South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Developing our 5 year strategy

Your views so far …

May 2014

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Introduction

About our 5 year strategy

NHS South Sefton Clinical Commissioning Group (CCG) and NHS Southport and Formby CCG have come together to create a borough wide strategy for improving the health and wellbeing of local residents over the next five years.

The strategy focuses on eight programme areas - enhancing primary care, children's services, cardiovascular disease (CVD), respiratory conditions, diabetes, cancer survivorship, mental health and end of life support. The main programme areas are the same for both CCGs but there are often different approaches to services and schemes in the north and south of the borough to take account of the differing needs of people living in different parts of Sefton. To identify these programme areas we have collected and analysed all the information and medical evidence about current health and health services in Sefton. The views of Sefton residents gained at a range of public events over the past 18 months have also helped us design our programmes and understand what more we need to do in the future. The schedule of public engagement is outlined in Appendix 1.

Because the work of our partners also impacts on the health of local people, we are working closely together to ensure our plans are aligned to Sefton's Health and Wellbeing Strategy. This means that collectively, we have the opportunity to achieve more by sharing resources, reducing duplication and strengthening our combined efforts whenever we can.

We will finalise our strategy by the end of June 2014 and up until then we are continuing to talk to people about how our programmes are shaping up and how they can be further refined.

We would like to thank those Sefton residents who have shared with us their views and ideas about improving future health services over the past 18 months at events including - Big Chats, Mini Chats, Sefton CVS network forums and individual meetings with member organisations, our joint events with Sefton Council to develop the Health and Wellbeing Strategy, as well as the recent series of Healthwatch Sefton Community Champion Chats with Sefton Opera, The Brunswick Youth and Community Centre, Galloway's Society for the Blind, People First, the Alzheimer's Society, the Knit and Natter group at May Logan, the Breathe Easy Group, Southport Service Station, Cambridge Road Children's Centre Toddler and New Mum's Groups and the Bowersdale Centre.

About this information pack

This information pack gives an overview of our plans in each of our programme areas so far and describes where our current thinking has been informed by people's views.

We have collated all the information that we have gained to date from our conversations with individuals and groups, summarised it and arranged it into key themes. There is not space to include all the individual comments that we have received to date in this factsheet but you will see that we have picked out a number of pertinent comments that reflect and illustrate the overall key themes made by people.

In doing this, you can see where people's views concur with our current thinking, and where we need to further consider what we have been told by local residents as we continue to develop our key programmes.

In this information pack, we focus on making improvements in the areas of health commissioning for which we are responsible. The things that people felt were important in relation to services where we are not the lead commissioner will need addressing in partnership with bodies like NHS England, Sefton Council and Specialised Commissioning.

You will notice that there are lots of connections between our different programmes and that a number of the services we have already, or will be developing, address more than one of these key priority areas. We have received many comments about urgent care services during all our conversations with people, and we have highlighted where those views are being considered within each of our programme areas.

We still want to hear your views, so any feedback we gain from our future events – today – will also help us to further shape and refine our work. If you cannot be at any of our future events but would still like to submit your views contact us by:

Emailing us: communications@sefton.nhs.uk

Telephoning us: 0151 247 7050

Enhancing primary care programme

Our plans so far…

Each CCG has developed a Primary Care Quality Strategy identifying work that needs to be done. A joint Primary Care Quality Board has been established to oversee this work between 2014 and 2017. Its key areas for development include:

1. **Collaborative working** – where services work together right across health and social care to better meet people's individual needs
2. **Mapping what we have and what we need** - to see where we need to do more or make improvements
3. **Clinical services** – which are more effective and some examples of how we are doing this include Care Closer to Home in Southport and Formby and the Virtual Ward in south Sefton which links to work in our long term conditions programme (page 10).
4. **Estates and IT strategies** - to ensure our premises meet future needs and our IT systems ensure consistency and access to information needed to provide the highest level of care in a more seamless way
5. **Health outcomes** – getting better results for our population by investing in primary care and increasing capacity in GP practices

1. Collaborative working

You said - what we are doing

"Integrated care needs to be truly integrated, funding and communications need to support this."

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

This feedback supports our thinking about how we plan to spend our joint Better Care Fund with Sefton Council, to help create more joined up services that are wrapped around individuals' needs and where a variety of support services are coordinated to prevent duplication and improve patients experience. This will also help us to bring as many services as possible closer to home, with the aim of reducing the need for urgent hospital treatment.

