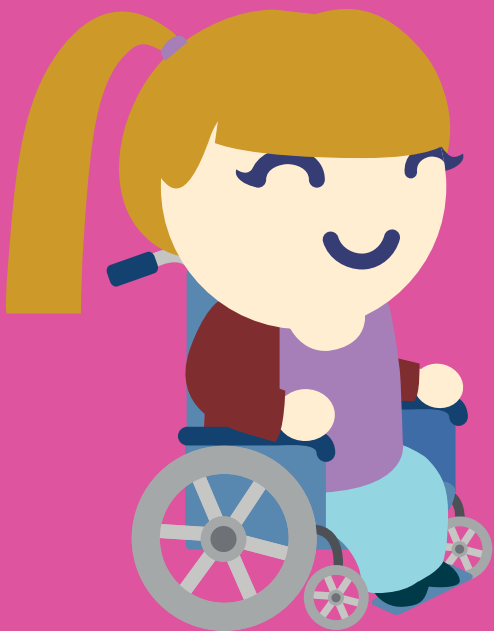
Commissioning for Excellence

Staying local & together

10. Our transformational programmes

Community centred care

Primary care transformation



Community centred care

Our approach

This is an area where we believe we can make the biggest difference to the quality and effectiveness of health and social care. There are clear links between this and all our other programmes.

There are two emerging programmes that are central to our vision for more integrated, personalised services in Sefton – known currently as Care Closer to Home for Southport and Formby and Virtual Ward in south Sefton.

We have agreed with Sefton Council to use our local Better Care Fund to continue to develop these programmes. Our aim is to achieve services that better link together right across health and social care – from hospitals and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

We believe this offers great benefits to patients, particularly those who are vulnerable or who are at most risk of becoming ill and being admitted to hospital.

This is what we have agreed to focus on over the coming five years:

- Early intervention and prevention
- Health promotion, self-care, self-help, self-management, with the longer term aim of reducing reliance on public sector services
- Encouraging self-determination and responsibility
- Information, advice, signposting and where necessary, redirection to appropriate services
- Developing integrated approaches across professional and organisational boundaries e.g. primary and secondary care clinicians working together in the community, assessment, meeting care needs, single gateway and seamless ‘front door’
- Facilitating a significant shift in culture and behaviours, across professions and organisations, but also in individuals in our community
- Innovation and whole system change



What people told us

People often need to answer the same questions and provide the same information each time that they are assessed by a new service, and this can result in a lack of consistency of care. So services should be more seamless and better joined up.

Care packages should address the needs of the whole person rather than treating an illness or trying to alleviate a collection of symptoms – often care packages miss the social and practical needs that can make a difference to a person's health such as financial concerns, lack of informal support networks, loneliness and isolation.

Many people felt that the NHS is not always the most appropriate organisation to address people's needs, and that wider health and social care services have a role to play in supporting patients – particularly the voluntary, community and faith sector.

Often people need reassurance, mutual understanding and informal advice and support. This is often the missing link in integrated care.



What we're doing

Bringing together so many different partners to integrate care presents us all with great challenges but we believe we are already making good, early progress.

Here are two examples that describe what good, integrated care can look like, and which highlight the benefits that this more seamless approach offers our patients.

Community Emergency Response Team

This nurse led, multi-disciplinary team was set up in winter 2013 as part of the Care Closer to Home programme. The Community Emergency Response Team (CERT) provides care to some of our most vulnerable, older patients. It acts as a bridge between hospital and primary care, working with those patients who need extra support but who do not need to be in hospital. GPs refer patients whose condition may be deteriorating to CERT, and the team steps-in to give additional, more appropriate care.

Previously, these patients would have been admitted to hospital and often their recovery would have taken much longer. CERT also works with hospital patients, so they do not stay on the wards any longer than they need to. To do this CERT also works closely with intermediate care – which provides community based beds and treatments - so patients referred to them either by a GP or from hospital benefit from more tailored support to get them well and back home as soon as possible.

Pro-active care programme

This element of the Virtual Ward was launched across practices in south Sefton in August 2013 following an earlier pilot in Maghull. It focuses on patients who are at most risk of being admitted to hospital and aims to address and improve their health, as well as their wider wellbeing.

The programme works to prevent the health of these patients from deteriorating, resulting in them needing urgent or emergency care. Those who will benefit are identified by their GP practice. Patients are then referred to the programme for around 12 weeks of intensive support. There are four pro-active teams providing patients with care, mirroring our GP practice localities. Each is led by a community matron, who assesses patients and works with their doctors to oversee their care.

