NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

COMMISSIONING STRATEGY, VISION AND BLUEPRINT FOR TRANSFORMATION PROGRAMMES

NHS Southport and Formby CCG and NHS South Sefton CCG Version 1.10 – June 2015

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FOREWORD

Over the last year our two Clinical Commissioning Groups, South Sefton and Southport and Formby have spoken to people across Sefton about their own health conditions, the services they access, their experiences of local health care and the kind of care and support they want to help them get back to independent living.

The case for change across the whole health and social care system is made by the need to address the demands arising from an ageing population, increasing numbers of people with multiple long-term conditions and significant reductions in public expenditure.

Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place. We are therefore working in collaboration with our health and social care colleagues and partners across Sefton to define the ***'New Models of Care'*** required for Sefton residents, with a particular emphasis on ***'Integrated Care'***.

Delivery of these models requires strong leadership, effective partnership working and a commitment to deliver change. Success will be measured on the improved health and care outcomes for our Sefton residents.

As public sector organisations we are facing unprecedented challenges and we need to ensure we can support increasing demand, as well as improving the quality of care provided patients, with more limited resource.

Fiona Clark
Chief Officer
CCGs in Sefton

Dr Rob Caudwell
Chair
NHS Southport and Formby CCG

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NHS South Sefton CCG

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

EXECUTIVE SUMMARY

Clinical commissioning groups are the statutory bodies responsible for commissioning local health services for local communities. The people we serve deserve to have a premium quality health service. Working together, South Sefton and Southport and Formby clinical commissioning groups have engaged with key stakeholders in the wider local health economy and with local people to identify priorities for improving health and health care.

As two CCGs we have identified three main strategic priority areas as the focus for all our work:

- Caring for our older and vulnerable residents
- Unplanned care
- Primary care

This strategy is at a point in time in terms of its development and alignment. Alongside the development of the CCG plans, we are working with partners on the delivery of our system wide Vision for 2020. In recent weeks the CCGs and its partners across health and social care have begun a process to strengthen planning and delivery of our future system and this was launched through a successful event titled 'Shaping Sefton', held in February 2015.

The event was supported by the King's Fund, who demonstrated evidence of the benefits, in particular to the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be co-ordinated around the needs of people and populations.

We will build on this event and undertake an in depth process with our partners to include more detailed agreement of the whole system programmes to be undertaken and work to establish cross-organisation governance protocols.

Therefore the CCGs key transformational programmes described later in this document are representative in terms of purpose and content, but will continue to be refined as we work with partners in the system to develop plans and mobilse resources. The intention is to harmonise effort into one single plan for the system.

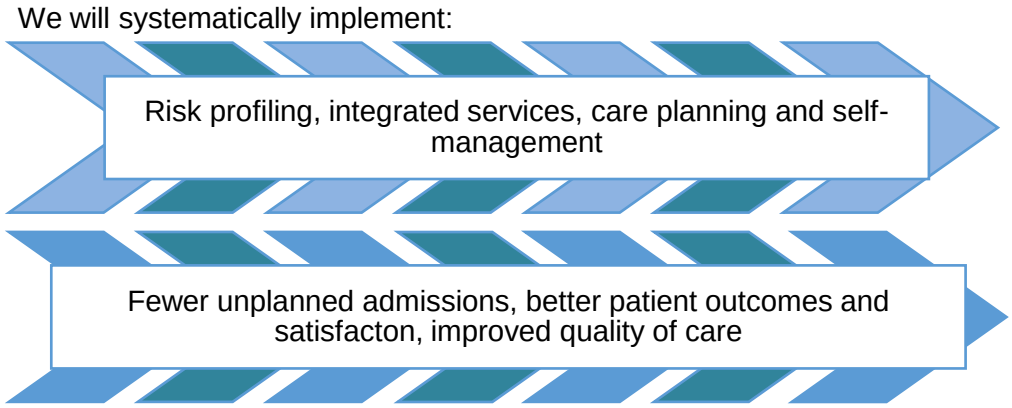
Integrated care is a key lever to commission for patient outcomes. From direct NHS health care services through to social care and voluntary services, who can provide additional on-going support for recovery and management. Every service provider will be expected to work together to improve overall outcomes of service users.

Whilst there are services available in the community to support people to manage their long term conditions and help prevent hospital admissions, these are not comprehensive and sometimes 'dis-jointed', also information sharing is limited. Services are not always straight forward to access or able to offer a rapid response and are not as well-known as emergency departments.

We will commission integrated out of hospital services, which support all patients especially those with long term conditions. In doing so, we aim to:

- Decrease the gap between expected prevalence and recorded prevalence of long term conditions
- Improve the health outcomes for people who have been diagnosed with a long term condition
- Increase the provision of healthcare in the community for people who have been diagnosed with a long term condition
- Reduce inequalities in the identification of treatment and services for people with long term conditions
- Support people with long term conditions to maintain their quality of life through being better able to manage their own care
- Provide more care closer to home

We are keen to drive forward integrated care, giving explicit consideration to ways we can increase joint working.



The core of the diagram below has been developed by the Kings Fund and outlines the different stages of care, it has been enhanced to show what services in Sefton available to support our residents at each of the individual stages. The vision will be to deliver care at neighbourhood level through integrated locality teams based on the needs of the residents.

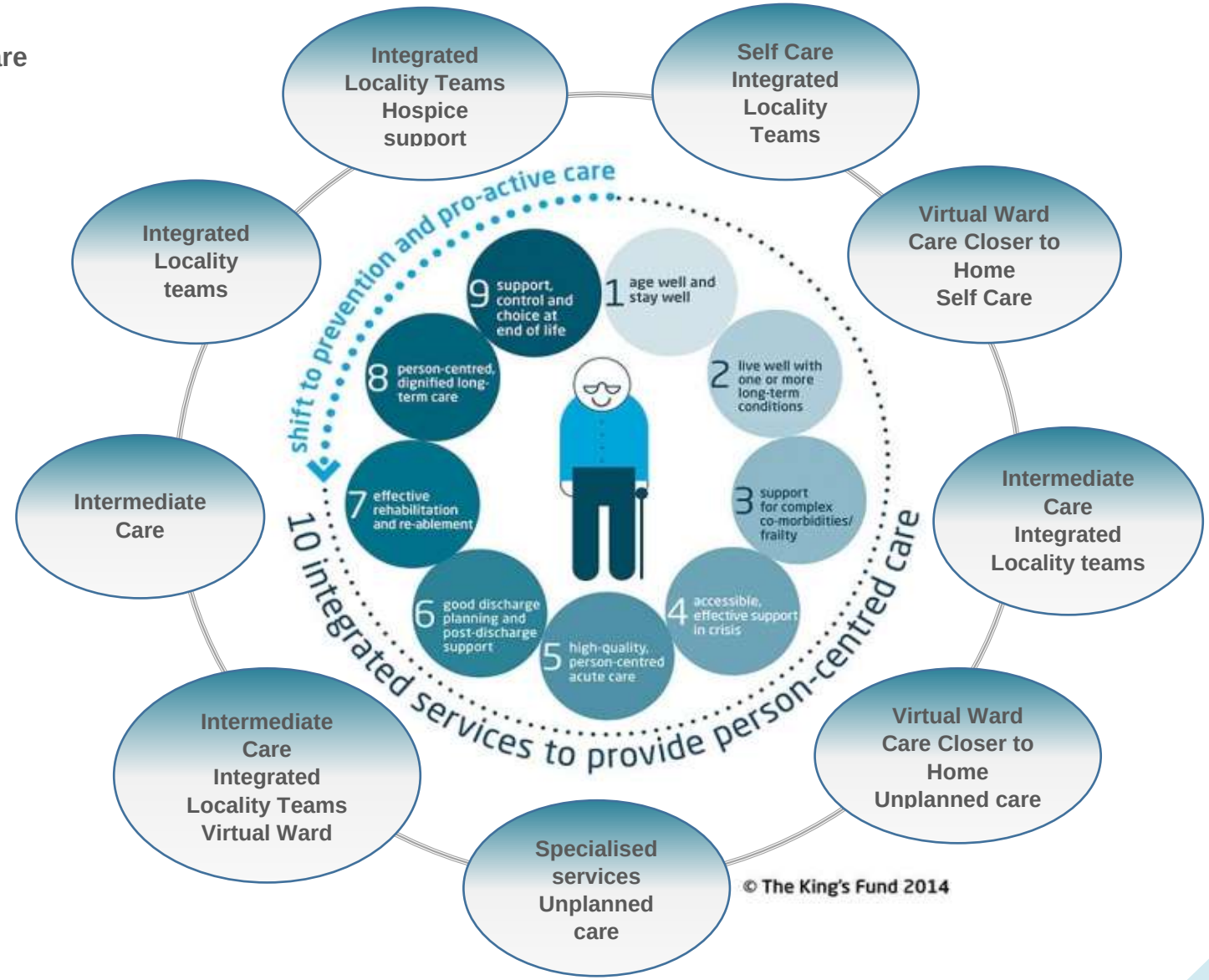
Diagram one:
Components of Care

South Sefton Localities:

- Bootle
- Crosby
- Maghull
- Seaforth and Litherland

Southport and Formby Localities:

- Ainsdale & Birkdale
- Central Southport
- Formby
- North Southport

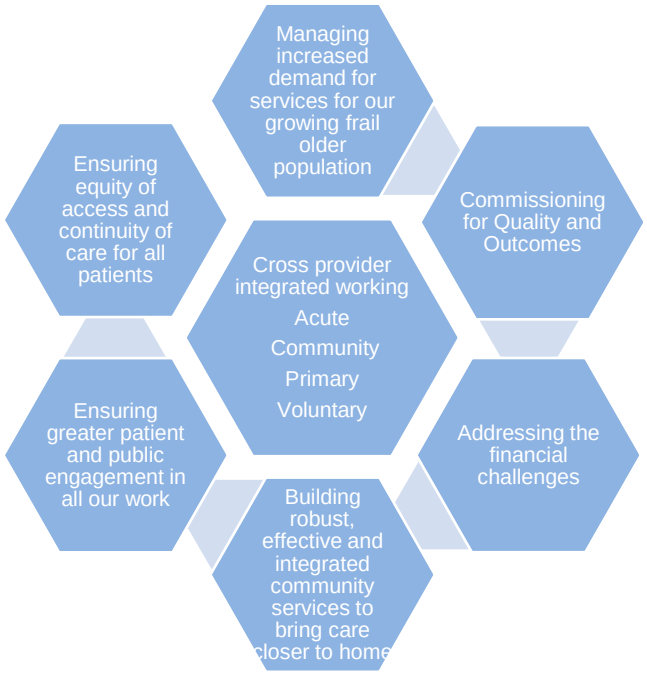


INTRODUCTION

The purpose of this document is to describe the aims and ambitions for our transformation programmes and how we are working across the health and social care system to improve quality and outcomes for our patients, as well as drive efficiencies and achieve sustainable services that meet the needs of our local population and improve outcomes. This documents articulates the changes required within the Sefton health and social care system and how the commitments made to implement our vision are being translated into programmes of work.

We describe our major transformation programmes, highlighting what we are doing and how we plan to do it amidst a national context of profound financial challenge.

We know there are specific underlying challenges in our local health economy that we must address over the next two years and into the future if we are to achieve our vision:



- The system is too complicated: it has grown organically, not strategically
- Access to many services is limited, because the system is difficult for both patients and professionals to navigate
- In particular, the system is failing to provide co-ordinated and integrated care for frail elderly and patients with complex needs
- Prevention and early treatment services are often inadequate, allowing patients to continue 'cycling' around the system until their issue become acute
- A&E is the easiest part of the system for patients to access, hence receives the largest flows
- Queues build up in A&E as a result of difficulties with flow management
- Information is not shared effectively between, and sometimes within, provider organisations

BLUEPRINT

A blueprint is used to define a programme of transformational change. It articulates the future state in more detail than a high-level vision and sets out the operational capability that will need to be put in place to enable the required outcomes and benefits. The blueprint comprises the key aspects of the business operations of not only the CCGs but also all stakeholders that must change for the system to work.

This document provides an outline of how comprehensive healthcare services for physical and mental health for all age groups and its interactions with social care could be configured in the future to maintain and improve patient experience and clinical outcomes while demand for care increases despite increasingly tight budgetary constraints.

It is a model for how services should be configured regardless of the organisations involved of its delivery. It has been designed based on input by a broad base of stakeholders that included representatives of all local providers, commissioners, patients and the general public of Sefton. We will build on this model with our partners to include more detailed agreement of the whole system programmes to be undertaken and work to establish cross-organisation governance protocols

This document is focused on the following Transformational Programmes currently underway across Southport and Formby CCG and South Sefton CCG:

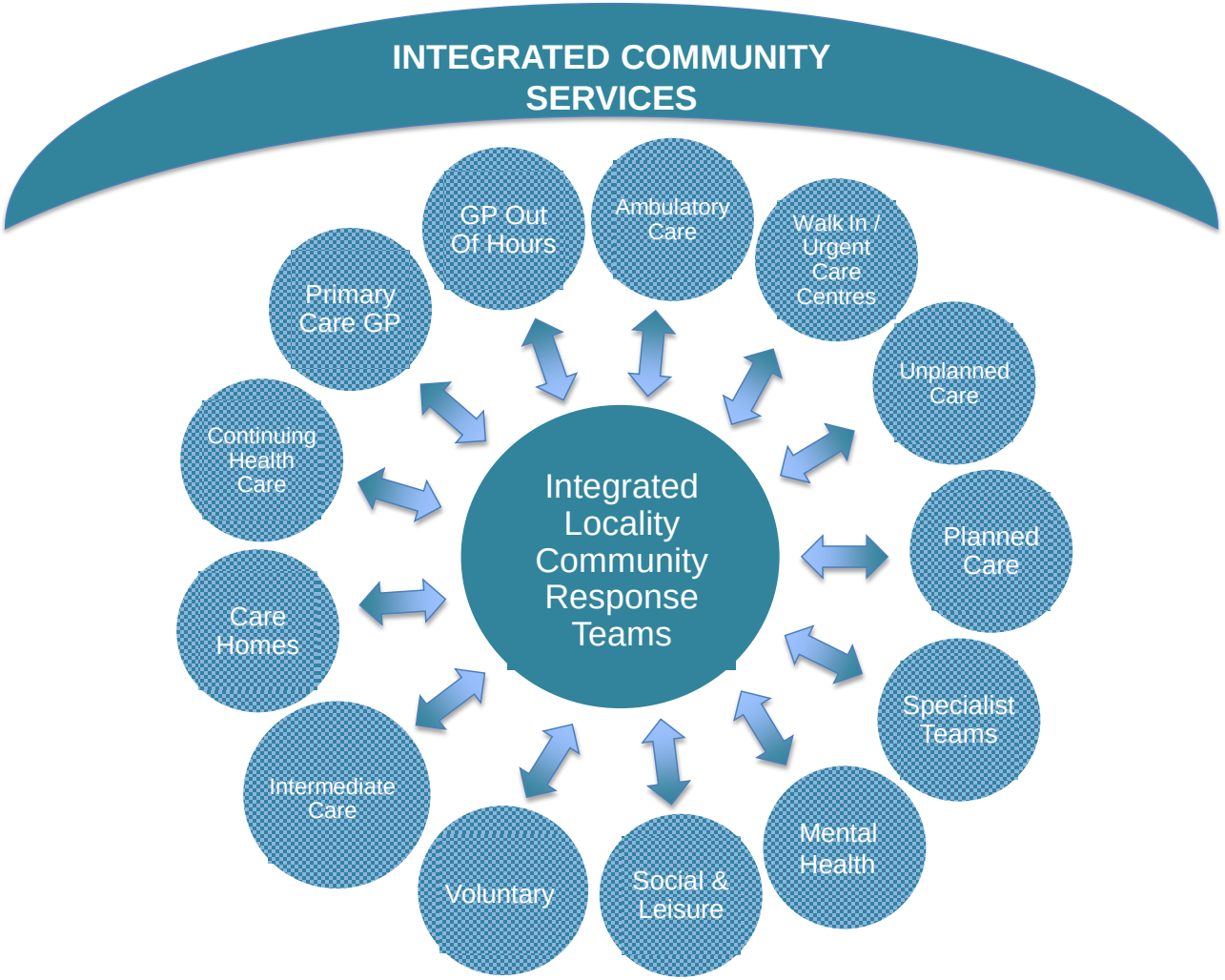
- Primary Care
- Community Care
- Intermediate Care
- Urgent Care
- Mental Health

These programmes are central to our vision for integrated, personalised services in Sefton. An additional work programme focussing on elective and planned care is currently being scoped to identify additional opportunities to provide care closer to home.

A whole system approach has been developed to focus the model of care required to deliver integrated services. The system blueprint model for integrated services is shown in Diagram two below:

Diagram Two:

System blueprint for Integrated Community Services



OUR VISION - SOUTH SEFTON AND SOUTHPORT AND FORMBY CLINICAL COMMISSIONG GROUPS

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

Our vision will be delivered in collaboration with our partners through our high impact transformation programmes. These programmes will focus on three key principles:

- Whole system transformation with collective ownership and culture change of all partners
- Patient pathways rather than organisational structures
- Clinical and patient led

OUR AIMS	• An empowered workforce with a common understanding of our vision • Breaking down of silos – building trust amongst organisations • Organisations have shared responsibility for issues in the health economy • Autonomy to act beyond organisational boundaries
KEY ENABLERS	• Access to shared medical records and care plans for all care professionals anywhere • Improved communications and relationships between all care professionals • Risk management across the system contributing to more efficient and effective care (financial risk and clinical governance) • Financial and contractual levers aligned
KEY DELIVERABLES	• Reduce hospital avoidable deaths by 13% • Improve health related quality of life for people with one or more long term conditions by 8.5% • Reduce emergency admissions by 20% • Achieve a 3.5% reduction in non-elective activity • Improve in-patient experience by 13% • Improve patient experience in GP and out of hours care by 30%

POTENTIAL CHALLENGES TO DELIVERY:

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

NEXT STEPS

- Undertake an in depth process with our partners to include more detailed agreement of the whole system programmes enabled through the overarching Shaping Sefton programme
- Establish cross-organisation governance protocols
- Agree phased priority approach
- On-going evidence-based analysis of outcomes of new care models
- Regular review of programmes against plan
- Changes to be implemented from years 2015/16, with whole system change embedded by 2020

This document, and our vision for integrated and co-ordinated care, aligns to the vision and objectives set-out in The NHS Five Year Forward View "High quality care for all, now and for future generations"[1].

It also supports the recommendations outlined in The Dalton Review[2], which focusses on reducing variation in the quality of care across Provider organisations and developing new organisational forms. It encourages organisations to look at developing models of care that best suit local circumstances and individuals rather than existing organisational structures. This document reflects those recommendations and focusses on the patient receiving the right care at the right time and in the right place.

Integration is built upon collaborative working, shared decision making and jointly defined priorities. We have worked with our partners and patient representative groups to ensure our local priorities are appropriately aligned.