"Understanding the emotional impacts which people (and their families and carers) experience when accessing health and social care services is crucial. Often people need reassurance, mutual understanding and informal advice and support. This is often the missing link in integrated care."

We are already looking at how some groups of patients, like those with breathing conditions, can be supported to better manage their conditions to prevent their health

deteriorating and to improve the quality of their lives. This is closely linked to work we are doing in our long term conditions programme. Positive feedback about some of the activity currently happening includes people finding benefit from some GPs having respiratory trained nurses carrying out regular checks and advising people about using their medication correctly. *Ensuring care is of a consistent quality, involving patients in discussions about their care and signposting people to the right help once they have been diagnosed*

Our Protected Learning Time events provide a forum which can enable sharing and discussion about best practice amongst clinical and support staff. The latest national guidance requires all staff to better involve people in decisions about their care.

You said – we will consider

Stronger links between GPs, patients, their families and their carers

“The NHS have been talking about holistic care for a long time but we can't feel it in the community”

Collaborative care needs to include informal as well as formal carers to create a truly consistent approach to care. People think that there also needs to be an increased awareness of all workers supporting vulnerable people to recognise and (know how) to signpost changing medical needs. This would require training for workers so that they recognise and flag changes so that any concerns raised are acted upon.

2. Mapping what we have and what we need

You said – we are doing

“Consistency of GP is very important as they know you and listen to you. This may stop unnecessary referrals and save money.”

Access was a very common issue raised by people in all our discussions about primary care. Whilst many people report that their practice has a good system in place that works for them, a great many more report problems – particularly getting appointments when they need them and having enough time available within their appointment to discuss all their health needs. Other important issues for people included not being able to see the same GP every time they need an appointment and difficulties in getting through receptionists to see the doctor.

Protected Learning Time sessions for clinicians can be used to share good practice. This also links to work that is being undertaken at locality level to help create consistency and share what works so well in some practices.

We see great value in having primary care services near to where we live at the GP practice or places like May Logan.

This supports our work to bring services closer to home whenever we can and make access easier for people.

People pointed out that it is not always distance to service that creates a transport issue for people who don't drive but the actual bus routes which may not easily connect local people to services that are close to home.

You said – we will consider

We want longer GP opening times, fewer locums and all doctors to really listen to the concerns we bring.

People also report wanting consistency of prescribing practice, length of prescription and medication reviews for example some people return for monthly repeat prescriptions whereas others return bi-monthly and actual medication reviews can be much further apart. Concern was also raised about occasional repeat prescriptions being incorrectly written and issued

It was suggested that having Respiratory trained nurses in all Practices would help with many of these issues.

Mothers feel that it would be helpful to have a named GP for children in the same way that the elderly are meant to have one now.

People whose GPs are able to provide a phlebotomy service are also positive about being able to access this facility locally.

People with mental health problems feel that they should be given priority when trying to make an appointment with the GP and that there should be a flagging system to encourage receptionists to spend more time helping people with their queries. People also reported difficulties in a new system that has been implemented in more than one surgery where they are no longer able to ring to check if a prescription is ready necessitating multiple journeys to drop in the prescription, to check if it is ready and then to return to collect it if it wasn't ready the first time. These issues will be fed into the work that is ongoing around improving access.

People also told us that appointments for children should be prioritised, this is not a consistent experience in all practices. Some parents also felt that it would be helpful for children and babies to have a designated GP in the same way that is being introduced for older people.

People's experience of all these things differs from practice to practice and addressing some of these involves working with NHS England, the lead commissioner for primary care.

So we will be using the findings of the GP Patient Survey to help build and develop our plans for long term conditions and out of hours services, whilst the hospital in-patient survey will inform our plans for future acute services.

Other issues that were raised relate to communication, between services, in-patient, out-patient and GPs, and between patients and medical staff. Lack of consistency of process across practices can also be difficult for people to understand when talking with friends

and acquaintances, for example when some practices receive positive feedback for prioritising children; managing long term conditions more and access to appointments, when people are unhappy about these processes within their own practice.

As per national guidance, we are looking at ways to extend GP opening hours, ensuring that all patients over the age of 75 have a named GP. We are also developing a local quality contract with practices to support improved access and support for patients.