The teams bring together a wide range of health and social care professionals to coordinate and tailor support based on each patient's individual needs – this could be medical treatment provided by a nursing team, or help and advice about improving their lifestyle from a community Health and Wellbeing Trainer.



Primary Care transformation

Our approach

Our five year primary care quality strategy has been developed in partnership with our member practices and has a real focus on energising the services provided in our local surgeries.

It maximises the opportunities that new GP contracting arrangement presents in the following five areas:

Practice demographics

planning for the changing health needs of our patients

Workforce development

to ensure staff have the skills for the future

Clinical outcomes

improving results for those with long term conditions and other medical problems

Estates and IT

so our infrastructure is fit for purpose

Health outcomes

to better support people's wider wellbeing



What people told us

People's experience of booking an appointment at their practice is not consistently good. Some report difficulties in getting an appointment at the time they need one, or having enough time with their GP to discuss all their health needs.

Being able to see the same GP is important because they often know a patient's medical history.

GPs should be better informed about the range of community and voluntary services that can help people improve their health and wellbeing.

What we're doing

One of the most important areas of our work to transform primary care is through the introduction of our Local Quality Contract for member practices in August 2014. Nearly all signed up to take part in a range of schemes aimed at improving and widening the services that practices offer to patients including:

Primary care access

Improving access and opening hours of GP practices across the week to make it easier for patients to get care closer to home at times that suit them.

A&E

Better review and aftercare of patients who have required emergency A&E treatment to help reduce the need for them being readmitted to hospital in the future.

Phlebotomy

Enabling patients to have their blood sample taken at their GP practice so they do not need to travel to hospital to have this done.



11. Our health programmes

Cancer

Cardiovascular and stroke

Children's health

Diabetes

End of life care

Mental health and dementia

Respiratory or lung disease

Liver disease

Kidney disease

Neurology



Cancer

Our approach

We expect the coordination of cancer services to be better integrated with community services.

We will put in place an advanced lung diagnostic pathway.

We will work with our colleagues in public health to increase the number of people being screened for cancers.

What people told us

There should be greater awareness of the symptoms of cancer and improved promotion of screening programmes to increase early detection of the disease.

Psychological support should be offered to patients and their families at the right time, as well as making more information available to help them live and cope with cancer.

Travelling distances for specialist treatments can be difficult, as is being given medication that can only be prescribed by a consultant.

What we're doing

Early detection is vitally important, so our programme will include awareness raising to help people recognise the early signs of cancer. We will also work with our partners to further enhance cancer screening services.

We know that people need better support to help them live with cancer. So we will introduce the Macmillan Recovery Package for patients in recovery, which focuses on wellbeing. We will also ensure patients have improved access to psychological therapies.

We will work with our partners who provide cancer services to ensure that they meet nationally required waiting times, enabling patients to receive timely treatment.



Cardiovascular disease and stroke

Our approach

We want a community based model of care for cardiovascular disease, as part of a wider integrated approach to long term conditions within community services.

The quality of cardiology services will be greatly enhanced.

There will be a proactive approach to the management of hypertension and atrial fibrillation on a scale basis.

What people told us

We want as much of our care as possible to be provided closer to or in our homes, so we do not need to go to hospital and we want all the services involved in our care to work better together.

People wanted support to help them come to terms with the impact that their condition is having on their lifestyle and if possible to develop creative ways of achieving the outcomes that they hope for. The voluntary, community and faith sector has a role to play in providing services to support their wider needs.

It is important that the dignity of all patients of all ages is maintained when they are receiving care, and that their views and feelings are respected at all times by health professionals.

What we're doing

We expect our new community cardiac service to encompass all aspects of care from screening and diagnosis to treatment and rehabilitation. It will also support patients to self-care and better manage their condition.

There will be more training for staff working in primary care so they can better manage patients with conditions like atrial fibrillation, hypertension and peripheral vascular disease.

The possibility of a telehealth pilot will be explored to support home based consultations for patients.



Children's health

Our approach

We want an integrated community model of care for children and young people, underpinned by community nursing, support and therapies.

Palliative care and psychological services for children and young people will be enhanced. We want services which are better equipped to deal with a child's transition to adult care.

What people told us

There needs to be easier and earlier diagnosis of conditions such as Hyperactivity Deficit Disorder and Autism.

There should be more psychological support for children, young people and their families and carers – this could prevent longer term and more severe mental health problems into adulthood.