[1] Five Year Forward View NHS England October 2014 http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] Examining new options and opportunities for providers of NHS care The Dalton Review December 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

BETTER CARE FUND

The Better Care Fund (BCF) provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients, services users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare the Better Care Fund in 2015/16[3]. Local Better Care Fund plans must meet a number of national conditions:

- Plans must be jointly agreed and include an explanation of how local adult social care services will be protected;
- Include how 7-day services in health and social care will support patients being discharged and prevent unnecessary admissions at weekends;
- Use the NHS number to enable better data sharing between health and social care;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional; and
- Consider the impact of changes on the acute sector.

The Health and Wellbeing Board in Sefton has worked together with local people, communities and partners to develop a Vision for the Borough. Our vision is:

Together we are Sefton – a great place to be!

We will work as one Sefton for the benefit of local people, businesses and visitors

Underpinning the Health and Wellbeing Vision is the promise that in commissioning and delivering services the different partners, stakeholders and organisations in Sefton will work together to seek to improve the health and wellbeing of everyone, with the resources available.

Our vision for integration is to deliver personalised coordinated care,

health and wellbeing services with, and around, the person

[3] http://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance-1516.pdf

By working together and aligning our resources, we aim by 2020 to:

- 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

We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults, and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment, and provide early support so that people can remain independent for longer.

We aim to provide cost effective support in the right place, at the right time, at the right quality, and we will seek to achieve this by focussing on the following key integration schemes:

- Promoting self care, well-being and prevention through the development of an ***Integrated Wellness and Health Improvement Service***, a Healthy Places Healthy Homes initiative (to address housing, environment, transport and employment) and a robust information and advice service. The Healthy Places scheme seeks to tackle the "causes of the causes" of ill health and reduce demand on both wellness and illness services
- Building on the existing ***Virtual Ward and Care Closer to Home programmes*** to deliver *integrated care at a locality level* - which will deliver greater coherence of processes, methods and tools used by all at a locality level, supported by integrated teams; - *delivering better patient experience and health outcomes in support of a reduction in unplanned admissions to hospital*
- Deliver *a* ***new Intermediate Care and Reablement pathway*** to support more people to receive intermediate care and reablement services based on need and pulling together a joint strategy for intermediate care focussing on delivering care closer to home; *with the aim of helping people regain their ability to carry out activities of daily living and reduce need for long term care packages*

These schemes will offer better, early intervention and prevention opportunities promoting greater self-care/self-help/self-management and a reduction on reliance of public sector services. This will be achieved by appropriate advice and information, and integrated approaches to service provision across professional and organisational boundaries through a single point of access (a seamless front door).

These schemes align to the CCGs transformation programmes and will be supported by a series of enablers, namely:

- a single point of access for all service users, supported by integrated single assessments
- transformational leadership - changing behaviours and cultures in the workforce
- enablement of appropriate sharing of person specific data, risk stratification tools and information across partner agencies
- a consistency of messages through a regular communications and engagement process
- an integrated approach across the CCG's and Council, whereby all engagement relates and contextualises integration and the Better Care Fund as part of our joint strategic approach
- development of a robust integrated commissioning process for all health and social care provision
- support for the changes, through effective finance & resource management

We are focusing on a core cohort of people – those with mental health issues, dementia, and other long term conditions and the frail elderly and people who care for others - an approach which aligns with the continued ambitions of the Health and Wellbeing Board in protecting the most vulnerable.

These deliverables are consistent with, and evidenced through, the feedback and data within our Sefton Strategic Needs Assessment, the Health and Wellbeing Strategy, the Strategic Plans for NHS Southport and Formby and South Sefton CCGs as well various forums and patient engagement events - including "Big Chat", "Mini Chat" and "Community Chats" events hosted throughout the Borough. The Health and Wellbeing Board has also utilised the National Voices approach to ensure that the public, patients and service users (including carers) have directly influenced the priorities within our Health and Wellbeing Strategy.

SEFTON PEOPLE AND THEIR NEEDS

Sefton Strategic Needs Assessment

The Sefton Strategic Needs Assessment (SSNA) [4] provides the data and intelligence on which the commissioning and delivery of health and social care services is based. We have a duty to have regard to the SSNA when developing our plans for health services for the local population. Sefton Council also use the SSNA to shape commissioning strategies for adult, children's and public health services. Together, the partners on the Health and Wellbeing Board use the SSNA to set the Sefton Health and Wellbeing Strategy 'Living Well in Sefton' and inform joint commissioning priorities.

The SSNA 2014/15 has taken a different approach to previous years and is based on the principle that understanding health and wellbeing first requires an understanding of the ***people*** who live and work in the Borough, the ***place*** and the influences on health across the ***life course*** (being born, growing up, being an adult and growing old in Sefton). The benefit of this life course approach is that it encourages thinking around the broad range of factors that impact on health and wellbeing at different stages of life and helps to promote a joined up strategic approach across the Health and Wellbeing Board and its partners.

A summary of the key issues, are included below.

[4] http://sefton.gov.uk/your-council/plans-policies/strategic-needs-assessment-(ssna).aspx

SEFTON PEOPLE AND THEIR HEALTH NEEDS

Children and Young People

- One in five children live in **low income** families
- One in five 14-17 year olds state they drink **alcohol** once a week
- 13% of 14-17 year olds claim to **smoke**
- By year 6 one in three children are **overweight or obese**
- **Low birth weight** babies

Long Term Conditions

- One in four have their day-to-day **activities limited** due to a long term condition
- **COPD** – two out of every three sufferers resides in South Sefton
- More than 11,000 Sefton residents are registered as having **chronic liver disease**
- 13,171 residents suffer from **Diabetes** which is predicted to increase by 14% by 2030
- One in 16 suffer from **Asthma**
- One in six suffer from **high blood pressure**
- Incidence rate of **Cancer** in Sefton is significantly higher than the national rate

Older People

- **Ageing population** set to increase further by 2021
- 49% predicted increase in **Dementia** sufferers between 2015 and 2030
- 57% of **Diabetes** sufferers over 65
- **Joint replacements** account for 15% of elective admissions
- Higher mortality rates for **COPD** and **Heart Attack** against the national average

Lifestyle

- 560 patients admitted annually to hospital with **drug** related conditions
- One in five adults admit to **binge drinking**
- One in five adults are **smokers**
- 14.7% of pregnant mothers are **smokers** at time of delivery
- More than half of adults in Sefton are **overweight, obese** or **very obese**
- 7.3% of Sefton residents classify themselves as in **bad** / **very bad health**, compared to 5.5% across England

Mental Health

- Around one in five females and one in eight males are thought to have some sort of **mental illness**
- South Sefton CCG amongst top 10% of CCGs for sufferers of **Depression**
- **Anti depressant** prescribing in Sefton in 13/14 totalled £1.7m
- Three in four **suicides** are male
- There has been a 47% increase in emergency hospital admissions over the last five years for people with **Schizophrenia**

Further detailed information on both the JSNA and the Health and Wellbeing Strategy can be found at:

http://sefton.gov.uk/your-council/plans-policies/strategic-needs-assessment-(ssna).aspx

http://www.sefton.gov.uk/media/450582/health-wellbeing-strategy-2014.pdf

OUR STRATEGIC PLANNING PROCESS

Throughout 2014 a series of events and meetings were held to inform and support the future model of commissioning for South Sefton CCG and Southport and Formby CCG. Partners from across the health economy including, patients, clinicians, and representatives from the community and voluntary sector were invited to these events and the outputs have informed the future model described in this document.

Both Commissioners and Providers of services to the localities have agreed that the work must focus on meeting population health needs, patients must be at the centre of this transformation.

The size of this change cannot be underestimated. It is a large scale change in terms of the level of ambition, the number of organisations involved and the emergent final state. The scale of change is a leadership challenge and will require distributed leadership to deliver the significant process, structure and cultural change.

The next steps will be for the health economy to continue working together to agree the financial and activity/contractual agreements and for operational and clinical staff to work together across organisational boundaries to deliver the vision for the Sefton population.

We will deliver our vision through the following five transformational programmes:	
Primary Care	**We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.**
Community Care	**We will commission services that better link together right across health and social care – from hospital 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.**
Unplanned Care	**We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.**

Intermediate Care	**Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.**
Mental Health	**Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long term neurological condition within community based networks of care**

Our transformation service models will all encompass the following six characteristics:

New approaches to ensuring the citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	**Wider primary care provided at scale, bringing services closer to home**	**A model of integrated care between health, social and the third sector**
Access to the highest quality urgent and emergency care when appropriate	**A stepped change in the productivity of elective care**	**Specialised services concentrated in centres of excellence**

PHASED DELIVERY APPROACH:

Throughout the planning of our programmes we are adopting a four phased delivery approached, outlined below:

Phased Approach			
Phase One **Assessment**	**Phase two** **Strategic Planning**	**Phase three** **Implementation**	**Phase four** **Delivery**
Situation summary Recognise the need for change either to solve a problem or take advantage of an opportunity ➢ Review evidence that a change is required via stakeholder engagement, data analysis and reports on service provision. Test out others' views on the need for change ➢ Networking and establishing connections across health and social care to test current service provision including review of patient experience data Using appropriate diagnostic techniques, confirm the presence of hard complexity and difficulty rather than a mess ➢ Current data analysis re patient flows between services in acute and community, interaction with third sector organisations	**Generate options** Develop ideas for change into clear options for achievement of the objectives ➢ Engage provider re discussions about areas of excellence in service provision and ideas the provider and local authority may have re service improvement. Understand national examples of excellence. Consider range of options ➢ Link providers to consider alternative provision	**Develop Implementation strategies** Select preferred options and plan how to implement ➢ Finalise implementation plan with CCG, providers and Local Authority ➢ Agree implementation plan with provider	**Implement performance dashboard** Agree set of metrics to be monitored and reported on ➢ Discuss and agree with Providers as necessary

Identify objectives and constraints	**Edit options and detail selected options**	**Carry out the planned changes**	**Monitor Activity and Performance**
Set up objectives for systems of interest ➢ Review national guidance as to performance measures. ➢ Understand referral patterns and challenges to service delivery.	Fully describe chosen option ➢ Present findings to senior leadership team within the CCG and Local Authority ➢ Informal sharing with providers Decide what is in scope and how it will work ➢ Understand wider financial pressures and impact upon project. ➢ Agree financial value to provide scope for changes Open engagement with provider as to change model ➢ Link with provider organisations to discuss and shape likely vision for future delivery Consider whether higher level change is feasible ➢ Understand funding mechanism arrangements between CCG and local authority. Develop operational detail of pathway ➢ Plan stakeholder engagement event, in partnership between CCG, Local Authority, acute and community providers, to understand the challenges and	Involve all interested parties ➢ Seek approval from CCG Membership ➢ Seek ratification by CCG Board ➢ Publish Strategy Allocate responsibilities ➢ Discussions with provider ➢ Agree Commissioning Intentions ➢ Contractual levers Monitor progress ➢ Develop performance dashboard	Receive activity reports ➢ Frequency to be agreed dependent upon provider/activity ➢ To be based on outcomes Report Activity ➢ Agree reporting structure and frequency to various stakeholders Highlight issues ➢ Review activity and performance and highlight issues/concerns with relevant provider and SMT

	facilitate discussions to progress project.		
Identify performance and measures Describe how the achievement of the objectives can be measured ➢ Discuss feasibility of data collection with service providers. Benchmark service delivery – outcomes and performance - against proposed measures ➢ Request and collate evidence from providers Benchmark service delivery – patient experience - against proposed measures ➢ Request and collate evidence from providers to form benchmark against which to monitor future performance.	**Evaluate options and measures** Finalise operational details of pathway ➢ Summarise findings and circulate to all parties. ➢ Evaluate requirement for framework/memorandum of understand. Evaluate the performance of the chosen options against performance criteria identified ➢ Formally present outline strategy to CCG and local authority ➢ Outline new performance measures with providers and reinforce data collection Wider clinical engagement ➢ Engage clinicians for comments on strategy		
	Governance Strategic and operationalisation ➢ Draft Governance framework ➢ Agree Governance framework Legal framework ➢ Draft Memorandum of Understanding ➢ Execute Memorandum of Understanding		

FINANCIAL

The overriding financial strategy is to safeguard a long term sustainable financial position which ensures the CCGs overall objectives around patient care for our population can be achieved.

This can only be attained through sensible and realistic financial planning, a measured approach to risk and long term view of the local health system, which will mean difficult financial decisions will have to be taken.

Sefton health economy faces significant financial pressures - those experienced currently requiring additional support, and those anticipated into the future for which there is unlikely to be support available from external sources. This means that the basis upon which commissioners fund services will need to change radically so that it can continue to provide for the care needs of the community now and into the future.

Significant investment is going to be required to redesign and rebalance the system so that it is both effective and affordable. For us to manage pressures in a sustainable way the shape and size of existing providers will need to change dramatically, with more care being provided outside of acute settings and greater emphasis on community partners to manage and reduce overall demand entering into the care system. We will need to work collectively across the health and social care system to share resources and remove unnecessary duplication. Patient centred care provision will mean cross organisational boundaries and funding mechanisms need to change to facilitate and incentivise this.

Projected gap in 5 year if do nothing

The choice to 'Do Nothing' is not an option, outlined below is the annual profile. You will notice the pressure is primarily front-loaded in 15/16 and 16/17 this is to embed the transformational programmes outlined in the blueprint.

		2015/16 (£m)	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	Total (£m)
Southport and Formby CCG	Incremental QIPP Requirement	6,052	3,622	772	1,066	11,512
South Sefton CCG		3,437	4,904	1,361	1,966	11,668

Diagrams 3 and 4 below illustrate each CCG's spending on health by high level category of care

Diagram 3: South Sefton CCG total budget spend = approximately £230m

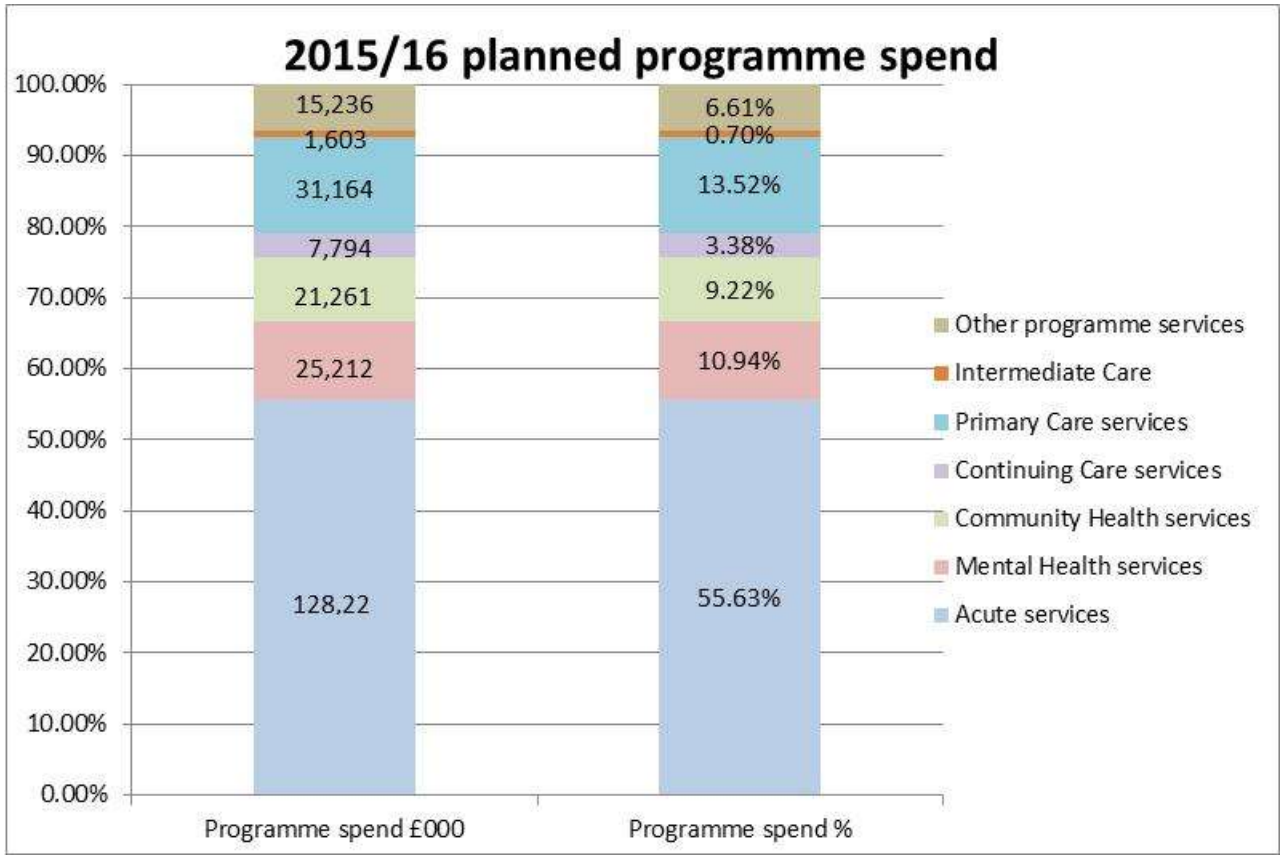


Diagram 4: Southport and Formby CCG total budget spend = approximately £170m

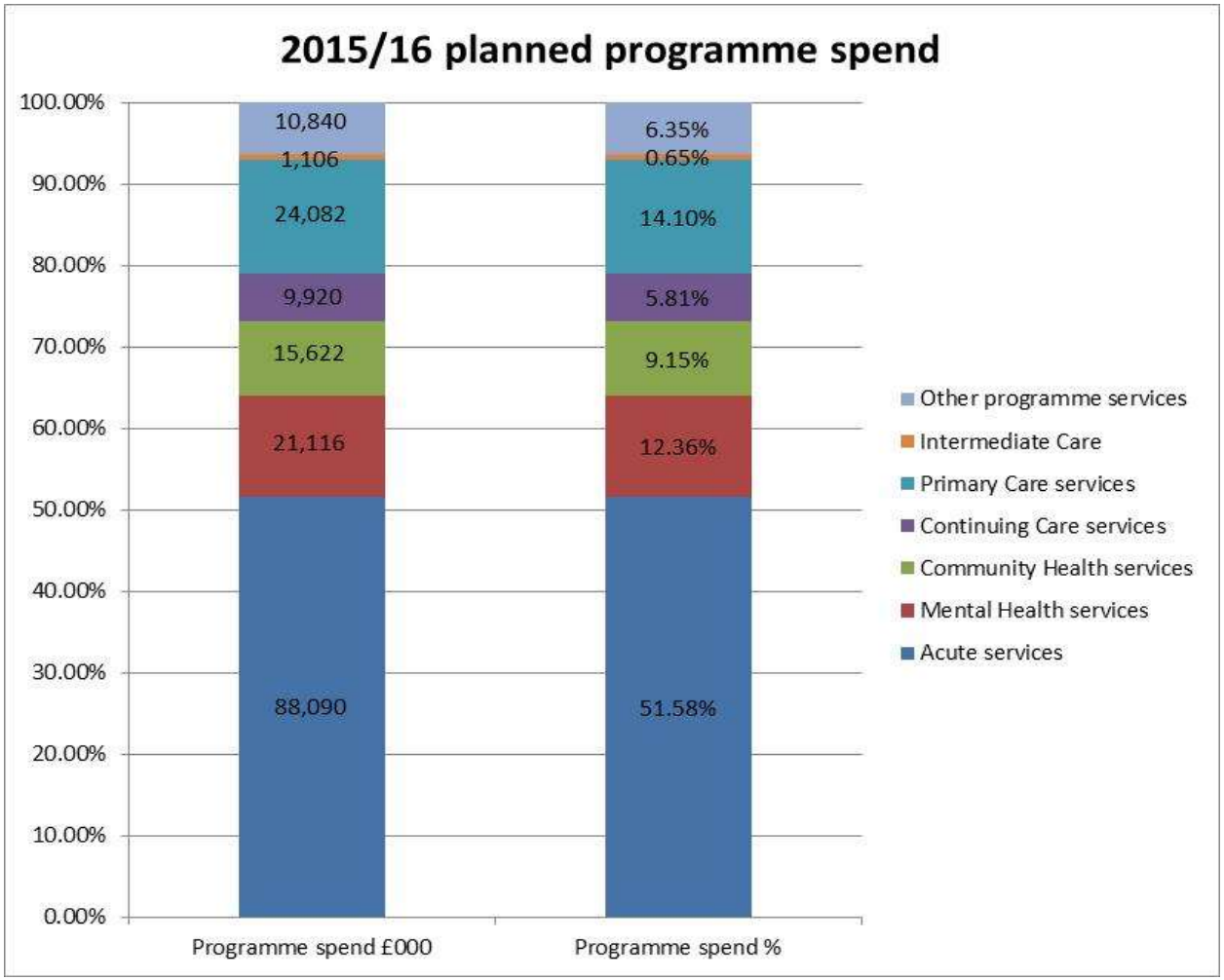


Table one below outlines the potential savings that could be generated from a 15% reduction in unplanned admissions for South Sefton CCG