In general people feel that community based services currently work well. These are services that people can access close to home without having to go to hospital - such as locally run clinics and Litherland walk-in centre. However, people would like increased access to these types of services and more diagnostic facilities such as the ability to have an x-ray out of hours.

Transport to the walk-in centre and clinics was something that can be difficult for people living in Maghull and Netherton, where public transport is more limited. *'Need to work more with public transport to ensure we can get to clinics in the community.'* People also mentioned that it would be useful to have *"regular, reliable mini bus services within hospital sites,"* to help people move between appointments, clinics and parking areas.

Transport is an issue that is discussed as part of the Health and Wellbeing Strategy. It is not something that the CCG can resolve alone but there are ongoing discussions where this feedback is shared and it is also a consideration when exploring new services. Parents also reported that it would be useful to have x-ray facilities for children in the community rather than having to attend A&E and that it can be frustrating to wait to be triaged in the Walk-in centre only to be advised to attend A&E.

3. IT strategy

You said – we are doing

We want IT and other communications systems between health professionals to be joined up.

In general, people felt that current fragmented systems mean that patient information is not shared quickly enough and in some cases leads to duplication or patients not receiving a rounded care package.

Healthcare IT systems are complex and it takes time to join them up between different organisations, as we need to keep patient information protected. We are exploring ways to do this through a number of pilot projects.

You said – we will consider

We want to choose who our information is shared with through the use of hand held records

There is work ongoing around record sharing, integrated care and involving patients more in the decision making process relating to their care that will incorporate some of these issues.

4. Health outcomes

You said – we are doing

We would like more support for patients to better manage their health and make healthier lifestyle choices.

Providing people with information and support is a reoccurring theme and suggestions to improve this include longer appointments so people can talk about their symptoms and where doctors have more time to give a more holistic response to patients needs – such as healthier living. Several people mentioned the difficulties faced by people around their ability or motivation to take more responsibility for their own health. These are issues that are being considered as part of the Sefton Health and Wellbeing Strategy. We are also addressing this in various ways within our long term conditions programme around the work that is ongoing within that to help people recognise and manage their symptoms / condition.

Patient Reference Groups were seen as a good way to be able to help increase public awareness of some of these issues. The CCG is committed to supporting the development and maintenance of Patient Reference or Participation Groups and keen to explore ways of taking this forward in individual practices.

You said – we will consider

We value the work that the voluntary and community sector does in helping us to improve our health and wellbeing and we want GPs who are better informed about the range of community and voluntary services that can help us improve our health and wellbeing.

People felt that the online Sefton Directory will help to raise awareness of the voluntary and community support available. They also suggested market place events where GPs could spend some time meeting services and hearing first hand what they can offer. Other suggestions included adopting text messaging services to encourage people to attend regular medical reviews or healthy living services.

Children's services programme

Our plans so far…

We are focusing on areas where we need to do more to bring us in line with England averages. So, our children's programme focuses on improving health outcomes for children with long term conditions and reducing emergency admission to hospital for children with:

- Epilepsy
- Asthma
- Diabetes
- Poor mental health and self-harm
- Alcohol related issues

In addition to this we are working with partners to improve the overall health outcomes for Sefton's children and young people – examples of this are supporting work to reduce childhood obesity and smoking in pregnancy, along with increasing breastfeeding rates.

1. Children's services in general

You said – we are doing

We would like services to work better together and be located closer to where we live.

We have extended the children's community nursing team pilot in Southport and Formby for a further 12 months. There is already a similar community based nursing team in south Sefton. Both of these services aim to reduce the need for emergency hospital care through supporting those with long term conditions in the community, and helping those who do need hospital care to return home as quickly as possible.

We will review all community provision, along with the findings from the pilot, with a view to commissioning an integrated, joined up nursing model from 2015 – 2016.

We will also be exploring the roll out of self-management programmes and the use of telehealth and telecare systems, reviewing their effectiveness and how they may be able to contribute to preventing the need for emergency care whilst improving the quality of life of our children and young people.

There were concerns raised about early diagnosis for children with specific conditions such as attention hyperactivity deficit disorder and autism. We are linking in with the Cheshire and Merseyside Clinical Network, which is also looking at these conditions and the provision of the service across Merseyside. In addition, we are working with our providers to review current provision of these services locally.