The role of young carers should be acknowledged, and the impact that caring has on their health should be more widely recognised.

What we're doing

We expect our dedicated community nursing teams to support the full range of children and young people's needs from complex and long term conditions to chronic ill health and acute illness. These teams will also support children to be discharged from hospital as quickly as possible, as well as providing early assessment and treatment so children can stay at home whenever possible.

Reviews will be carried out for children's therapies, paediatric audiology services and complex nursing care for children. We will also review the diagnosis and care of Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder.

Psychological therapies known as IAPT services will be developed for children and young people.

We are working with our partners to review and redesign services to improve children's transition to adult services.

With our partners we are striving to do more for young carers and promote their positive health and wellbeing through a range of initiatives.



Diabetes

Our approach

We will develop a one stop model of care. An enhanced diabetes nursing model will be developed that is integrated with community services and linked to localities.

We will commission a self-care service model based on wellbeing and rehabilitation.

What people told us

People want to be better equipped to manage their own health – this could be through informal sessions where people can gain a fuller understanding of their condition, in an environment that makes it easier for people to take on board the key things want to know.

Pharmacies are well placed to provide advice and support and raising awareness of the services they offer would be beneficial.

Being able to see the same GP who understands their patient's condition and has a good level of knowledge about their support needs is even more important for patients with long term conditions.

Some people struggle to manage their own health, and services need to be more creative in thinking about ways they can help with this.

What we're doing

More training and support will be made available to primary care staff so that they can better manage patients with diabetes closer to home in GP practices.

We will monitor the Impaired Glucose Regulation Diabetes Prevention Pathway to ensure it is effective in supporting the education and self-care needs of patients.

With our partners in public health, we will encourage people to lead healthier lives with the aim of reducing obesity levels as the associated risk of developing diabetes.



End of life care

Our approach

We will develop and commission an integrated model for end of life care spanning hospital and palliative services.

This should be underpinned by an Advanced Care Practitioner to better coordinate support for end of life patients.

This will include enhanced bed capacity for end of life care outside of hospitals.

What people told us

End of life care should be discussed as early as possible with patients, their families and carers.

Greater understanding and awareness is needed amongst the professionals providing care either at home or in nursing / residential settings.

Family members and informal carers of all ages need to be recognised for the input they provide, and should be seen as an integral part of the care team.

Rapid discharge and the home referral team received good feedback but the quality of services that follow on from these based around social care needs to improve.

What we're doing

As well as developing a more integrated approach to end of life services, we know that better education is also essential to ensuring high standards of palliative care - for care homes, hospitals, community health teams and patients.

The use of the Gold Standard Framework, advance care planning and greater promotion of patient choice are all important ways that we can improve the skills of healthcare workers and at the same time increase people's awareness of end of life issues.

We will review district nursing services, including nighttime nursing services, and we will commission additional beds for end of life care.



Mental health and dementia

Our approach

We will review and redesign mental health services so they are built around the needs of Sefton residents. This will include a recovery based clinical model, supportive of home care. We want a more integrated psychological therapies service.

Dementia services will be enhanced so they can meet the growing demands of local people, their families and their carers.

What people told us

People value wellbeing services known as 'social prescribing' in helping them to cope with mild to moderate mental health conditions. Social prescribing can include schemes like regular art, or activity programmes.

People often need advice and support outside normal working hours, so more information about where to get help at these times would be helpful.

Poor physical health often impacts on mental health and these links should be more consistently acknowledged by health professionals.

People want to be more involved in developing their care plan so it is more personalised.

More information, education and awareness should be available to people about dementia, particularly around prevention and the treatment and care options available to them as their illness progresses.

Support for carers, easier access to talking therapies, prevention awareness, the de-stigmatisation of mental health and help for people to stay living at home are all areas that would benefit from greater investment.

What we're doing

A major review of all mental health and dementia services, coupled with the views and experiences of patients and service users will help to shape new and more integrated models of support and treatment.

This will include reviewing how effectively the nationally recognised 'recovery model' is being employed by mental health services in Sefton to secure the best outcomes for their patients, including developing clear network of support services.

We expect people to have improved access to psychological therapies, which offer better recovery rates. With our partners in Sefton Council, we will implement our joint dementia strategy to ensure services support early identification and meet the needs of 90% of the population by 2018-2019.



Respiratory disease

Our approach

Our respiratory pathway will be in line with guidance from NICE, the National Institute for Health and Care Excellence.

There will be an enhanced self-care model for patients underpinned by training and education.