Table 1: 15% reduction in unplanned admissions

South Sefton CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	£21,796,036	11,804	£26,155,244	14,165
Alder Hey Childrens NHS F/T	£973,958	681	£1,168,749	817
Central Manchester University Hospitals Nhs Foundation Trust	£4,800	5	£5,760	6
Countess of Chester Hospital NHS Foundation Trust	£9,464	10	£11,357	12
East Cheshire NHS Trust	£1,099	2	£1,318	2
Liverpool Heart and Chest NHS F/T	£108,226	50	£129,872	60
Liverpool Womens Hospital NHS F/T	£2,157,781	1,233	£2,589,338	1,480
Royal Liverpool & Broadgreen Hospitals	£1,398,842	841	£1,678,611	1,009
Southport & Ormskirk Hospital	£1,657,495	1,484	£1,988,994	1,781
ST Helens & Knowsley Hospitals	£268,465	231	£322,158	277
University Hospital Of South Manchester Nhs Foundation Trust	£1,867	3	£2,240	4
Wirral University Hospital NHS F/T	£53,007	53	£63,609	64
Wrightington, Wigan And Leigh Nhs Foundation Trust	£13,407	8	£16,088	10
			£34,133,337	**19,686**
	Average price			£1,734
	15% reduction in activity			2952.9
	15% reduction in cost at average Non-elective tariff			**£5,120,001**

Table two below outlines the potential savings that could be generated from a 15% reduction in unplanned admissions for Southport and Formby CCG

Table 2: 15% reduction in unplanned admissions

Southport and Formby CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	593,553	309	£712,264	371
Alder Hey Childrens NHS F/T	293,583	172	£352,300	206
Central Manchester University Hospitals Nhs Foundation Trust	13,076	16	£15,691	19
Countess of Chester Hospital NHS Foundation Trust	1,239	2	£1,486	2
East Cheshire NHS Trust	1,604	2	£1,925	2
Liverpool Heart and Chest NHS F/T	338,420	103	£406,104	124
Liverpool Womens Hospital NHS F/T	142,928	78	£171,514	94
Royal Liverpool & Broadgreen Hospitals	446,341	203	£535,609	244
Southport & Ormskirk Hospital	19,704,834	12,891	£23,645,800	15,469
ST Helens & Knowsley Hospitals	142,439	119	£170,927	143
University Hospital Of South Manchester Nhs Foundation Trust	5,373	9	£6,448	11
Wirral University Hospital NHS F/T	28,359	23	£34,031	28
Wrightington, Wigan And Leigh Nhs Foundation Trust	13,534	10	£16,241	12
			£26,070,340	**16,724**
	Average price			£1,559
	15% reduction in activity			2508.66
	15% reduction in cost at average Non-elective tariff			**£3,910,551**

Table three below outlines the potential savings that could be generated from a 20% reduction in A&E attendances for South Sefton CCG

Table 3: 20% Reduction in A&E attendances

South Sefton CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	2,837,109	25,883	£3,404,531	31,060
Alder Hey Childrens NHS F/T	571,095	6,593	£685,313	7,912
Central Manchester University Hospitals Nhs Foundation Trust	6,569	62	£7,883	74
Countess of Chester Hospital NHS Foundation Trust	3,955	43	£4,747	52
East Cheshire NHS Trust	1,072	9	£1,287	11
Liverpool Womens Hospital NHS F/T	134,016	1,452	£160,819	1,742
Royal Liverpool & Broadgreen Hospitals	310,362	3,646	£372,435	4,375
Southport & Ormskirk Hospital	424,075	4,453	£508,890	5,344
ST Helens & Knowsley Hospitals	39,757	430	£47,709	516
University Hospital Of South Manchester Nhs Foundation Trust	2,492	25	£2,990	30
Wirral University Hospital NHS F/T	17,718	163	£21,261	196
Wrightington, Wigan And Leigh Nhs Foundation Trust	3,937	38	£4,724	46
			£5,222,589	**51,356**
	Average price			£101.69
	20% reduction in activity			10271.28
	20% reduction in cost at average A&E tariff			**£1,044,518**

Table four below outlines the potential savings that could be generated from a 20% reduction in A&E attendances for South Sefton CCG

Table 4: 20% Reduction in A&E attendances

Southport and Formby CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	76,183	721	£91,419	865
Alder Hey Childrens NHS F/T	37,791	443	£45,349	532
Central Manchester University Hospitals Nhs Foundation Trust	7,157	76	£8,588	91
Countess of Chester Hospital NHS Foundation Trust	3,228	32	£3,873	38
East Cheshire NHS Trust	1,086	10	£1,303	12
Liverpool Womens Hospital NHS F/T	9,033	95	£10,839	114
Royal Liverpool & Broadgreen Hospitals	55,263	657	£66,315	788
Southport & Ormskirk Hospital	3,072,763	29,930	£3,687,315	35,916
ST Helens & Knowsley Hospitals	15,584	178	£18,701	214
University Hospital Of South Manchester Nhs Foundation Trust	2,279	21	£2,734	25
Wirral University Hospital NHS F/T	4,948	48	£5,938	58
Wrightington, Wigan And Leigh Nhs Foundation Trust	4,379	44	£5,254	53
			£3,947,631	**38,706**
	Average price			£101.99
	20% reduction in activity			7741.2
	20% reduction in cost at average A&E tariff			£789,526

Table five below outlines the potential savings that could be generated from the management of new to follow up rates for South Sefton CCG

Table 5: management of new to follow up rates

Areas identified as outliers compared to peers New to follow ups to:	Annual value of cost reduction	Reduction Average Follow up = £100
National Average: Aintree University Hospitals FT - Rheumatology	218,000	2180 appointments
National Average: Liverpool Womens Hospitals - Gynaecology	188,000	1880 appointments
National Average: Royal Liverpool Broadgreen University Hospitals - Ophthalmology	53,000	530 appointments
Current plan – Southport & Ormskirk Trust - Rheumatology	10,000	100 appointments
Current plan - Renacres – Trauma & Orthopaedics	47,000	470 appointments
Total	**516,000**	

Table six below outlines the potential savings that could be generated from the management of new to follow up rates for Southport and Formby CCG

Table 6: management of new to follow up rates

Areas identified as outliers compared to peers New to follow ups to:	Annual value of cost reduction	Reduction Average Follow up = £100
National Average: Aintree University Hospitals FT - Rheumatology	40,000	400 appointments
National Average: Liverpool Womens Hospitals - Gynaecology	27,000	270 appointments
National Average: Royal Liverpool Broadgreen University Hospitals - Ophthalmology	76,000	760 appointments
Current plan - Southport & Ormskirk Trust - Rheumatology	196,000	1960 appointments
Current plan - isight - Ophthalmology	16,000	160 appointments
Current plan - Renacres – Trauma & Orthopaedics	63,000	630 appointments
Total	**418,000**	

Planning assumptions

The CCGs maintain a five year financial planning model that provides a view of future financial sustainability and saving requirements. This financial model has been updated in the light of NHS England Planning Guidance for 2015/16 and revised CCG allocations, both published in late December 2014.

- Key financial planning assumptions are in line with national guidance as set out in *The forward view into action: planning for 2015/16* and supporting guidance issued by NHS England;
- Funding has been set aside from the allocation received for non-recurrent expenditure as specified in the guidance. This equates to 1.0% in 2015/16, plus a further contingency of 0.5%;
- Running costs will not exceed the allocation for this purpose;
- Clinical Commissioning Groups are required to make a surplus equivalent to 1% of allocation received.

Table seven below outlines the five year planning assumptions for both CCGs.

Table 7:

	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19
	%	%	%	%	%
Allocation assumptions					
CCG Allocation Growth	2.14%	1.94%	1.30%	1.70%	1.90%
Movement to Target	0.00%	0.00%	0.00%	0.00%	0.00%
Net Growth/(reduction)	**2.14%**	**1.94%**	**1.30%**	**1.70%**	**1.90%**
Running Costs assumptions					
Running Cost Allowance		-10.00%			
Cost increase assumptions					
Tariff assumptions - provider inflation	2.80%	2.70%	4.40%	3.40%	3.40%
Tariff assumptions - provider inflation (non-acute)	2.80%	2.70%	4.40%	3.40%	3.40%
Tariff assumptions - Efficiency Savings	-4.00%	-3.50%	-4.00%	-4.00%	-4.00%
Tariff leakage - acute care	0.00%	1.50%	2.00%	2.00%	2.00%
Non-demographic growth - Prescribing	5.00%	4.00%	4.00%	4.00%	4.00%
Non-demographic growth - Acute	0.50%	0.50%	0.50%	0.50%	0.50%
Prescribing Efficiency Savings	-4.00%	-1.00%	-1.00%	-1.00%	-1.00%
Non-demographic growth - Continuing Healthcare	4.00%	5.00%	5.00%	5.00%	5.00%
Non-demographic growth - other (non acute)	0.00%	1.50%	2.00%	2.00%	2.00%
Demographic Growth	0.18%	0.15%	0.29%	0.11%	0.25%
Business Rules					
Non Recurrent requirement for CCGs	1.50%	1.00%	1.00%	1.00%	1.00%
CCG Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
"Call to Action" Fund	1.00%				

RISK

Each organisation that are members of the Health and Wellbeing Board have their own strategic and operational risk management arrangements in place for managing risks to their business operations and the achievement of improved outcomes. Set out below articulates the approach taken by both NHS South Sefton and NHS Southport and Formby CCGs.

Since taking up its full statutory functions on 1 April 2013 the CCGs have had in place risk and assurance arrangements capable of preventing, deterring, and managing risks. The Risk Management Strategy sets out the CCG's commitment to the management of all risk using an integrated approach covering clinical, non clinical and financial risk.

The overarching broad risks to the effective implementation of the transformation programmes are as follows:

Risk Description	Mitigation Controls
The overall system's financial risk is high. Financial risks include: • Impact of CCG allocations formula • Reduction in management cost allowance • Continuing Healthcare (CHC) activity growth • Council financial position	• Working closely as a systems to achieve service transformation and avoid destabilisation • Comprehensive savings programmes (QIPP) • Plan allows for growth
Partners relationship and trust, where the challenge to each organisation is significant. There is a risk of organisations being protective and working against the best interest of the system.	• Set of principles for working together agreed • Open communications and sharing of issues • Formal and informal forums set up to discuss issues and agree delivery
Capability and capacity is a risk within organisations as the scale of the transformation stretches resources in terms of people and budgets.	• Strong programme management in place • Project support requirements identified
Joint commissioning strategies and plans do not deliver the scale of transformation required across the system.	• Continued performance management • Robust business cases • Contract levers and risk share arrangements
IT interoperability - Risk to effective delivery of integrated records, technologies and information.	• iMersey to develop IT strategy • iMersey to provide detailed implementation plan and timeline

TRANSFORMATION PROGRAMMES:

PRIMARY CARE

Primary care, and in particular care delivered by general practitioners and practice nurses, has been the cornerstone of the healthcare system since the inception of the National Health Service (NHS) in 1948. Good quality primary care is considered an essential feature of all cost-effective healthcare systems delivering improved outcomes at lower cost and with higher patient satisfaction. General practice is often quoted as providing the majority of care in the NHS whilst utilising only 9 per cent of the budget. In the NHS in England, more than 300 million consultations take place in general practice per year, which represents 90 per cent of all NHS contacts.

The two CCGs have a three year primary care quality strategy that has been developed in partnership with our member practices and has a real focus on energising the services provided in our local surgeries. The primary care system is currently running in a highly reactive way (i.e. managing patient demand simply by working longer and harder), with little time to actively find and support patients who are in potential danger of hospitalisation. General practice and wider primary care services face increasingly unsustainable pressures:

- **An ageing population**, **growing co-morbidities** and **increasing patient expectations -** resulting in large increase in consultations, especially for older patients, e.g. 95% growth in consultation rate for people aged 85-89 in ten years up to 2008/09. Number of people with multiple long term conditions set to grow from 1.9 to 2.9 million from 2008 to 2018
- **Increasing pressure on NHS financial resources** - which will intensify further from 2015/16
- **Funding streams are complicated** – fragmented and perceived as inequitable
- **Growing dissatisfaction with access to services** - Most recent GP Patient Survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours services. 76% of patients rate overall experience of making an appointment as good
- **Persistent inequalities in access & quality of primary care** - including twofold variation in GPs and nurses per head of population between more and less deprived areas
- **Growing reports of workforce pressures -** including recruitment and retention problems

What is primary care for?

In 2007, a prominent primary care academic, Barbara Starfield, described primary care as:

"The provision of first contact, person-focused, ongoing care over time that meets the health related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care."[5]

Primary care provides universal and comprehensive access for all. It provides a holistic approach to an individual's care, diagnoses and manages disease, prevents illness and protects health by promoting healthy behaviours, having a whole population focus. It is the first element of the continuing healthcare process and supports patients to navigate across multiple care providers and settings.

What primary care represents

The general practice registered list establishes a primary care 'home' for patients, carers and their families and represents the potential for a close, direct relationship with a single coordinator of their care right from their birth through to the end of life.

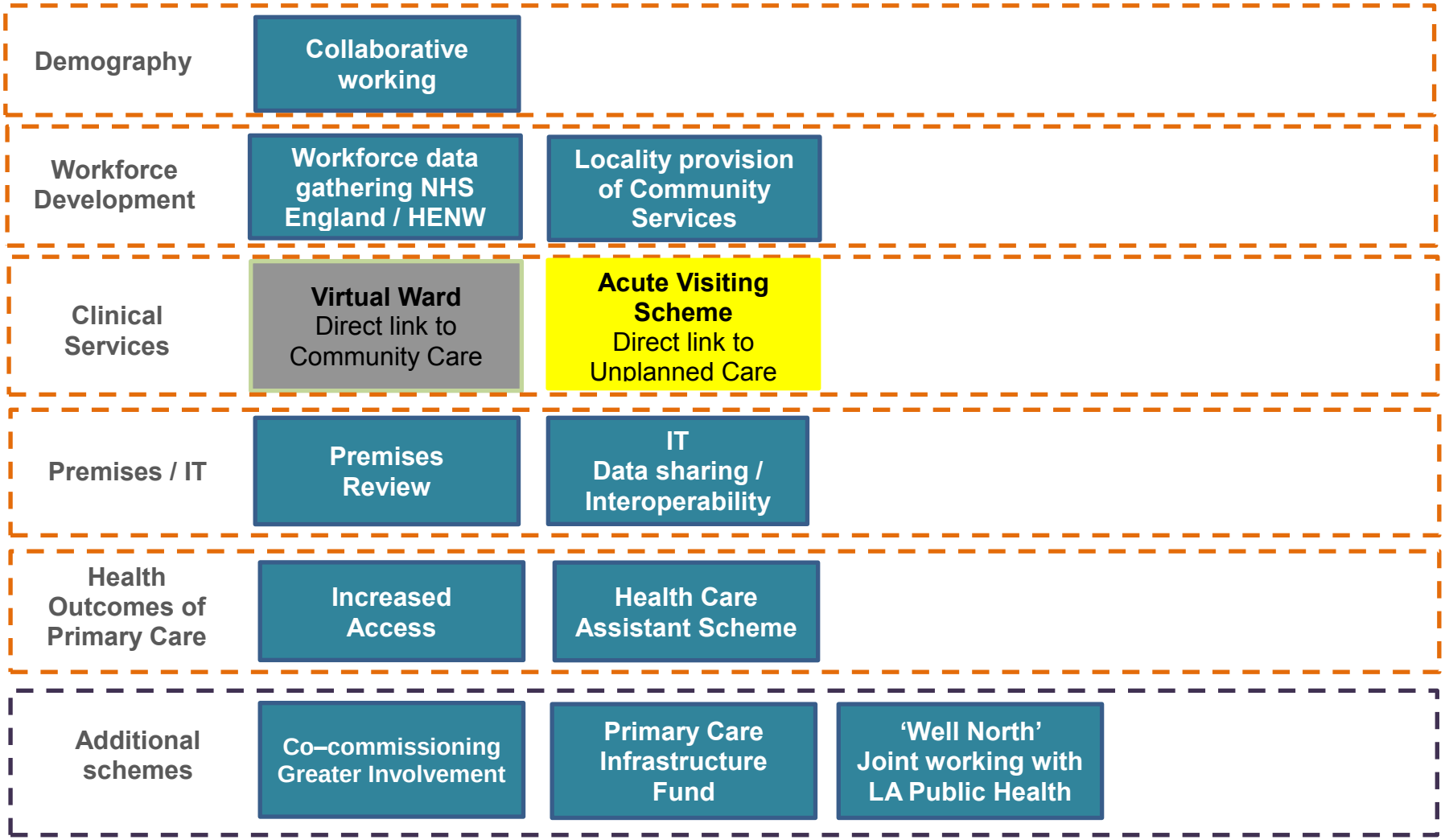
We already know from our public engagement work that people in Sefton want a service that provides timely and convenient access to care. Those with more complex physical and mental health needs want a service that provides GP-patient continuity, is seamlessly coordinated and supports them to stay well.

We are committed to supporting our member practices to look at new models of care in general practice. Our aim is to develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service in support of a reduction of 15% in unplanned admissions.