A number of people provided positive feedback about the Common Assessment Framework (CAF) and the way that it coordinates services for children and young people. However they did feel services were stretched and do not cover a wide enough age range. These are issues we will feedback to Sefton Council.

You said – we will consider

Feedback shows that people think it is important to focus on improvements in the psychological support required to help children and their families cope with the implications of living with long term conditions including epilepsy, asthma and diabetes.

Obesity and lack of access to activities was also raised as an issue that could have an impact on living with long term conditions.

Feedback shows that people are positive about occupational therapy input although there is a long wait for this service.

Questions that arose on one table include:

- Sexual health for our younger population have we got outreach in Southport?
- Are you reaching the people in the colleges and secondary schools?

2. Poor mental health

You said – we are doing

We would like to see more investment in prevention and training around psychological support for children, young people and their families and carers and we think this will be a key factor in saving money later in life by preventing the need to move into adult mental health services.

The Sefton Children and Young People's Emotional Health and Wellbeing Steering Group has been tasked with supporting partners to develop a Children and Young People's Emotional Health and Wellbeing Strategy and an accompanying action plan for Sefton, along with a service specification for Child and Adolescent Mental Health Services. Linked to this, there is a mapping exercise to explore and understand all services which contribute to the emotional health and wellbeing of children and young people. Once the mapping has been completed we will be able to identify any gaps and where appropriate decommission and commission services to meet the needs of the children and young people in Sefton.

You said – we will consider

A lot of feedback focused on the need for services to take a more holistic approach to care, by considering social aspects as well as health needs.

Lack of communication between professionals and also between professionals and families was another theme seen as being integral to reducing unplanned hospital admissions.

Training and the perceived lack of capacity within teams were felt as contributing to long waits for a diagnosis, as was the reduction in services that have previously supported families, such as the Family Nurse Partnership.

Difficulties faced by 16-25 year olds who have been receiving support as children and then have to try to make a transition between losing support altogether or moving into adult services is another theme raised.

It was felt that education and open discussions with children and young people about mental health, living with domestic violence, gangs and health issues like obesity would be helpful to provide children and young people with awareness of how to access help and support and help reduce mental health related problems.

Long term conditions programme

Our plans so far…

This programme covers the following three priority areas:

Current thinking on cardiovascular disease (CVD) includes a focus on:

- Community cardiac rehabilitation
- Developing a community cardiac model that includes screening, investigation, diagnosis, treatment and rehabilitation and end of life care
- Developing a shared vision with patients to help decide what a good service would look like
- Developing an integrated lifestyle programme

Current thinking on respiratory diseases includes a focus on:

- Continuing to improve community pathways to support care closer to home
- Developing ongoing respiratory training for practices to reduce variation and improve the quality of care
- Developing ways of identifying individuals with respiratory conditions who would not be recognised via the usual routes
- Commissioning an enhanced home oxygen assessment and review service
- Exploring ways of delivering pulmonary rehabilitation in the community alongside the self management programme
- Reducing unnecessary A&E attendances and hospital admissions for respiratory patients

Current thinking on diabetes includes a focus on:

- Improving community pathways to support care closer to home
- Reducing length of stay in hospital for patients with diabetes
- Exploring the benefits of running joint community clinics for patients with diabetes and kidney problems
- Supporting the development of training that improves primary care competencies and reduces variation in GP practice performance
- Exploring the benefits of a ‘one stop’ community diabetic clinic
- Increasing recording of the 8 key diabetes care processes
- improve pre-pregnancy care by investigating the development of a pre-pregnancy clinic
- Working with the North Mersey network to implement current best practice in order to improve footcare

General feedback about long term conditions

You said – we are doing

We agree with plans to diagnose conditions as early as possible and to provide patients with as much of their care as possible closer to home, outside hospital by services that work better together. People report receiving good care for lung conditions in both local hospitals and feeling that A&E is better for people with lung conditions as the out of hours doctors can't always help.

Our Care Closer to Home and Virtual Ward programmes are examples of how we are integrating services and at the same time bringing support to people nearer to where they live and sometimes in their own homes.

The Virtual Ward and Care Closer to Home programmes receive positive feedback relating to the integrated way of working and the level of care, advice and support that people receive within these programmes. People appreciate the way that these services focus on" the whole issues around the person's needs, not just health."