We will develop an integrated model of rehabilitation and prevention in symmetry with cardiovascular disease and diabetes.

What people told us

Patient support groups can help people to develop awareness of and confidence in managing their condition/s, helping them to feel more in control of their care and treatment.

Voluntary, community and faith organisations are well placed to provide support groups, as they provide care in a less formal way and can be more flexible in their approach.

We value the support we receive from specialist nurses in helping us to manage respiratory conditions like Chronic Obstructive Pulmonary Disease (COPD).

People with chronic conditions often need more time with their GP, and it would be better if they were able to see their own GP, who has an understanding of their medical history.

What we're doing

Enhancing home oxygen therapy services will bring them in line with NICE guidance. We will explore how we can commission more effective community based respiratory services through projects like hospital at home, supportive discharge, better rehabilitation and support for patients to manage their conditions more effectively.

Raising awareness of respiratory illnesses will help us to identify the millions of people whose condition goes undetected each year, and who are at greater risk of needing emergency hospital treatment.

More training for primary care staff will ensure that patients benefit from improved, individually tailored and supportive care planning at their GP practice.



Liver disease

Our approach

Nationally liver disease is increasing. This is often associated with alcohol abuse, which is evident within areas of Sefton.

The long term health and economic consequences of alcohol abuse and liver disease are well recognised.

Alcohol consumption amongst young people has been identified as a challenging area for us to address.

We will review and assess local needs to inform this new work programme.

What people told us

People want more information about making healthier lifestyle choices so they can stay well for as long as possible.

There are often barriers preventing people from making healthier choices – such as motivational or social factors affecting people ability to take more responsibility for their own health.

More innovative approaches to making lifestyle information available would be welcomed, such as text messaging, or the online Sefton Directory.

Regular medical or lifestyle reviews would help people to improve their health and wellbeing.

What we're doing

We are working closely with our partners, including Sefton Council, to identify if there are any gaps in current alcohol services and to understand what more we can do together to prevent the harm that alcohol abuse causes to individuals and their families.

This includes assessing a number of innovative projects in other parts of the country, which may help us here in Sefton to identify those at greatest risk of alcohol abuse much earlier than now, as well as offering them better treatment and support.



Kidney disease

Our approach

Acute kidney problems are common amongst our older patients, often resulting in admission to hospital and prolonged but preventable stays.

Kidney problems can occur for a number of reasons including poor fluid intake, which can cause dehydration and make existing conditions such as heart problems, diabetes and hypertension worse.

So, to help us meet our strategic priority of reducing unplanned care we have included kidney disease as one of our health programmes.

What people told us

Because there are often a number of services and agencies providing care to people with long term conditions, it can be confusing for people to know who to contact if they have an urgent problem.

Sometimes people end up going to A&E because they had problems accessing community based services.

What we're doing

We will review and assess local needs to help shape this new programme of work. Our programme is expected to include education and support for older patients and those with dementia around the importance of keeping adequately hydrated.

Ongoing monitoring of patients with existing health conditions will also help to ensure early detection of kidney problems to avoid unnecessary hospital admissions.



Neurology

Our approach

Services for Sefton residents with neurological conditions like Motor Neurone disease, Parkinson's disease, headaches and epilepsy need to improve.

Because our population is ageing, we expect the number of people with these conditions to grow.

The implications this will have on individuals, families, carers and health services will be significant.

So, it is right that we should provide additional focus on this area as part of our strategic plan.

What people told us

Often wider social and economic factors prevent people from taking more control of their own health – such as fuel poverty or employment opportunities – identifying and providing support or training to overcome these barriers would help.

Carers should be better supported and treated as a priority so that the impact of their caring activity, on their health, is accounted for.

What we're doing

CCG clinical and programme leads to be identified to support further development of pathways and networks.

Undertaking a review of data and benchmarking against our peers to understand areas of need.

We are also making links with partners including those in the third sector to understand how we can shape future services for our patients and their carers.



12. What will this look like?

This is what we expect for Sefton residents by 2019



13. What's next?

Every year we will develop annual business plans or 'commissioning intentions', setting out the work each CCG intends to do towards meeting the vision in this strategy.

We will continue to involve Sefton residents and all our other partners in this work.

So we can all be sure that our plans are working, our performance will be regularly assessed to help highlight where we may need to make adjustments or changes.

You will find our full five year strategy on our websites, along with more detailed feedback, comments and views that we have received from local people during its development.



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On request this report can be provided in different formats, such as large print, audio or Braille versions and in other languages.