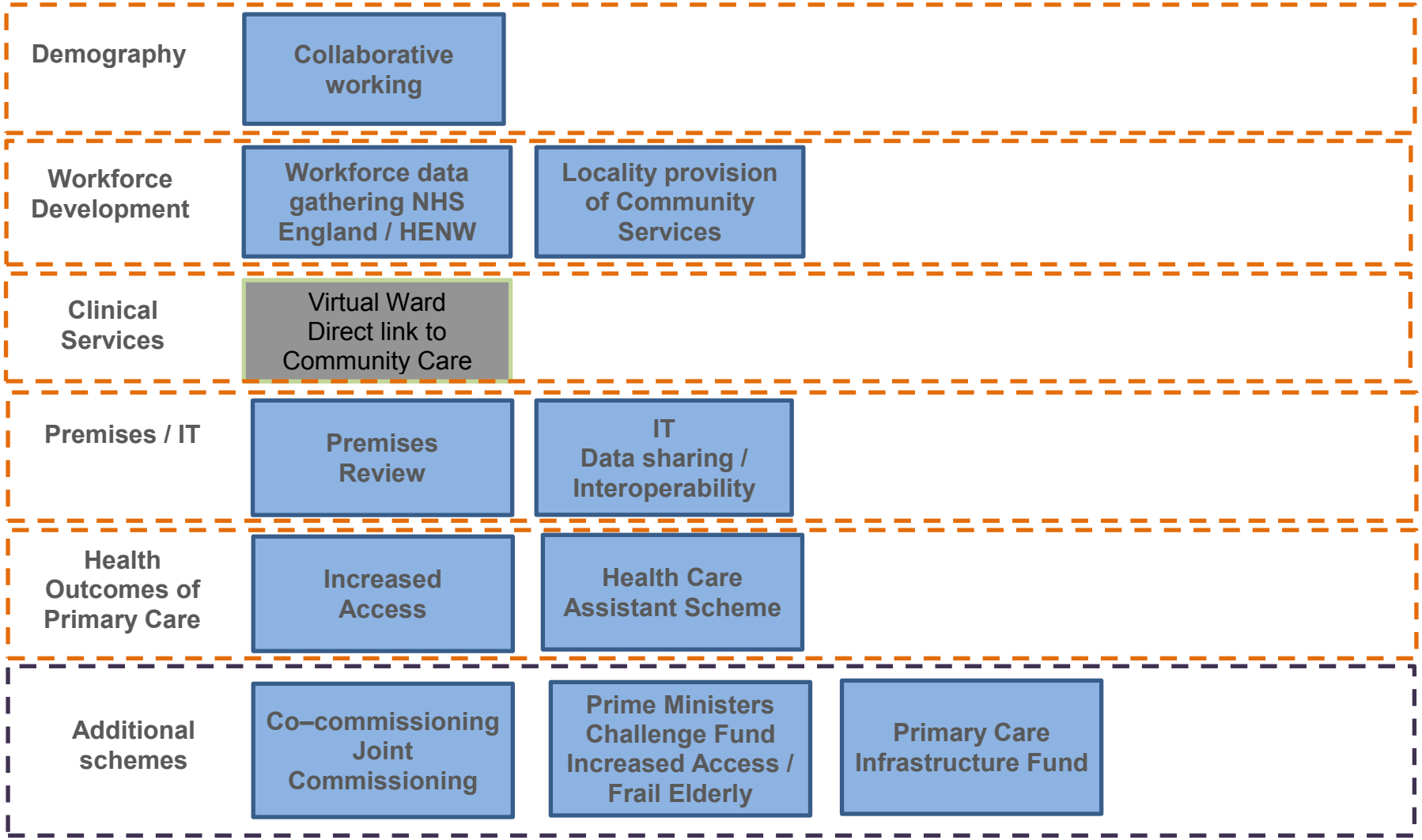
A three year Local Quality Contract was introduced in August 2014, to secure investment in General Medical Practice linked to locally driven quality markers. This has provided an opportunity for individual practice financial stability over a 3 year period in line with national drivers Improving General Practice – A Call to Action[6] as well as fulfilling our CCG strategic objectives.

[5] Barbara Starfield 2007
[6] NHS England Improving General Practice – A Call to Action (March 2014)

PRIMARY CARE PROGRAMMES SOUTH SEFTON



PRIMARY CARE PROGRAMMES SOUTHPORT AND FORMBY



COMMUNITY CARE

This is an area where we believe we can make the biggest difference to the quality and effectiveness of health and social care. Many people who receive both health and social care support have to cope with several sets of professionals coming to see them, asking similar questions and assessing them for many of the same conditions and problems. Many of these people are living with one or more long term condition and a significant number are elderly.

Working more closely together, we will empower staff in our provider and social care organisations to achieve a better understanding of how multi-professional teams can support people holistically – for example, staff will be encouraged and empowered to identify gaps in service and potential solutions for doing things better in the interests of the people they support.

Working in a more integrated way will help minimise delays, reduce duplication or fragmentation of services, reduce the number of different professionals who need to be involved, and ensure that information is shared between different professionals more effectively.

To be effective, the community care model must be the result of true partnership, not just between health and social care staff but also with people who use the services (along with their families and carers) and the local community in each locality.

We will review existing pathways, in conjunction with patients and local providers, in order to identify:

- Gaps in service provision
- Barriers to access which may result in unintended inequalities
- Potential improvements - such as provision of greater diagnostic services out of hospital

VIRTUAL WARD SOUTH SEFTON

Virtual Ward provides co-ordinated Health and Social Care for patients who are at high risk of emergency admission to hospital – such as those with long term conditions and frail or vulnerable older people.

It is called “Virtual” because you stay in your own home and “Ward” because it works like a hospital ward, where all the different members of the team meet regularly and work in a co-ordinated way to support you with your health and well-being needs.

By working together more closely through the Virtual Ward, the team can better manage each patient’s condition to keep them well and prevent them from being admitted to hospital unnecessarily.

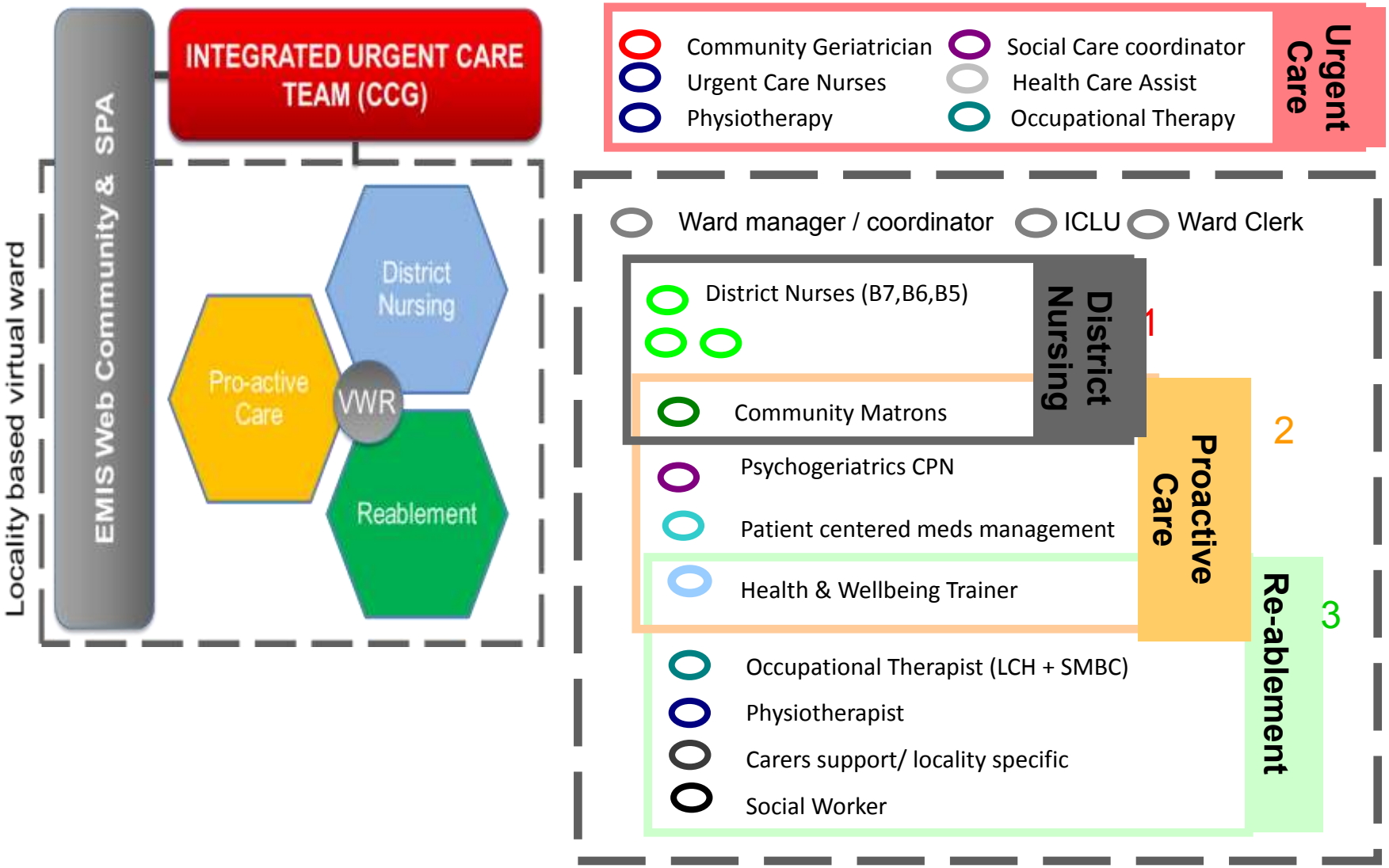
Virtual Ward teams are organised according to Community Nurse Team localities and there are four locality based groups. Each dedicated Virtual Ward team consists of a wide range of professionals from across health and social care. By working more closely together, these professionals provide more effective, joined up and collaborative care and treatment for patients:

Ward manager	**Ward clerk**
Community matron	**District nurse lead**
Health and wellbeing trainer	**Pharmacist**
Occupational therapists	**Physiotherapists**
Rehabilitation facilitator	**Community geriatrician**
Social worker	

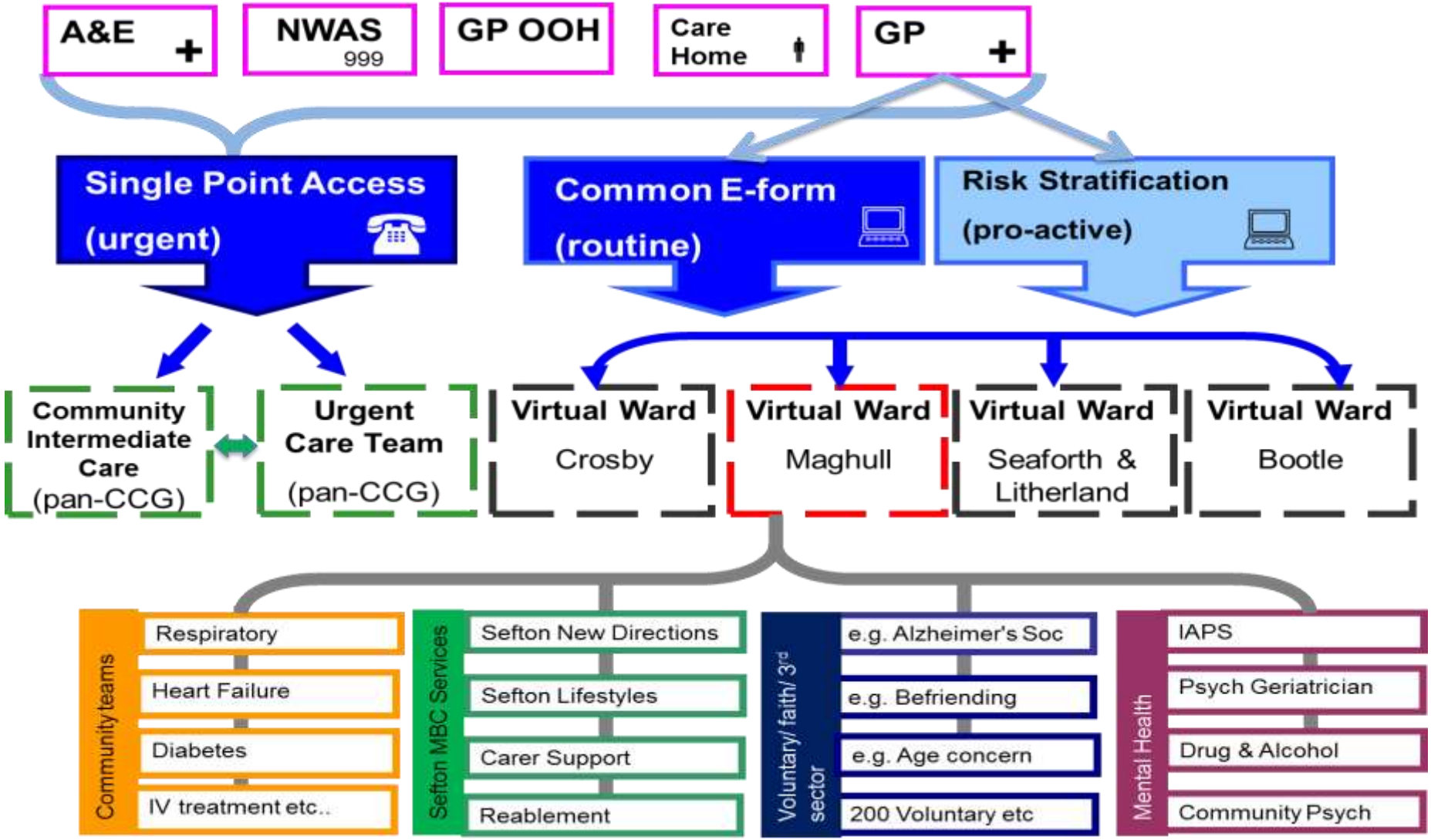
The teams hold fortnightly Virtual ‘ward rounds’, commonly known as a multi-disciplinary team (MDT) meetings. This is where all appropriate community health and social care professionals come together to review individual patients, and to decide how they can better co-ordinate their care. Decisions and information from these meetings is then communicated directly to the patient’s registered GP, updating their clinical notes.

This MDT approach reproduces the strengths of a hospital ward in the community by using a multi-disciplinary team approach in healthcare provision. It is called "virtual" because the ward does not exist physically and patients remain in their home.

The teams will look after the patients identified by the Risk Stratification tool as well as patients identified by other healthcare professionals who have been caring for them.

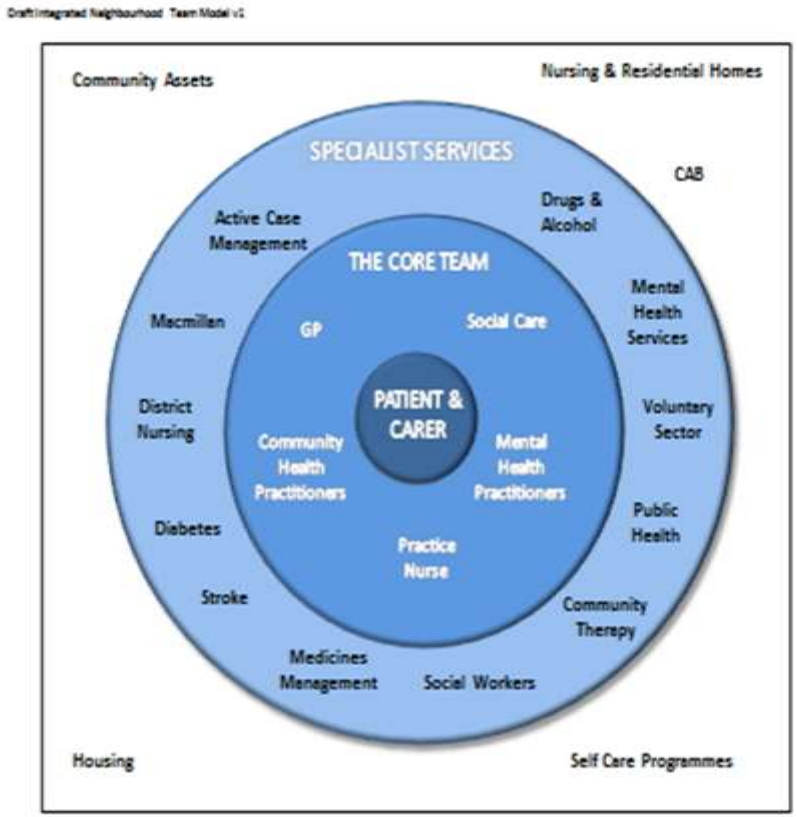

Locality based virtual ward
EMIS Web Community & SPA
INTEGRATED URGENT CARE TEAM (CCG)
District Nursing
Pro-active Care
VWR
Reablement
Community Geriatrician
Urgent Care Nurses
Physiotherapy
Social Care coordinator
Health Care Assist
Occupational Therapy
Urgent Care
Ward manager / coordinator
ICLU
Ward Clerk
District Nurses (B7,B6,B5)
District Nursing
1
Community Matrons
Psychogeriatrics CPN
Patient centered meds management
Health & Wellbeing Trainer
Proactive Care
2
Occupational Therapist (LCH + SMBC)
Physiotherapist
Carers support/ locality specific
Social Worker
Re-ablement
3

VIRTUAL WARD MODEL AND PATHWAY (SOUTH SEFTON)



CARE CLOSER TO HOME SOUTHPORT AND FORMBY

The Care Closer to Home programme is about allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, patient centred, accessible and seamless services. This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care. We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care.