The input people receive from voluntary organisations to support them to live more independently and to improve their wellbeing also receives positive feedback with people again receiving holistic support to help them maintain their independence.

'Patient responsibility needs to be a priority.'

Support to help people better manage their conditions was a reoccurring theme, recognising that patients are the experts about their own bodies and the impact their condition is having on their life. Coupled to this, people told us they prefer less formal sessions to help them to engage with health messages and understand their conditions.

This fits with our current work to develop self management and training courses for people with respiratory diseases. One example is a new pilot scheme based at a number of practices in Bootle. We have devised a series of patient education and advice sessions focusing on asthma and Chronic Obstructive Pulmonary Diseases (COPD) for those patients whose condition is difficult to manage and who frequently experience episodes of poor health as a result.

People provided very positive feedback about the rehabilitation courses available agreeing that it is a good local service which will only be improved by increasing access to them so that people can attend more than once if they need more confidence to help them manage their conditions.

Other examples that gained positive feedback include the 'Healthy Sefton' healthier lifestyles signposting service, Children Centre staff working with young mums and a scheme in Southport and Formby working with people with learning disabilities to promote healthy lifestyles.

We think pharmacies are well placed to provide advice and support. Not enough people know about the range of help they currently provide and there are some things pharmacies do that we would like to see them doing better.

Developing people's awareness of what pharmacists can offer is another theme and fits with the work that is ongoing in several of the programmes at the moment. However, people cited a number of reasons preventing them from fully benefiting from pharmacy services including changes to repeat prescription systems, waiting times and a lack of privacy when talking to the pharmacist. These issues will be shared with NHS England who commissions these services. Some felt the use of different branded medications, so tablets look unfamiliar, can impact on people's management of their condition because they can be afraid to take medication that looks different, thinking that they have been given the wrong thing. This issue will be addressed by the Bootle asthma and COPD pilot, where patients will receive full medication reviews as part of the self-management programme.

As in other programmes areas, people felt that being able to see the same GP, who understands their condition, and who has a good level of knowledge about their support needs would contribute to improving care for patients with long term conditions. This fits with ongoing work in the primary care programme.

You said – we will consider

People consistently acknowledged that wider social and economic factors often prevent them from taking more control of their health - barriers such as fuel poverty and employment opportunities. People wanted more support to help them overcome these barriers and amongst the suggestions were informal training and education sessions that help address these issues.

Telehealth is seen as something that can be used more widely to support people to manage their conditions at home. However the evidence on this is not consistent so any consideration would need to include reviewing supporting evidence and identifying specific areas where this could be of most value.

There was a feeling that what patients want to achieve from their treatment is not always the same as what a health professional considers to be a good health outcome. People wanted support to help them come to terms with the impact their condition is having on their lifestyle and if possible to develop creative ways of achieving the outcomes that they hope for. It is felt that the voluntary, community and faith sector (VCF) has a role to play in providing services to support their wider needs. One person asked *"how are we going to manage to invest in prevention, social prescribing and taking care of wellbeing in the current climate?"* GPs and other professionals also need to know about the wide range of services to support people across the whole of the VCF sector. We are working with Sefton CVS and Sefton Council to look at how we can commission services from the VCF sector more effectively to help us to meet our joint vision for improved health and wellbeing.

People told us that routine screening can be good but there is sometimes no follow up after initial screening for example no rehabilitation after Abdominal Aortic Aneurysm screening. This can be fed back to NHS England.

Retinal testing at the opticians is viewed positively though there can be confusion about when people are eligible for this with one person reporting that last year when being tested they paid for it but this year it was free.

One person reported that *"Diabetes feels now segregated. It all used to be in the hospital at the one place. I have my eyes photographed at Southport but the report goes to Liverpool for eye care then Liverpool writes to me to tell me that my eyes are ok"*

People also mentioned concerns about handing in medication from home when being admitted to hospital as it can lead to missed doses and feeling disempowered.

Another key theme people raised regards investment in informal carers being treated as a priority so that the impact of caring on their health is accounted for.

Cancer survivorship programme

Our plans so far…

Our current thinking on cancer survivorship includes a focus on:

1. **Earlier detection** – some of the good things that people raised under earlier detection include the fact that more people are surviving cancer and people recognise early detection is key to a better prognosis. People spoke about the people they know who have survived cancer (More than 50% of people now survive longer than 10 years after a cancer diagnosis). There is an increased sense of people taking greater responsibility for their own health by leading healthier lifestyles and taking advantage of cancer screening programmes where available. Diagnostic to treatment time is usually quick
2. **Tailored support during and after cancer treatment** – again services at Clatterbridge and in the local hospital trusts in general were praised as being good with Cancer Nurse Specialists, counselling at Aintree and the breast care treatment received at Clatterbridge and the Linda McCartney Centre receiving special mentions along with the McMillan Cancer Support Service.

1. Earlier detection

You said – we are doing

Current thinking is about promoting good awareness of cancer signs and symptoms in both the public and health professionals and exploring pathways that lead to quick cancer diagnosis or reassurance that cancer is not present.

Bowelscope screening is coming to this area shortly

Healthcare professionals are always encouraged to reflect on a cancer diagnosis and the journey leading up to it to consider if anything could have been done differently to diagnose the cancer earlier

You said – we will consider

People feel that seeing the same GP is important, to have someone familiar that they can comfortably discuss concerns with in order to ensure timely referrals and have a consistent approach to symptom recognition. This reoccurring theme in nearly all programme areas fits with work around enhancing primary care (see page 5).

People felt that having a cancer centre or community based cancer support services in Bootle and access to new technology would help earlier detection and provide the support that patients need during and after treatment.

People also raised the issue of different age ranges for screening programmes with one person particularly commenting, *“why don’t they send for now after 70 to have a mammogram?”* This is not something that we have control over but we can request an update from NHS England on the progress of age extension for breast screening and how to self request breast screening for those older than the invited age range..

Some people felt parking issues at treatment centres can be stressful - finding a space and having to pay for parking. Also when patients are in hospital for long term cancer treatments, family visitors have to pay parking fees which can add strain to an already stressful situation. It is worth noting that Clatterbridge and Aintree now offer free parking for people having cancer treatment.

2. Tailored support during and after cancer treatment

You said – we are doing

We think it is important to offer psychological support to patients and information to help them live with cancer at the right time for both individuals and their families.

We are working on providing access to personalised support at the right level, at the right time in the right place. The programme is also exploring ways of supporting people to help get their life ‘back to normal’ after their cancer treatment including support to return to work if that is what the person wants, support to deal with the financial impacts of cancer and to cope with the later effects of cancer and treatments. For example we held a Macmillan Cancer Health and Wellbeing event in Southport on May 1st and more events are planned.

You said – we will consider

Travelling distance for specialist treatment and access to medication that only consultants can prescribe. *“Every six weeks I need to travel to Clatterbridge to get my medication. They tell me this is because my consultant is a specialist and it’s only them who can prescribe it.”* This is feedback we can share with Specialist Commissioners. The proposed additional Clatterbridge cancer services unit on the new Royal Liverpool site will at least partly reduce travel time if the plans are agreed.

Other themes that were raised include the increased pressure on district nurses in relation to an increased signposting and advocacy role. Managing anxiety out of hours was also raised as an issue when the Clinical Nurse Specialist is unavailable.

Mental health programme

Our plans so far…

Current thinking on mental health services includes:

- Work on reducing premature death in people with serious mental illness by improving access to health services
- Improving access to psychological therapies
- Enhancing the quality of life for people with mental illness through supporting them to remain in their own homes, ensuring support and access to services when needed
- Developing an integrated more effective commissioning plan that meets changing demographic needs

Current thinking around dementia services includes:

- Increasing appropriate and timely diagnosis
- Ensuring quality dementia services are available
- Reducing the prescription of anti-psychotic drugs
- Supporting community initiatives that enable people to stay at home for longer
- Continuing to raise awareness of the impact of dementia and encouraging collaborative working across sectors

Mental health services

You said – we are doing

Things that people felt are working well within current thinking include Clinical Professionals, (Social workers and CPNs), being 'switched on to social prescribing alternatives', having a rapid access card that works well and the Recovery College being developed by Mersey Care NHS Trust.