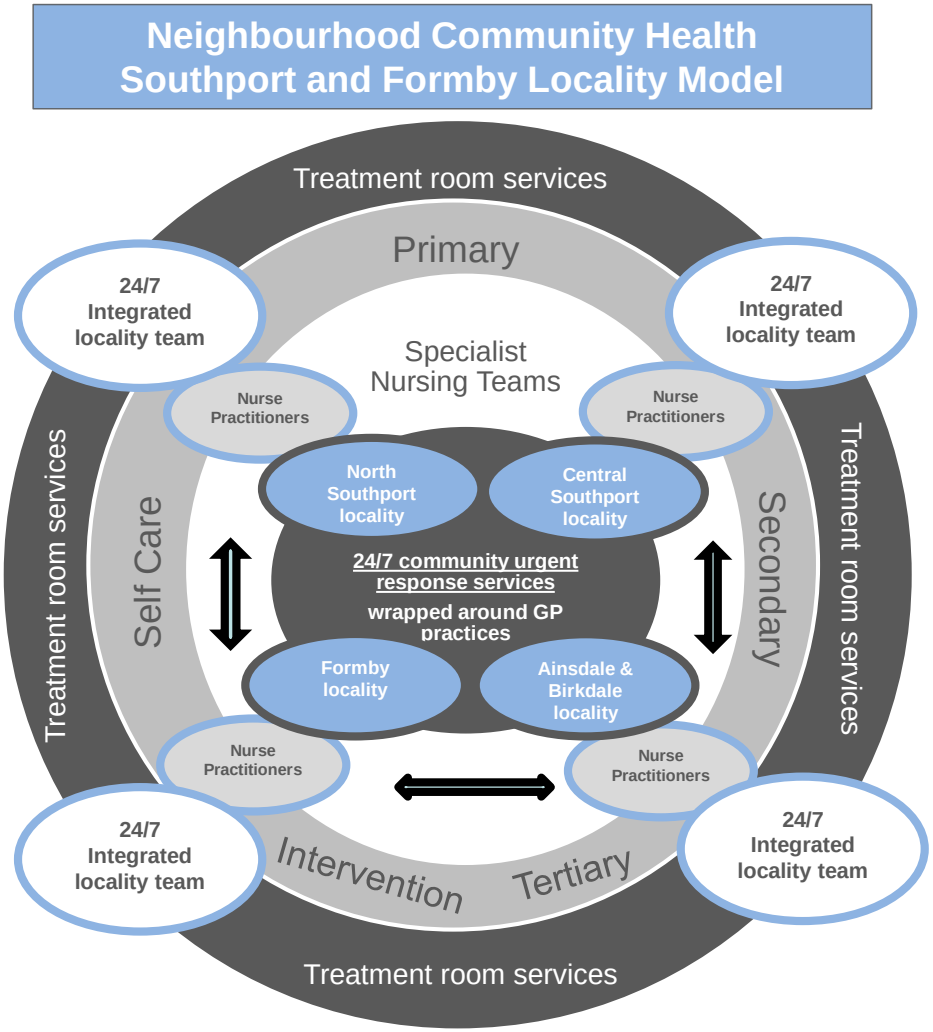
The core benefits of delivering this vision for the community and patients will include:

- Care and treatment will be accessible closer to home, or in the most appropriate setting
- Reduce need to visit A&E due to alternatives available locally
- Multi-disciplinary teams will be integrated and made up of individuals offering various clinical skills
- Care will be seamless and involve healthcare colleagues working closely together and working to a single care plan for a patient
- Everyone will learn more about self-care and how to help manage their own conditions
- Greater understanding of which health service to use and when, due to clear signposting and easier access

Our ultimate aim is to improve the outcomes and experiences of individuals and communities through the delivery of cost effective, integrated seamless care, support and treatment. To achieve this we will work together to transform our local health and care services to:

- Better co-ordinate, plan and deliver more personalised care and support to people living with long-term conditions and the frail elderly, in order to improve their quality of life and health outcomes
- Develop local community services to offer better access to care and support across the 7 day week
- Support the optimal delivery of elective care; utilising community support, where appropriate, to ensure individuals stay in hospital is minimised
- Design an urgent care system that delivers integrated services outside of hospital for people whose physical or mental health need for urgent care can be met by responsive advice, support and treatment closer to home
- Ensure that end to end integrated care pathways in and out of hospital run smoothly, ensuring evidence based care is consistently and equitably delivered to all individuals and communities in support of the best patient experience possible
- Empower communities and offer greater choice to individuals, by providing transparent information about the range and quality of health and care services available
- Effectively engage individuals, communities and our stakeholders in working with us to transform and redesign the way in which health and social services are provided to deliver better health and wellbeing for all

CARE CLOSER TO HOME MODEL (SOUTHPORT AND FORMBY)



CONTINUING HEALTH CARE

When it is assessed that an individual's primary need is a health need, the NHS offers a package of continuing health care. This is a package of ongoing care arranged and funded solely by the NHS.

If a patient requires continuing health care, South Sefton and Southport and Formby CCGs are committed to helping them to stay at home, provided that is safe for the patient and the staff looking after them to do so. We follow a number of key principles to guide this decision and if we are unable to support a package of care provided at your home we will offer you alternative care.

Eligibility is assessed through a process as defined in the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

The first step in the process for most people will be a screening process using the checklist.

If an individual is referred for a full assessment for NHS continuing healthcare, the decision support tool should be completed following a multi-disciplinary assessment.

The fast track pathway tool is used in circumstances where an individual has a rapidly deteriorating condition that may be entering a terminal phase.

The CCG currently commission (160 for South Sefton and 114 for Southport &Formby) packages of continuing healthcare. The CCG also contributes funded nursing care (FNC) for (354 patients in SS and 509 patients in S&F)

Joint Funding

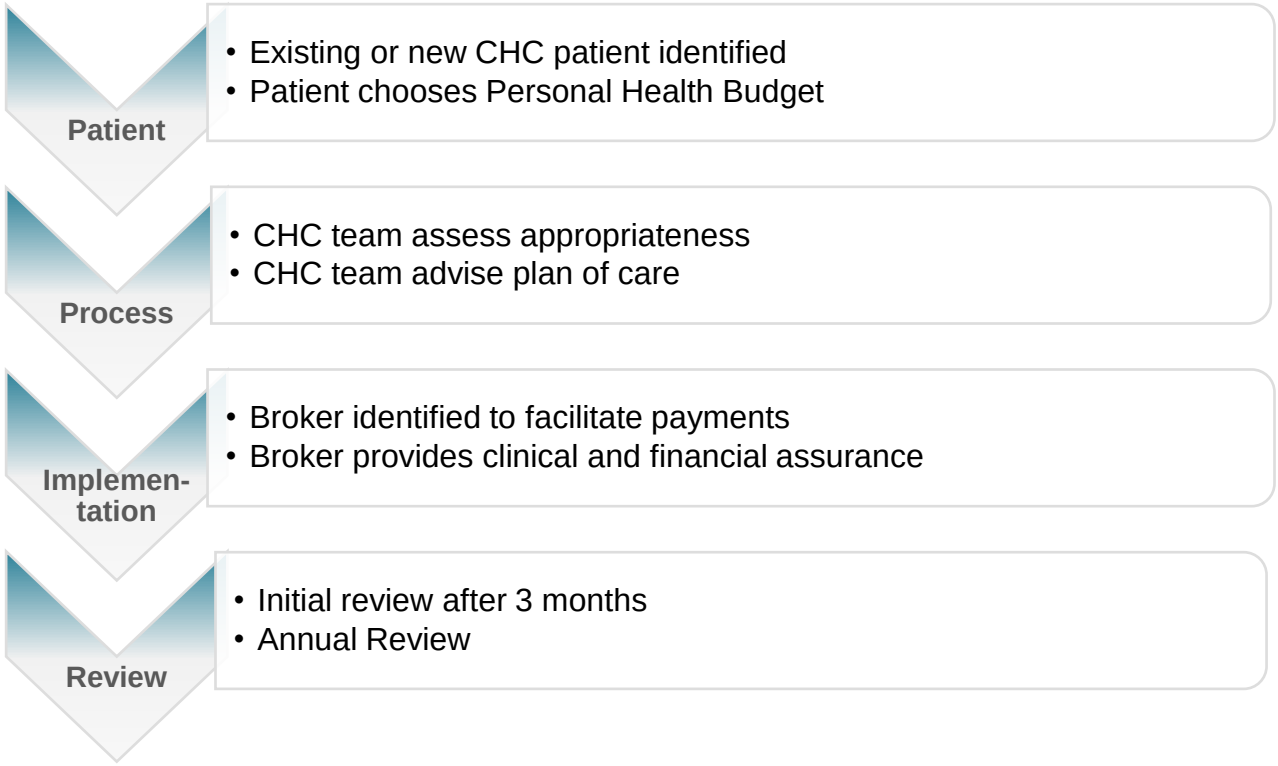
Adult: Informal arrangement with no panel in place. Agreement with CHC team and LA on the contribution of each organisation joint package.

Child: CHC team represent the CCG at joint panel meetings with the LA on assessment of the needs of the child, the care package to be provided and CCG contribution to the package.

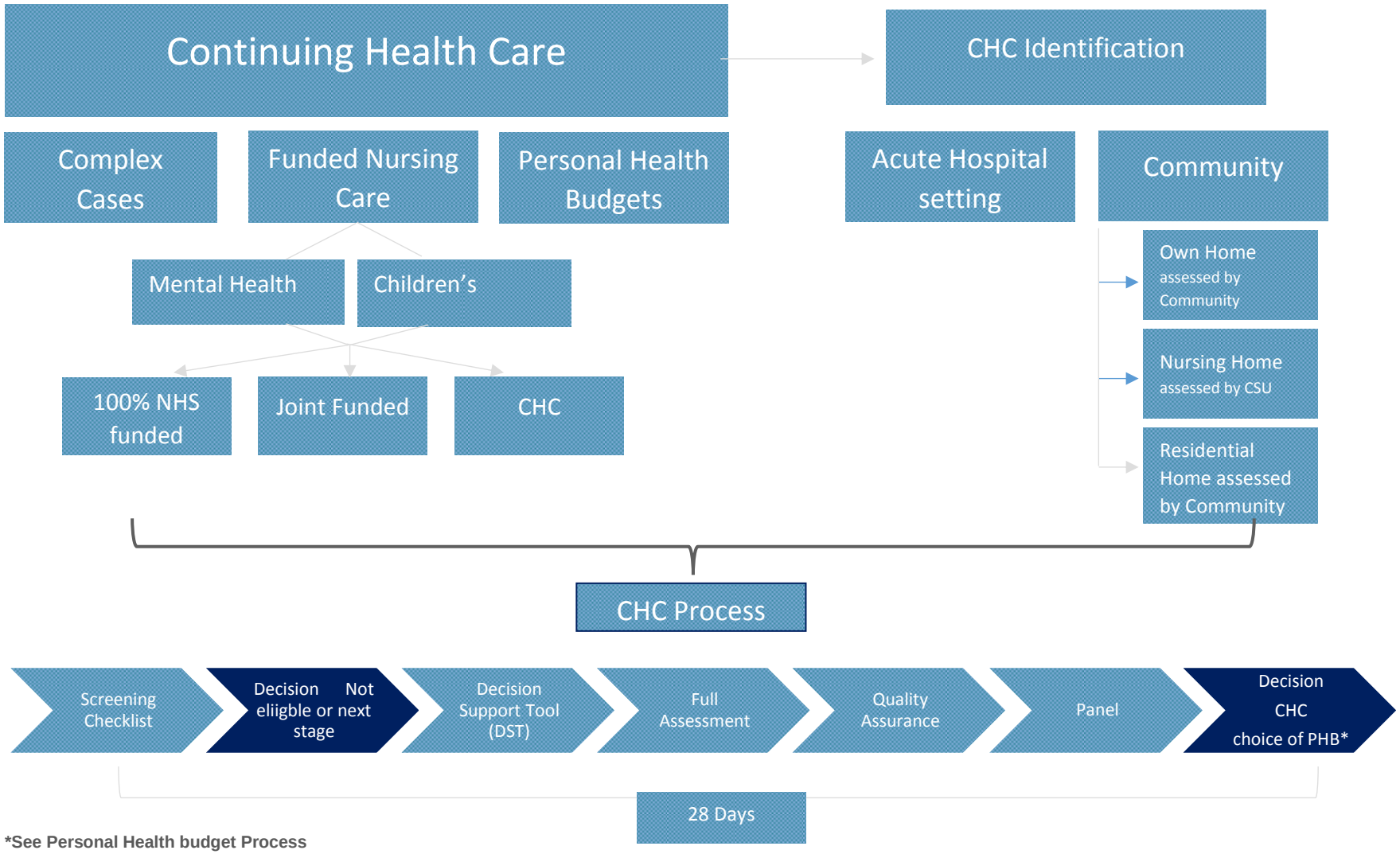
Personal Health Budget (PHB)

The CCG has a duty to ensure people eligible for NHS Continuing Healthcare and Continuing Care for Children benefit from the "right to have" personal health budget. A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual who is in receipt of Continuing Healthcare Funding and choose PHB as the option for provision of care. This is planned and agreed between the individual, or their representative, and the CCG. A care and support plan helps people to identify their health and wellbeing goals, together with their local NHS team, and set out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

Personal Health Budgets Process:



CHC DRAFT PATHWAY



*See Personal Health budget Process

INTERMEDIATE CARE

Intermediate care was defined by the Department of Health (2001)[7] and "Halfway Home" (2009)[8] as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

Partnership working is key to successful delivery of intermediate care and work is under way in Sefton to further align services in health and social care. Through the better care fund joint working, we now have in place an agreed strategy written in partnership with the Local Authority and we will monitor delivery via the joint Implementation Group which has a robust governance framework in place.

We know we must do better at commissioning our intermediate care facilities and we will commission an improved model to reduce admissions to acute care settings and facilitate the discharge and return home of patients following admission to our acute trusts.

Those accessing Intermediate Care services should not be in need of 24-hour access to consultant-led medical care, however, they may have medium to long-term medical conditions that make them liable to relapse.

The local approach is that intermediate care delivery is provided via a single point of access or "gateway", which includes a multi-disciplinary health and social care team and works cohesively with other community and third sector services, to provide a seamless intermediate care experience for our patients.

Following entry via the gateway, Intermediate Care required is provided in three 'tiers', with patients being "stepped up" or "stepped down" the model as appropriate.

Key to delivery of this model are a Community Emergency Response Team (CERT) based in Southport and Formby and a Community Intermediate Care Team (CICT) located in South Sefton. They will act as the 'gatekeeper' or single point of access to the Intermediate Care Service across the two CCG footprints. This will facilitate the "one point of access, one assessment, one care planning process" approach.

[7] http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf
[8] Intermediate Care – Halfway Home (DH 2009)

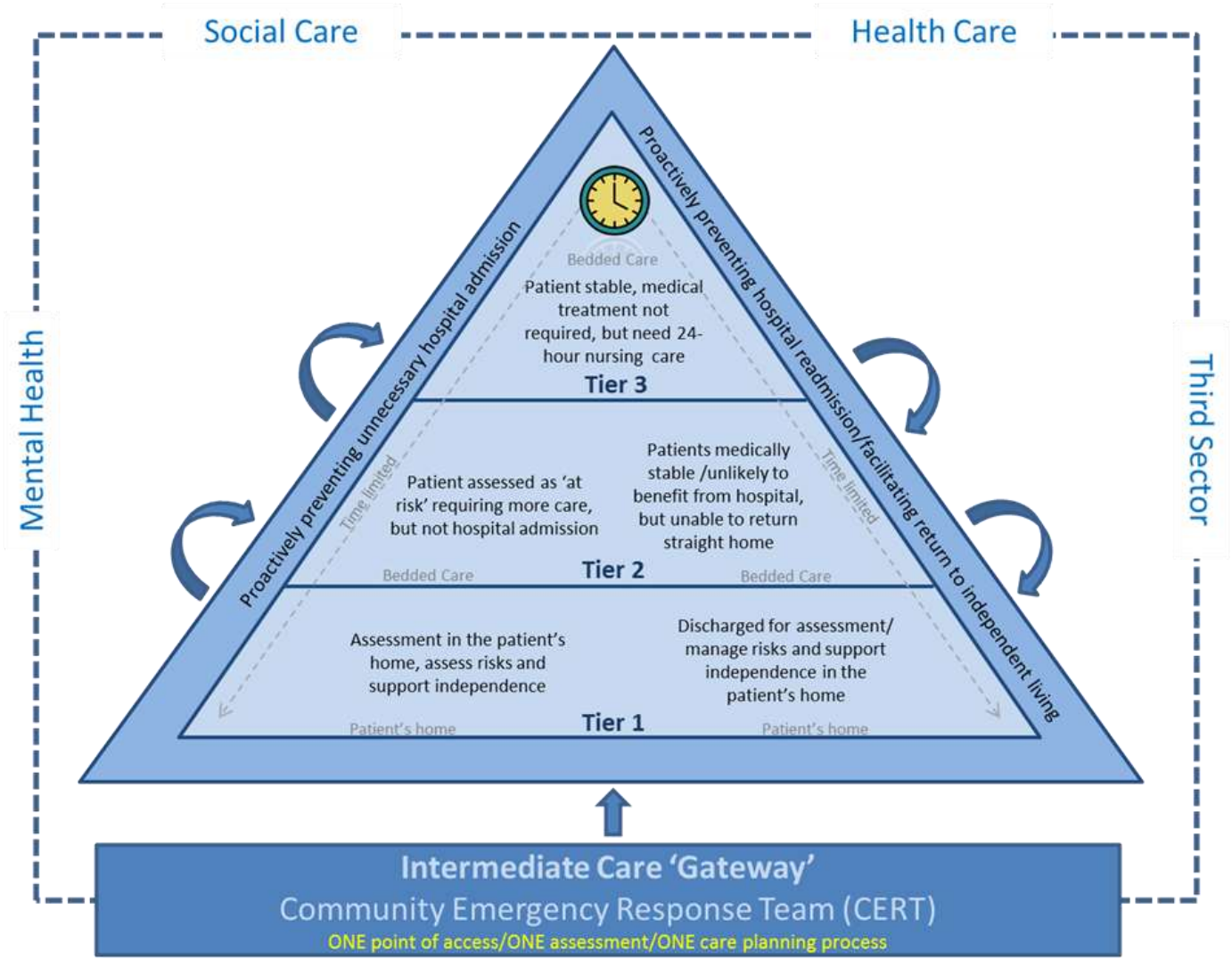
They will be an integrated, proactive, multi-agency and multi-disciplinary teams providing holistic short-term care and rehabilitation – it is not a series of standalone teams. The team will comprise:

- Nurses
- Occupational Therapists
- Physiotherapists
- a GP or Geriatrician
- Social Workers
- Mental Health Workers
- Technical Instructors
- Health Care Assistants
- Third sector representatives (ie, community, volunteer or faith services).

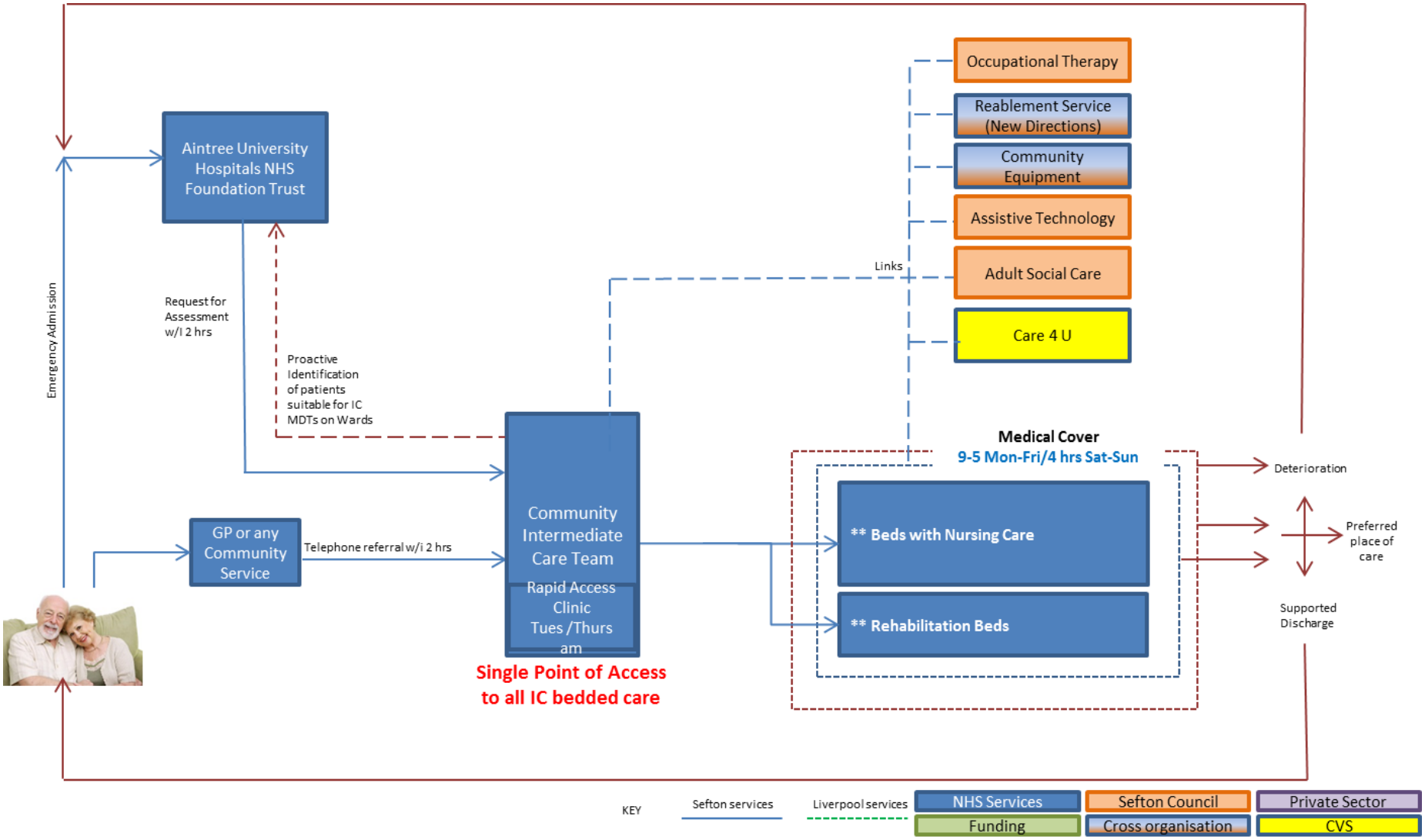
Both CERT and CICT will establish links with a variety of additional key health and social care community services to include, *inter alia*, stroke, falls, continence and respiratory services. Together with Sefton Council's Reablement and Continuing Health Care Teams they will ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

Intermediate care will largely be provided in the person's own home (Tier 1), but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting (Tier 2), or with some nursing care (Tier 3) may be the only viable option to avoid hospital admission.

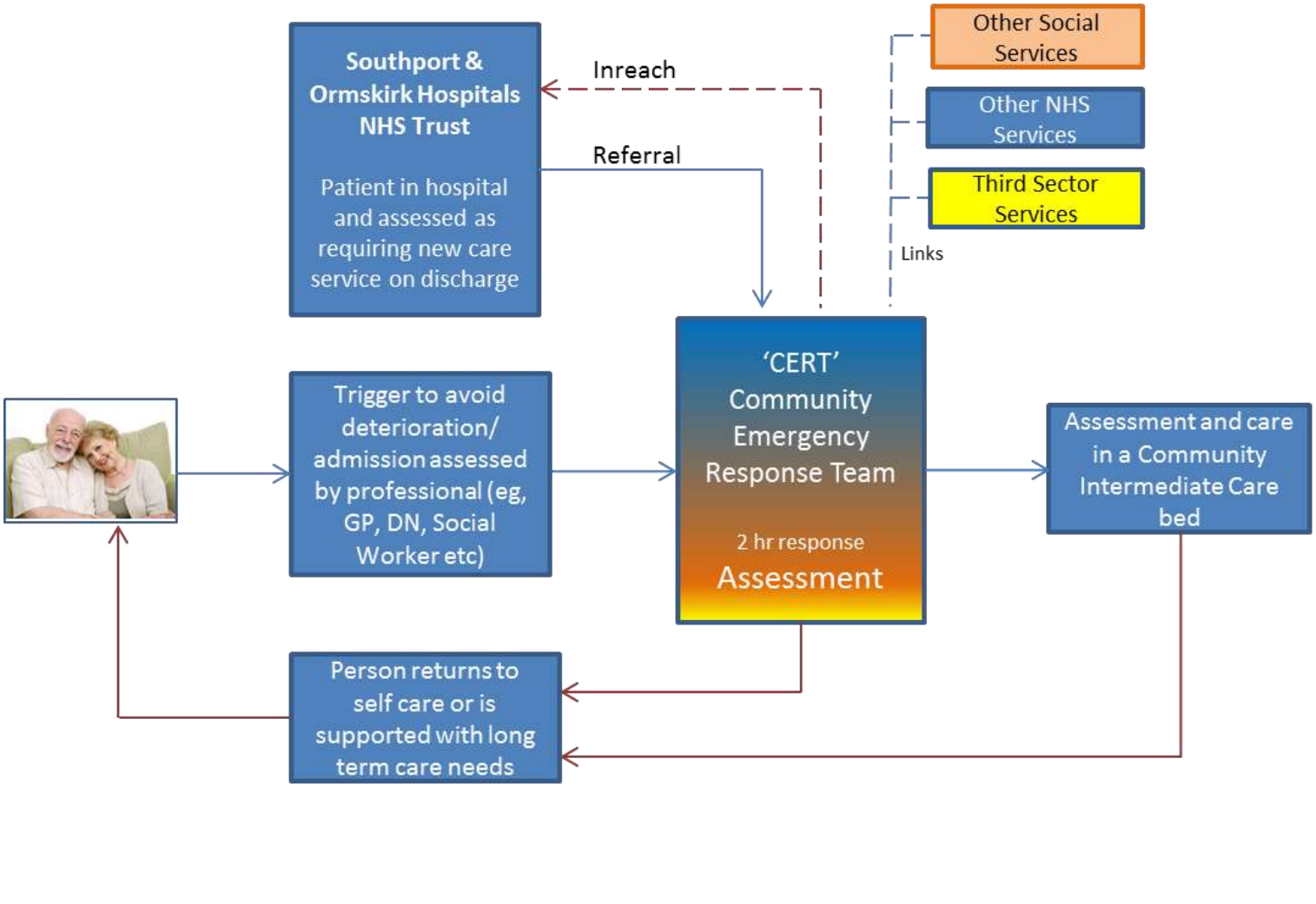
DRAFT INTERMEDIATE CARE MODEL



INTERMEDIATE CARE PATHWAY SOUTH SEFTON



INTERMEDIATE CARE PATHWAY SOUTHPORT AND FORMBY



UNPLANNED CARE

There is widespread national recognition and agreement that the health and social care system is under considerable pressure to deliver better patient outcomes against a backdrop of finite resources and increasing demographic pressures, alongside changing patient expectations. Over the last few years there has been considerable focus on the need for transformational change to manage these pressures to deliver better patient experiences and outcomes as it has been recognised that incremental change will not deliver the benefits that health and care suppliers (providers), patients and the government are seeking. These changes impact all areas of the health and social care economy, and over the last few years national attention has increasingly focused on the urgent and emergency care system.

Local strategies also reflect the national position with a desire to transform the urgent and emergency care system. The 5 Year Forward View (2014-19) sets out a collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It acknowledges the issues driving change within the urgent and emergency care system.

The real challenge in A&E is the flow of patients into, around and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full, and staff overstretched, people who need to be admitted to hospital end up waiting in A&E.[9]

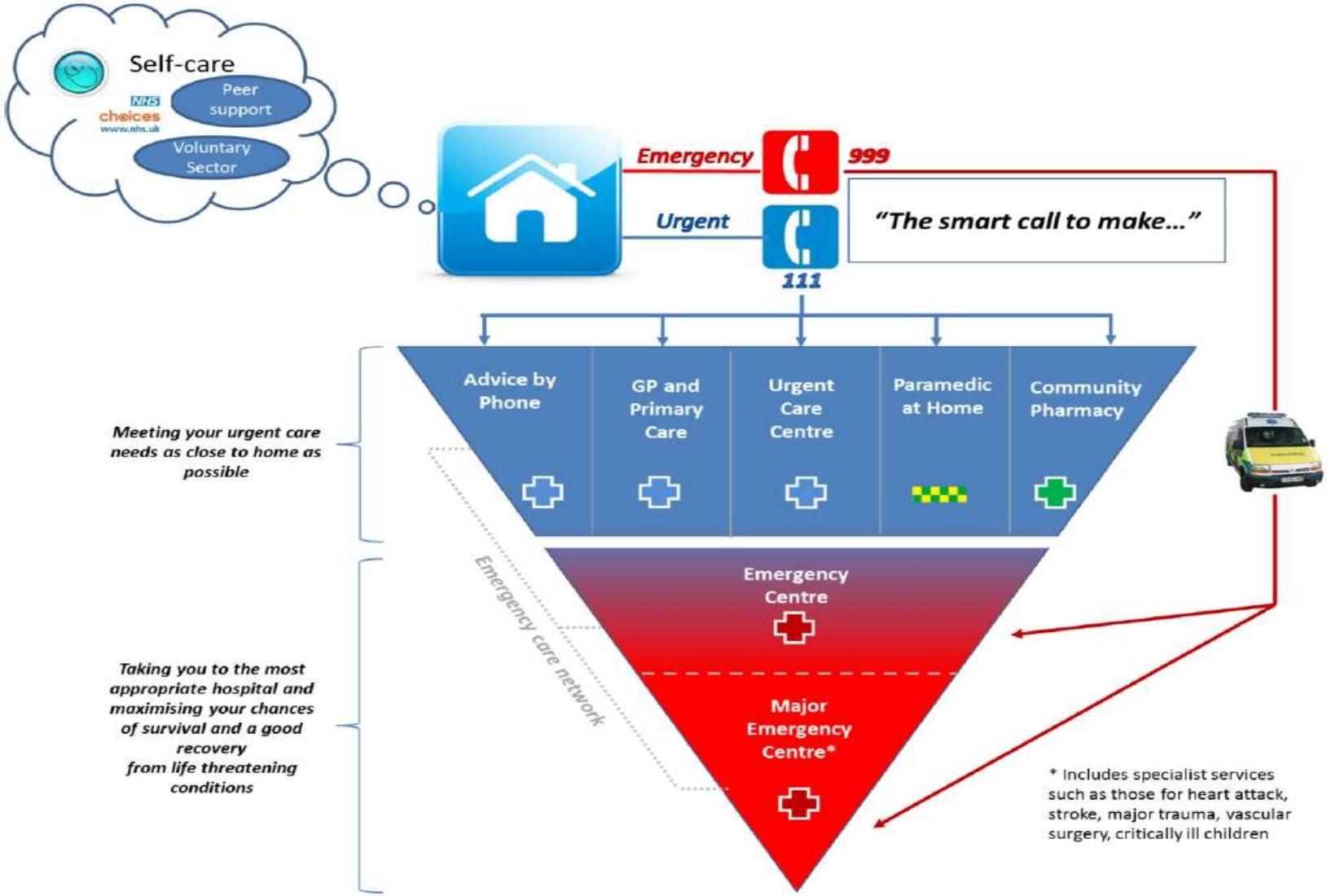
Urgent care should not be considered as a stand-alone, discrete service but embedded within patient pathways to ensure a joined up approach to care.

Evidence suggests that as attendances at A&E departments continue to rise, a significant proportion could be more appropriately dealt with by Primary and Community services. This would result in better utilisation of specialist A&E skills and enable more effective relationships being developed between the patient and primary care in managing their condition.

Professor Keith Willett who is leading on 'Transforming urgent and emergency care services in England'[10], has outlined the vision for urgent and emergency care, a visual model of this can be seen in Diagram three below:

[9] Alternative guide to the urgent and emergency care system animation transcript The Kings Fund January 2015
[10] Update on the Urgent and Emergency Care Review NHS England August 2014

Diagram three:



UNPLANNED CARE SOUTH SEFTON

South Sefton CCG will continue to improve immediate and emergency care across the system to ensure that our patients get the right care at the right time and in the right place - be that primary care, community, or acute care. The commissioning of high quality and accessible urgent care services for our residents continues to be an important priority.

In recent years there has been increasing pressure placed on urgent and emergency care systems as patients seek greater assurance regarding their condition and more rapid responses from services.

We are currently developing our model to provide urgent response within two hours for our community services led by a consultant geriatrician and supported by GPs and other clinicians to reduce the reliance on A&E departments.

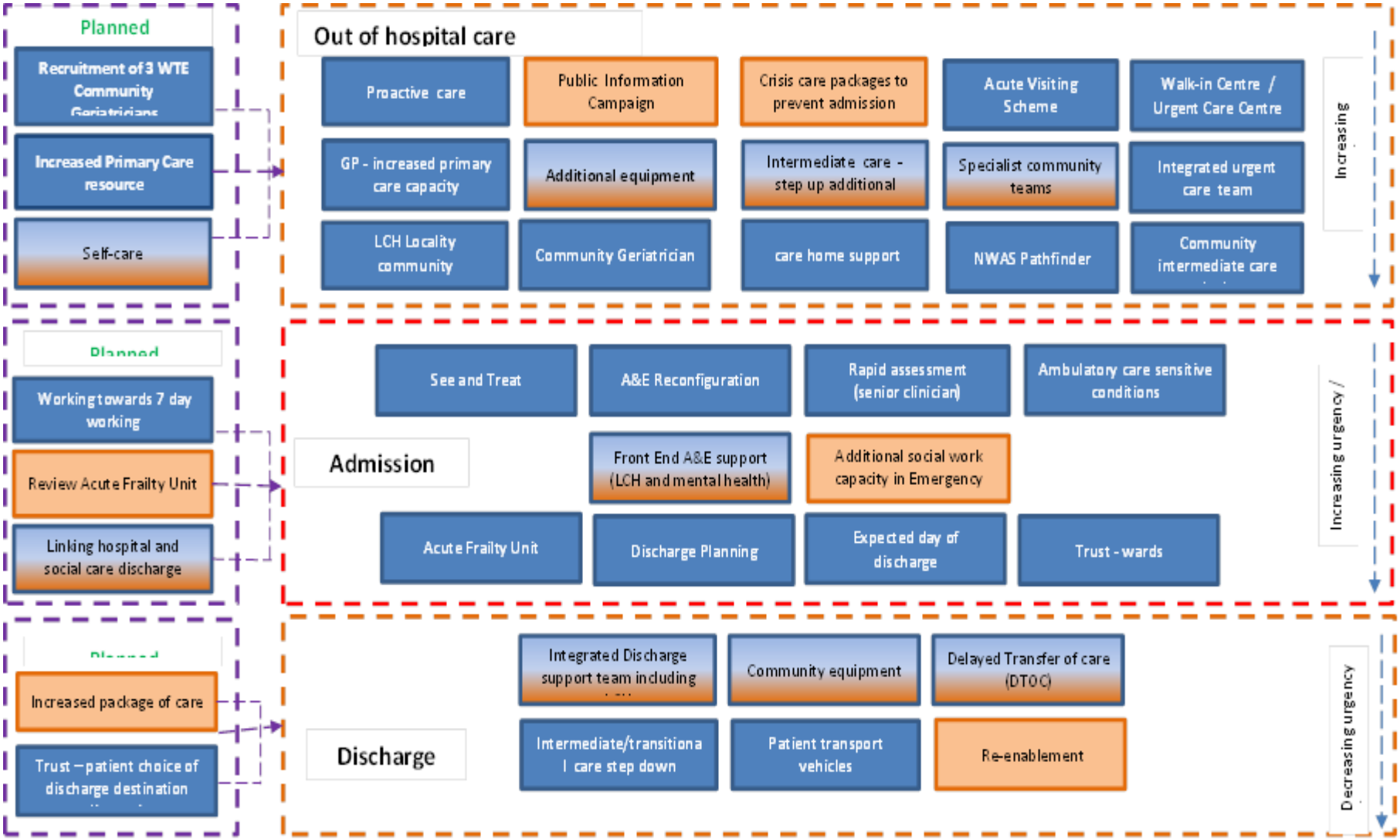
We will work collaboratively across the health sectors to ensure that patients are supported to access urgent care as needed. We will commission services across Primary Care, Community and Acute care to support patients and their clinical needs. Our integrated community mode includes social service, community services, mental health services, therapies and voluntary services, this is aimed to proactively identify and support patients at risk of future unplanned care episodes.

We will continue to develop clinically led pathways to deliver the most appropriate services to the patient need.

Our focus will be on:

- Unplanned Care teams are available to provide Urgent Care in the Home
- The Unplanned Care Team can call on support of the Unplanned Care Centre and utilise intermediate beds
- Patients can access an Unplanned Care Centre which has the support of the acute hospital
- At all times, patients with acute needs can be streamed to the acute hospital.
- Both the acute hospital and intermediate beds can step patients down to a supported discharge team
- There is whole system operational management and control

South Sefton Model for Unplanned Care



UNPLANNED CARE SOUTHPORT & FORMBY

The delivery of high quality and accessible urgent care services is an important priority for the Southport and Formby Health economy. We aim, as commissioners of care, to ensure that urgent care services in the future are delivered in a seamless integrated way to best meet the needs of our local population.

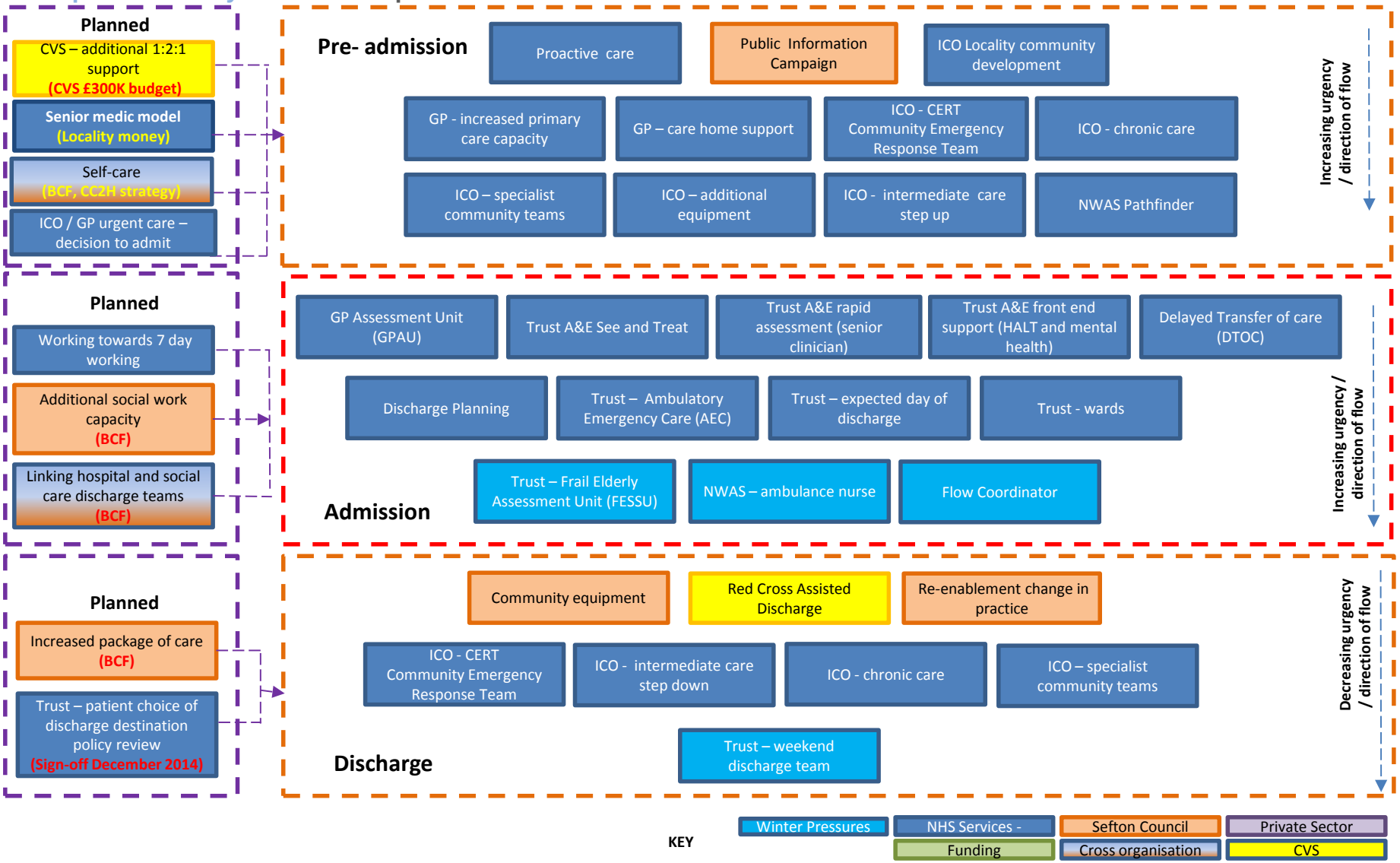
We recognise that the urgent care system is complex and the number of different entry points can be confusing to people. At times when people need things to be simple, in reality they are faced with a confusing set of options. We recognise that our role is to remove this confusion and present the public with a straightforward set of options that are obvious and easy to navigate.