Mersey Care NHS Trust are seen to be committed to service user and carer engagement and its new model of care moving towards integrating crisis resolution within the Community Mental Health Team received positive feedback because it will help to reduce the amount of different people coming into someone's home during a crisis episode. However one person did say that *"Mersey Care NHS Trust needs to move away from the one size fits all thinking and be more flexible to meet population needs"*, showing that the trust's developing approach has not been experienced by everybody as yet.

Bowersdale Resource Centre and the facilities that it provides also received positive feedback, *"works well, easy access and wide range of facilities to develop or improve wellbeing. It offers an ordinary integrated service."*

Alternatively, services that provide a mixed general mental health and substance misuse pathway are not so well received (Stoddard House) there is positive feedback around the plans to build a new site but people want to be reassured that people with substance misuse issues won't be treated in the same area as people with general mental health issues.

The Befriending Service is also seen as helpful in terms of reducing social isolation.

Other themes that were raised include access to information and support out of hours and identifying what people can do and building on that rather than focusing only on what they can't do. Work on enhancing quality of life and supporting people to remain in their own homes will help to address these issues which are pertinent for people with dementia also.

Continuity of care, better information and investing in *"prevention awareness, de-stigmatisation and information to help people to live at home"*, are also themes discussed that will be taken forward under the current work programme relating to enhancing quality of life and supporting people to remain at home.

We think people should be able to access talking therapies themselves, without having to go through the GP.

We have reviewed and revised the service specification for our Improving Access to Psychological Therapies Service (IAPT) to include a system that will allow people to self-refer. The new specification also allows third sector organisations to make referrals when people need extra help to refer themselves.

Third sector organisations have a role to play in supporting people with mental health issues.

Feedback from the voluntary, community and faith sector and mental health network include developing trust in the services available within the voluntary sector and working more closely together to help prevent people from relapsing, as well as working with the sector to provide more flexible, personalised support in less stigmatised venues, although 'groups' are still viewed as carrying a certain amount of stigma at times. Network members and people who attended a mental health focus group in October 2013 also raised the issue of less formalised support being increased with more of a focus on peer support and access to drop in facilities that people can use as and when they feel the need rather than for structured sessions / activities. In response to this feedback, we have invited organisations to explore ways of supporting people to help to minimise the issues that affect people in socially isolated situations and we are working with CVS to promote this opportunity to third sector organisations who might wish to bid to support this activity. This activity will also support people with Dementia.

You said – we will consider

There is nothing like the Bowersdale Centre that people are aware of in the north of the borough.

People felt there needs to be better understanding of the whole patient journey - from GP to in-patient, then discharge and back to GP.

People also reported concerns about urgent care for those with mental health crises. People expressed fear about attending A&E because of the wait and the anxiety worrying about being *"committed"* because people think this seems to be the only option someone is thought to be in crisis.

Another theme that comes through the feedback from different sessions relates to people wanting more access to main stream facilities and a wider range of *"alternative options to medication"*. People suggest that to help with this support groups and centres *"require more funding as they keep us well for longer."*

Dementia services

You said – we are doing

The new dementia service in Southport for couples received positive feedback.

People attending Mini Chats also recognised that it is not just about mental health or dementia, physical health needs are *"just as important"* and can have an impact on mental health. People suggested that care plans need to be more coordinated between health and social care staff and that there still needs to be more involvement from the patient in developing their care plan, so it is more personalised. Work that is ongoing around involving patients in decision making and integration will help to address these issues.

Education and awareness also come through from dementia service feedback with people wanting more information about prevention, treatment and care options available to them as the illness progresses. Work that is being undertaken within the current programme will help to address these issues.

You said – we will consider

Some people spoke about the difficulties in accessing GP appointments. (This issue should be addressed via the work that is ongoing to improve access under the primary care programme).

There is a lack of support available at weekends and carers need more access to respite and time for themselves to recover their energy.

"The dementia passport should be made compulsory at all hospitals" and there should be more recognition of people's support needs, for example if they struggle to feed themselves or have specific dietary requirements.

Communication between professionals was also a theme for dementia services with one person particularly stating that *"communication between clinics and hospitals should be improved"*.

End of life support programme

Our plans so far…

There are three main areas where we are focusing our work in this programme:

1. Commitment to education and skills development to support staff and patients
2. Support for people at home
3. Support for people in hospital or nursing and care homes

1. Commitment to education and skills development to support staff and patients

You said – we are doing

In general, it was felt that the way that people have the right to be more involved in planning and decision making about their care is working well. Occupational therapy, district nursing and GP services have also received positive feedback in the way that they support people with end of life care needs. The rapid discharge pathway and multi-disciplinary working and Hospice at Home services also received positive mentions in feedback.