Meeting the demand of unplanned care in Southport and Formby is inextricably linked to both primary and community care provision.

We will focus on delivering the following:

- The patient is supported in making informed decision
- Community Emergency Response teams are available to provide Urgent Care in the Home
- Community Emergency Response teams can utilise intermediate beds to avoid a hospital admission as well as step down from hospital care
- At all times, patients with acute needs can be streamed to the acute hospital.
- GP's proactively identify patients at risk of hospital admission and are able to enact (?) interventions through the community nursing teams
- Extra access to GP practices is being provided
- There is whole system operational management and control including escalation plans and urgent care dashboard

Southport & Formby Model for Unplanned Care



MENTAL HEALTH

Our mental health services require review and redesign to ensure they are built around the needs of Sefton residents. We will commission an all age mental health and dementia service across Sefton which is a recovery based clinical model, supportive of home care, visible, easily accessible, of high quality, safe and will deliver beneficial outcomes to the patient.

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

The Government has included a specific objective for the NHS to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole". In line with mental health strategy and the National dementia strategy there is a fundamental shift from output focused and volume driven commissioning to outcome focused and recovery orientated service provision.

A range of services will be available to meet the patients need. There will be a reduction in stigma associated with mental health issues and confidence in local services. A focus on patient recovery and satisfaction in their experience will be tangible in local services with equal regard for mental health as physical health.

We have identified the following key priority areas to focus on:

- Primary Care
- Parity of Esteem
- Dementia
- Redesign and commission and All Age service to include Child and Adolescent Mental Health (CAHMS)
- Brain Injury
- Outcomes and Activity Information

Primary Care: We will actively facilitate work with GPs and mental health services, including 3rd Sector, to enable collaborative working to be undertaken. We will undertake a training needs analysis to ascertain the level of mental health awareness across the GP community. There will be an increased focus on locality working which will enable mental health services to be targeted at a neighbourhood level.

Parity of Esteem: We will work with our current mental health providers, Mersey Care NHS Trust and all physical health providers, to ensure that physical needs of mental health and dementia patients are met in a timely and co-ordinated manner. A future model which envisages services working in integration is to be actively encouraged.

Dementia: The current pathways are disjointed and there is an inequity across the two CCG areas as to how the dementia services are delivered. The work undertaken to-date has identified that some patients could be better managed in a primary care setting. Current estimates suggest there are almost 4,500 people aged over 65 affected by dementia, as a result of an ageing population it is forecast that by 2030 that number will have increased by 49% to over 6,600. Dementia services might best be delivered by an integrated service comprising of integrated health, social care, the third sector and nursing home provision, this would be a major shift from the current model of provision.

Child and Adolescent Mental Health (CAHMS): The national framework for Children, young people and maternity services highlighted the importance of ensuring safe and effective transition. Locally, in mental health services, transition arrangements for 16-18 year olds appear to be confusing and having two organisations involved, Mersey Care NHS Trust and Alder Hey, exacerbates this issue and carries an element of risk. Organisational barriers may affect these patients, therefore, it is paramount that we look to redesign the current CAMHS pathway to aim for a single mental health provider for young people instead of the current system of multiple providers. This new pathway could be a precursor to the development of a single and ageless service for all mental health patients who require secondary mental health services.

Brain Injury: The Brain Injury pathway is disjointed and whilst there are links between the service provided by Mersey Care through their Brain Injuries Unit and the Intensive Rehabilitation service provided by Walton Centre for Neurology moving to a new contracting arrangement whereby Walton Neurology sub contract the Mersey Care NHS Trust element of provision would enable the overall Brain Injury pathway to be more co-ordinated than at present.

Outcomes and Activity Information: The planned introduction of mental health Payment by Results (PbR) is a major organisational change for both providers and commissioners. Commissioners will need to understand in detail how the services they are purchasing meet the needs of individual people, how this directly affects the prospects for patient recovery and crucially identify any financial risks. Financial modelling and profiling of risk will need to be undertaken by the CCGs for assurance purposes.

The current mental health contracting currencies are out of date and many activity indicators are catchment and not CCG based. The Task Group believes that mental health outcomes should be predicated on more social based outcomes and it has commenced discussions with Mersey Care NHS Trust to agree an initial suite of measureable outcomes and CCG based activity measures for inclusion in 2015/16 contracts.

Future Dementia Pathway

NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Secondary Care Presentation

Memory Service (MCT) for Assessment Monitoring and Review including medication

Alzheimers Society provide post diagnostic support

Community Care Navigators

- Social Services
- VCF Community
- Care Closer to Home/Virtual Ward
- Care Homes
- Care Home Liaison

Patient presents to Dementia Friendly Surgery with health concerns

Shared care

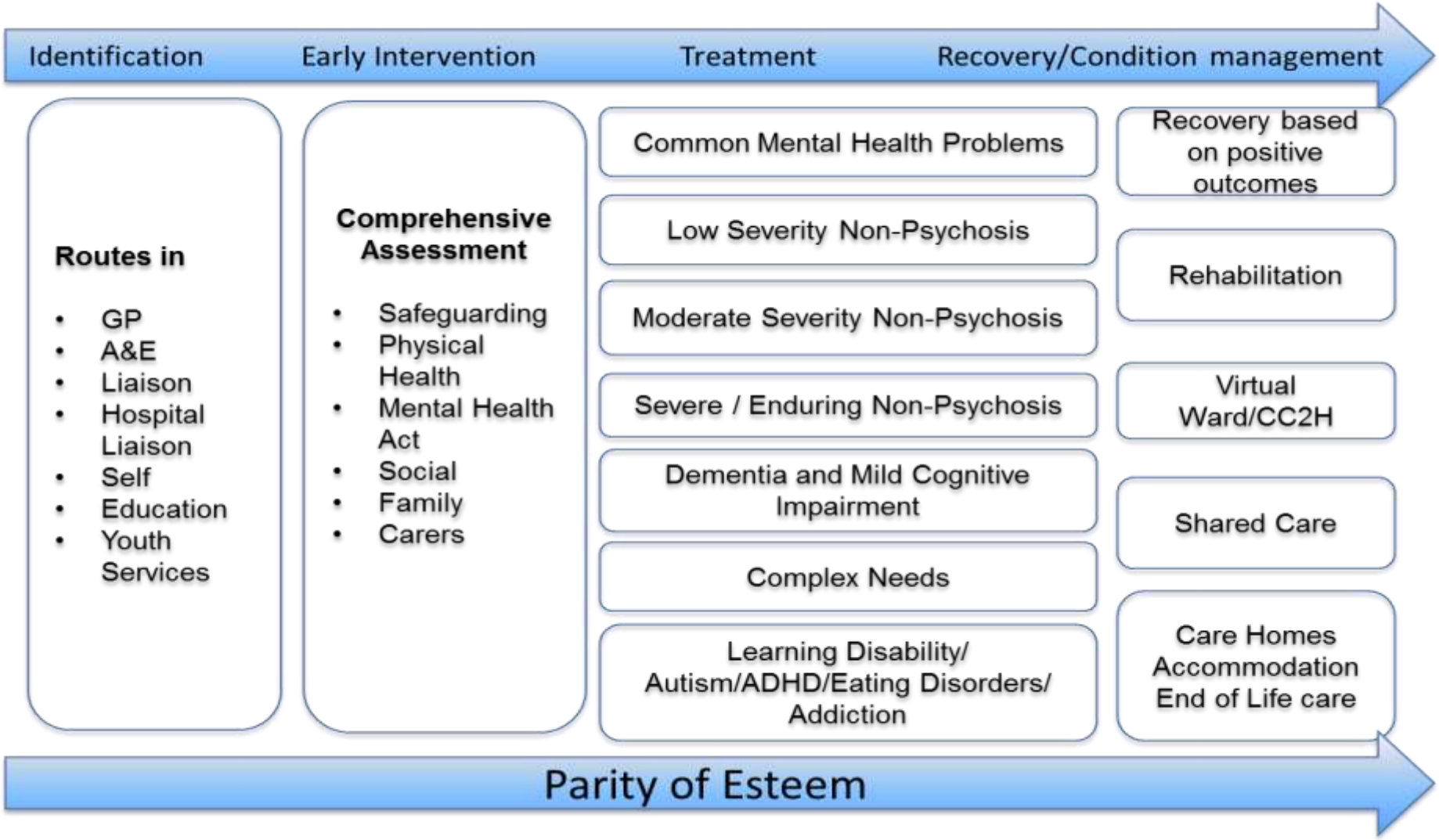
GP does initial assessment and may refer to Memory Clinic and also make referral to VCF Sector

Carer Support
Education
Signposting

Staying **local & together**

together with you

MENTAL HEALTH MODEL OF CARE



ACTION, DELIVERY AND GOVERNANCE

We will focus on delivery of our transformation programmes through the agreed governance structures outlined in Appendix one, whilst these transformational programmes are the main focus, they are not the only mechanism for delivering improvements and driving quality, safety and standards in health and care.

The ongoing improvement and enabling activity aimed at raising standards of care across the system are set out for each CCG below. The anticipated impact of these activities is being assessed and modelled to enable us to continue to improve health service within a sustainable local health and social care system. High level action plans, alongside benefits and measures are attached in Appendix two.

ACTIONS, DELIVERY AND TIMELINES SOUTH SEFTON CCG

PRIMARY CARE

Scope and Rationale

The aim of the Primary Care transformation programme is to develop a population-based approach to primary care and support them to improve access to primary care and enhance quality of service.

Outcomes

- Better patient experience
- Reduce A&E attendances
- Reduction in referrals
- Reduction in admissions
- Increased prevalence rates
- Reduction in re-admissions
- Reduced length of stay
- Reduced number of admissions from care homes
- Increased quality and provision of primary care diagnostics and monitoring

Priority Projects/Activities

- Increased access
- Enhanced management of patients over 75
- Workforce
  - Succession Planning
- Early detection:
  - CVD – increased uptake of Health Checks
  - Hypertension – recording, management and treatment
  - Atrial Fibrillation (AF) Management – improve case finding and management
- Planned Care
  - Increase use of Choose and Book utilisation

Contribution to Strategic Priorities

- Primary Care transformation
- Frail Elderly
- Unplanned Care

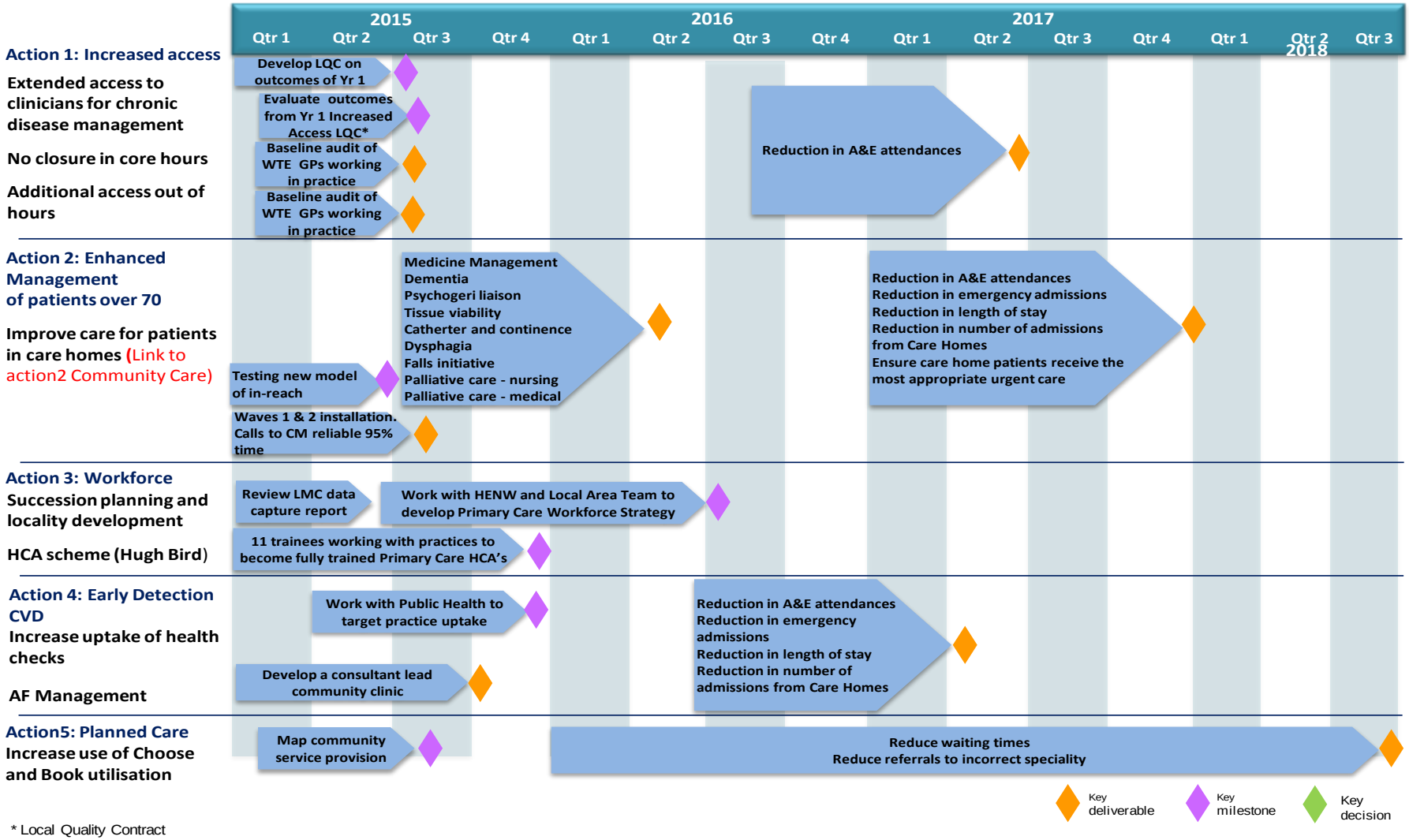
Workstream name: *Primary Care*	**Date:** *09 Feb. 15*
Senior Manager Lead: *Angela Parkinson*	**Updated**:

Programme Aim

We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

ID Number	Priority Area	Responsible Lead	Date due for Completion	Actual completion date	RAG
SSPC01	**Increased access** Extended access to clinicians for chronic disease management. No closure in core hours, additional access outside of core hours. Link to Local Quality Contract (LQC)	Angela Parkinson	Aug 15		
SSPC02	**Enhanced management of patients over 75** Improved care for patients in care homes by offering more intensive health treatment Link to Local Quality Contract (LQC)	Moira McGuiness	Sept 15		
SSPC03	**Workforce** Succession planning and locality development HEE data capture LMC report Link with HCA scheme in collaboration with Hugh Bird College	Angela Parkinson	Mar 17		
SSPC04	**Early detection** CVD Increased uptake of Health Checks. Hypertension – recording, management and treatment Atrial Fibrillation (AF) Management – improve case finding and management	Sharon Forrester	Mar 16		
SSPC05	**Planned Care** Increase use of Choose and Book utilisation for both acute and community services	Terry Hill	Sept 15		

South Sefton Primary Care - Timeline



* Local Quality Contract

COMMUNITY CARE

Scope and Rationale

We will commission services that better link together right across health and social care – from hospital 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.

Outcomes

- Improved support for frail elderly
- Reduction in unplanned/emergency admissions
- Reduction in re-admissions
- Reduced length of stay
- Better health outcomes
- Reduced mortality rates
- Reduce A&E attendances
- Better patient experience
- Care closer to home
- Reduce referrals into secondary care
- Increase number of people dying in usual place of residence
- Admission avoidance
- Self Care

Priority Projects/Activities

- Locality and virtual wards
- Care Homes
- Community urgent care team
- Review Integrated care pathways for long term conditions – focus on urgent care:
  - Diabetes
  - Heart Failure
  - COPD
  - Palliative Care
  - Dementia and Frailty
- Review of Community Tier 2 services and activity

Contribution to Strategic Priorities

- Frail Elderly
- Unplanned Care

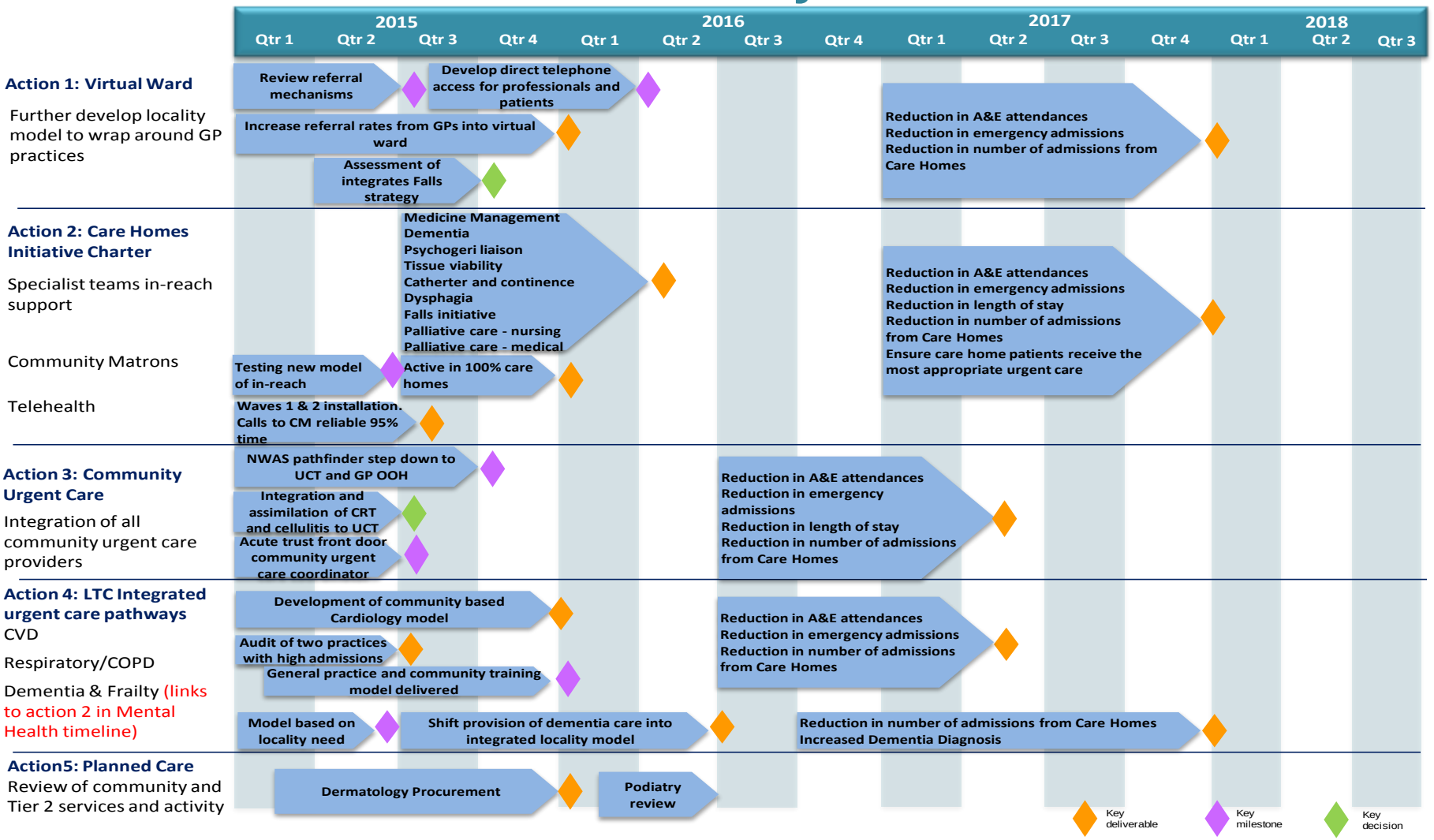
Workstream name: *Community Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Steve Astles*	***Updated****:*

Programme Aim

We will commission services that better link together right across health and social care – from hospital 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.