Themes that people raised in feedback that could be improved include having advance care plans made available for everyone indicating their end of life care wishes and for this being discussed at an earlier stage of life / illness, better education and for care homes about caring for their residents at the end of their lives, district nurses, GPs, hospital and social services working better together and more education for the general public about end of life care issues and the support available. These themes will be addressed by work ongoing within the current work programme.

You said – we will consider

"End of Life care needs to be discussed earlier" and there needs to be increased awareness amongst general population and those providing care either at home or in nursing / residential settings.

There needs to be proper recognition for informal carers, education and support for them as well as recognising the input they provide, they need to be seen as an integral part of the care team.

There needs to be better signposting of current services available and how to access them.

There needs to be better communication between all people / professionals involved in providing care.

2. Support for people at home

You said – we are doing

Themes arose around the quality of care available to support people at home with the Home Referrals team receiving good feedback but people feel that care standards are lower then when social care takes over, agencies are not able to provide the same level of input and 'this needs to be addressed'. This will be fed back to Sefton Council.

Another theme that arises in this category is that the people providing care are often very time limited and task orientated. They don't have the time or the training to see people in a holistic way. These issues should be partly addressed by the work being undertaken in the current programme.

You said – we will consider

There were several issues raised about receiving care at home that we will share with Sefton Council - including home care providers covering task orientated activities and not having the time to deal with patients' wider needs.

3. Support for people in hospital or nursing and care homes

You said – we are doing

Rapid discharge is perceived to be working well, as is patient choice about where people receive care. A number of areas were highlighted for improvement - training and awareness amongst hospital, nursing and care home staff, particularly around patients having difficulty feeding themselves and difficulty in obtaining a diagnosis which can facilitate increased access to support such as hospice care. It was also felt that awareness in care and nursing homes about end of life services should be improved to enable their residents to remain there as long as possible through more effective care.

We expect these themes to be addressed by work that is ongoing within the current programme to help provide information, support and training for staff to enable them to provide a consistently high standard of end of life care.

Appendix 1

South Sefton CCG & Southport & Formby CCG: 5 Year Strategic Plan Engagement Schedule

Date	Event	Purpose
30th January 2014	Adult Health & Social Care Forum	Overview & scene setting of CCG 5yr Strategic Plan & share engagement schedule for input.
5th February 2014	Healthwatch steering Group	Overview & scene setting of CCG 5yr Strategic Plan plus Programme discussions
6th February 2014	Mini Chat: Southport & Formby	Overview & scene setting of CCG 5yr Strategic Plan plus Programme discussions
7th February 2014	Mini Chat: South Sefton	Overview & scene setting of CCG 5yr Strategic Plan plus Programme discussions
26th February	Mental Health Service users Forum	Overview & scene setting of CCG 5yr Strategic Plan & ask advice on specific user engagement to inform Programme plan.
15th March 2014	CVS led Mental Health Service user event	Discussion of mental health service experience and ideas for developing services to feed in to strategy development
20th March	Every Child Matters Forum	Overview & scene setting of CCG 5yr Strategic Plan & share engagement schedule for input.
21st March 2014	HW community chat Sefton OPERA and Brunswick Youth and Community Centre	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
31st March 2014	HW community chat Galloways Society for the Blind	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.

1st April 2014	HW community chat People First	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
2nd April 2014	HW community chat – Bowersdale Centre	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
10th April 2014	HW community chat Alzheimers Society	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
11th April 2014	Mental Health service user forum	Sharing feedback from user led event to include in strategy development
14th April 2014	HW community chat May Logan Knit and natter group	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
22nd April 2014	HW community chat – Cambridge Road Children's Centre	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
2nd May 2014	HW community chat – Sefton Carers, Southport service station	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
7th May 2014	HW community chat – Breathe Easy Group	Community conversations led by HW re: CCG 5yr Strategic Plan for input to strategy development.
8th May 2014	Feedback chat	Sharing information leaflets showing how information gathered so far has been used to help develop strategy
13th May 2014	Feedback chat	Sharing information leaflets showing how information gathered so far has been used to help develop strategy