ID Number	Priority Area	Responsible Lead	Date due for Completion	Actual completion date	RAG
CC01	**Locality and Virtual Wards** Further development of locality modelling to ensure community services are wrapped around GP practices	Steve Astles Peter Chamberlain	Ongoing		
CC02	**Care Homes** • Community geriatrician in-reach to care homes • Community Matrons • Telehealth	Steve Astles	Mar 15 Apr 15 Apr 15		
CC03	**Community Urgent Care** Integration of all community urgent care providers including: • NWAS pathfinder step down to UCT and GP OOH • Integration and assimilation of CRT and cellulitis to UCT • Acute trust front door community urgent care coordinator	Steve Astles Andy Mimnagh	Jun 15		
CC04	**Review and redesign Integrated Care Pathways for Long term conditions. Phase 1 focus on urgent care element** • CVD • COPD • Dementia & Frailty	Steve Astles Sharon Jenny Kevin Thorne			
CC05	**Review of Community/Tier 2 services and activity** • De-commission and procurement	TBC			

South Sefton Community Care - Timeline



INTERMEDIATE CARE

Scope and Rationale

The Intermediate Care aim is to have ONE point of access, ONE assessment, ONE care planning process. This will be enabled by commissioning co-ordinated care for patients via integrated services and being responsive to patient's needs.

Outcomes

- More integrated, efficient and effective intermediate care
- Reduce hospital admissions
- Reduce re-admissions
- Reduce length of stay
- Ensure decisions about long term care are not made in an acute setting

Priority Projects/Activities

- Better Care Fund priority
  - Integrated approach with local authority
- Single entry coordination for all intermediate care
- Integrated care at locality level
- Increase use of appropriate use of step up / step down beds
- Stroke:
  - Development of Intermediate care beds in nursing homes

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care transformation

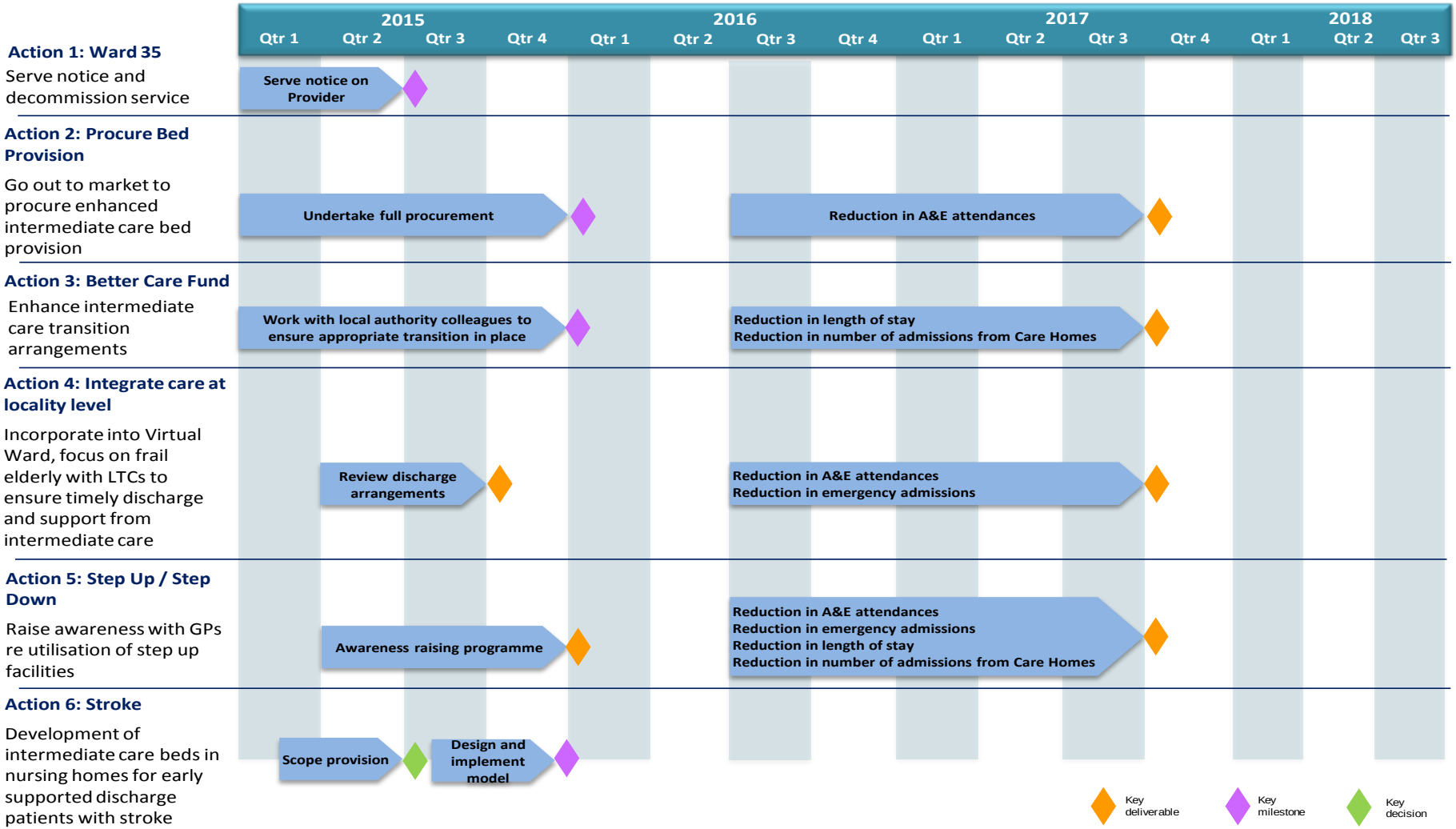
Workstream name: *Intermediate Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Melanie Wright*	***Updated****:*

Programme Aim

Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.

ID Number	Priority Area	Responsible Lead	Date due for completion	Actual completion date	RAG
IC01	**Ward 35** Serve notice to decommission current service	Mel Wright	01/04/15		
IC02	**Procurement** Go out to market to reprocure enhanced intermediate care bed provision	Mel Wright	*01/04/16*		*Not yet started*
IC03	**Better Care Fund** Work with local authority to enhance intermediate care transition arrangements Better Care Fund initiative	Mel Wright	Ongoing		
IC04	**Integrated care at locality level** Incorporate into virtual ward model with particular focus on frail and elderly with long term conditions, ensure timely discharge and support from intermediate care Better Care Fund initiative	Mel Wright	*01/04/16*		
IC05	**Step up/down** patient flow - appropriate increase in use of step up beds particularly requested by GPs - Awareness raising exercise with GPs	Mel Wright	*31/03/16*		*Not yet started*
IC06	**Stroke** Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Sharon Forrester	*31/03/16*		

South Sefton Intermediate Care - Timeline



UNPLANNED CARE

Scope and Rationale

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

Outcomes

- Reduced emergency admissions
- Reduced readmissions
- Reduced A&E attendances
- Reduced non-elective admissions
- Admission avoidance
- Reduction in admissions
- Increased availability of ambulances
- Increased discharges to home
- Reduced time from discharge to home
- Reduced patients in long term care
- Reduced average length of stay
- Increase number of adults making healthy lifestyle choices
- Increase people's feeling of involvement and confidence to be involved

Priority Projects/Activities

- Review of walk in centre and development of Urgent Care Centre
- Transportation review to support walk in centre model
- Acute visiting scheme
- NWAS pathfinder
- Development of bids from Community Voluntary Sector to support urgent care admissions

Contribution to Strategic Priorities

- Primary Care transformation
- Frail Elderly
- Unplanned Care

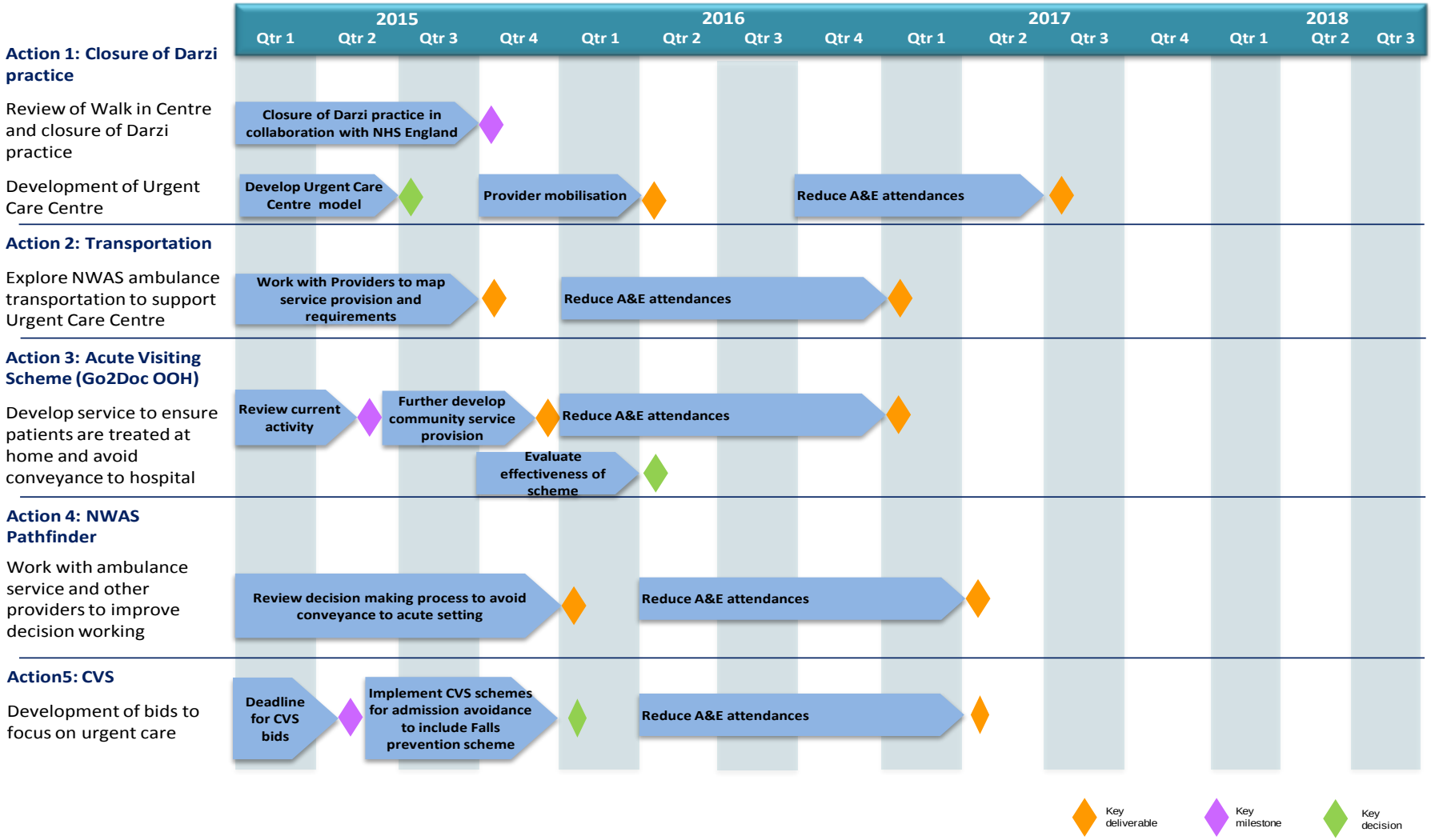
Workstream name: *Unplanned Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Steve Astles*	***Updated****:*

Programme Aim

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

ID Number	Priority Area	Responsible Lead	Date due for completion	Actual completion date	RAG
UC01	**Closure of Darzi practice** Review of Walk in Centre and impact of closure of Darzi practice, development of an Urgent Care Centre	*Steve Astles* *Andy Mimnagh*	*Sept 15*		
UC02	**Transportation** Explore ambulance transportation requirements to support Walk in Centre as part of new model of care as an alternative to A&E	*Steve Astles* *Terry Hill*	*June 15*		
UC03	**Acute Visiting scheme** Develop service to ensure patients are treated at home and avoid conveyance to hospital	*Steve Astles*	*Mar 16*		
UC04	**NWAS pathfinder** Work with ambulance service and other providers to improve decision-making before making transfer to urgent care settings.	*Steve Astles*	*Mar 16*		
UC05	**Community Voluntary Sector (CVS) and Public Health** Development of the bids from CVS to focus on urgent care to support patients to avoid admission	*Steve Astles* *Geraldine O'Carroll*	*May 15*		

South Sefton Unplanned Care - Timeline



MENTAL HEALTH

Scope and Rationale

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care

Outcomes

- Dementia diagnosis
  - 75% of identified population by 2015/16
  - 90% of identified population by 2018/19
- More people independently managing dementia
- Reduce Tier 4 placements
- Improve response times
- Reduce waiting times
- Early Identification
- Improve patient experience

Priority Projects/Activities

- Outcomes and Activity
  - Develop suite of measurable outcomes with Provider
- Dementia
  - development of integrated locality model
- Commission All Age Mental Health Service
  - To incorporate Child and Adolescent mental health services (CAMHS)
- Brain Injury
  - Move to new contracting arrangements following review by Cheshire and Mersey Clinical Network
- Primary and Community Care Development
  - Training analysis

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

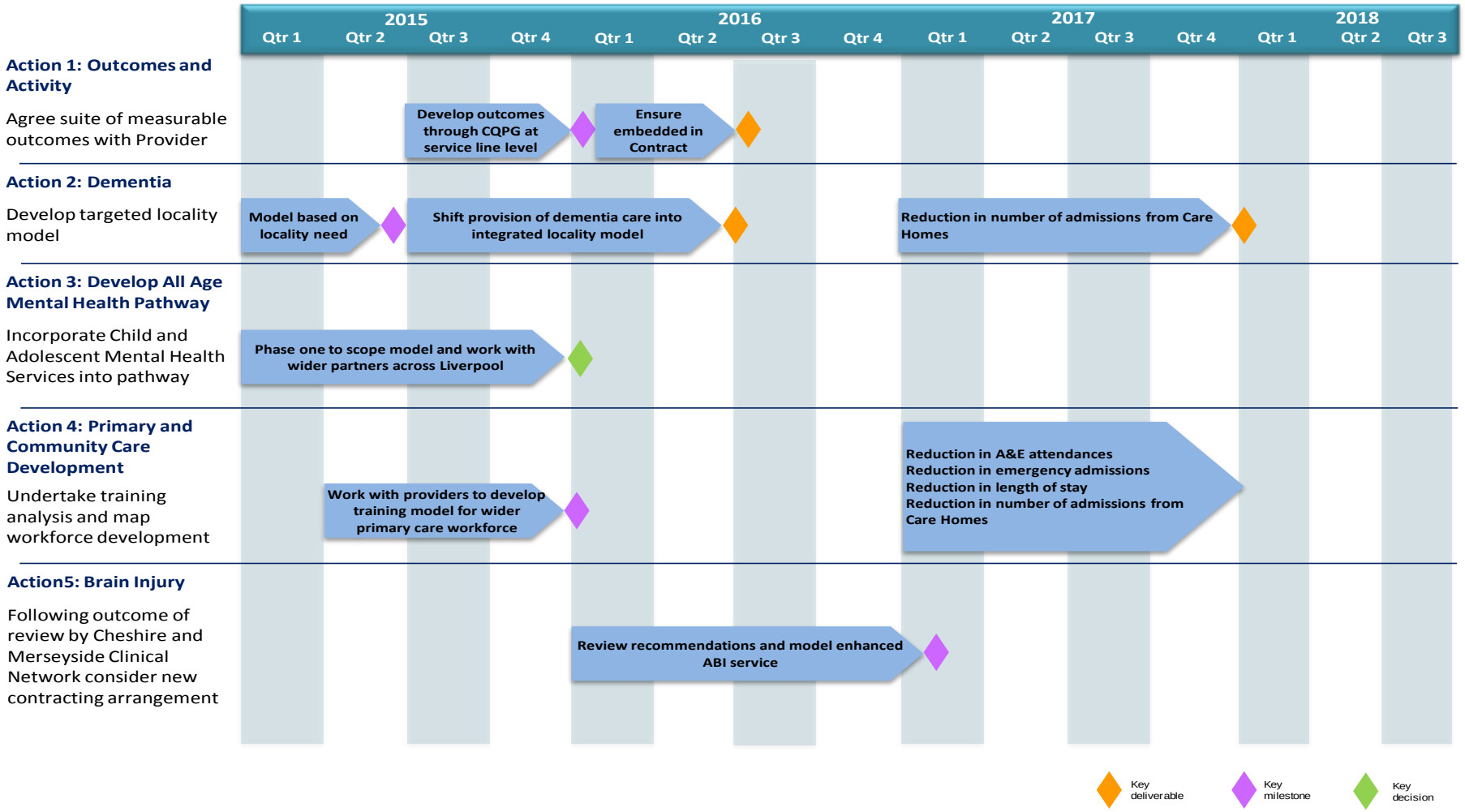
Workstream name: Mental Health	*Date: 09 Feb. 15*
Senior Manager Lead: *Geraldine O'Carroll*	***Updated****:*

Programme Aim

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care

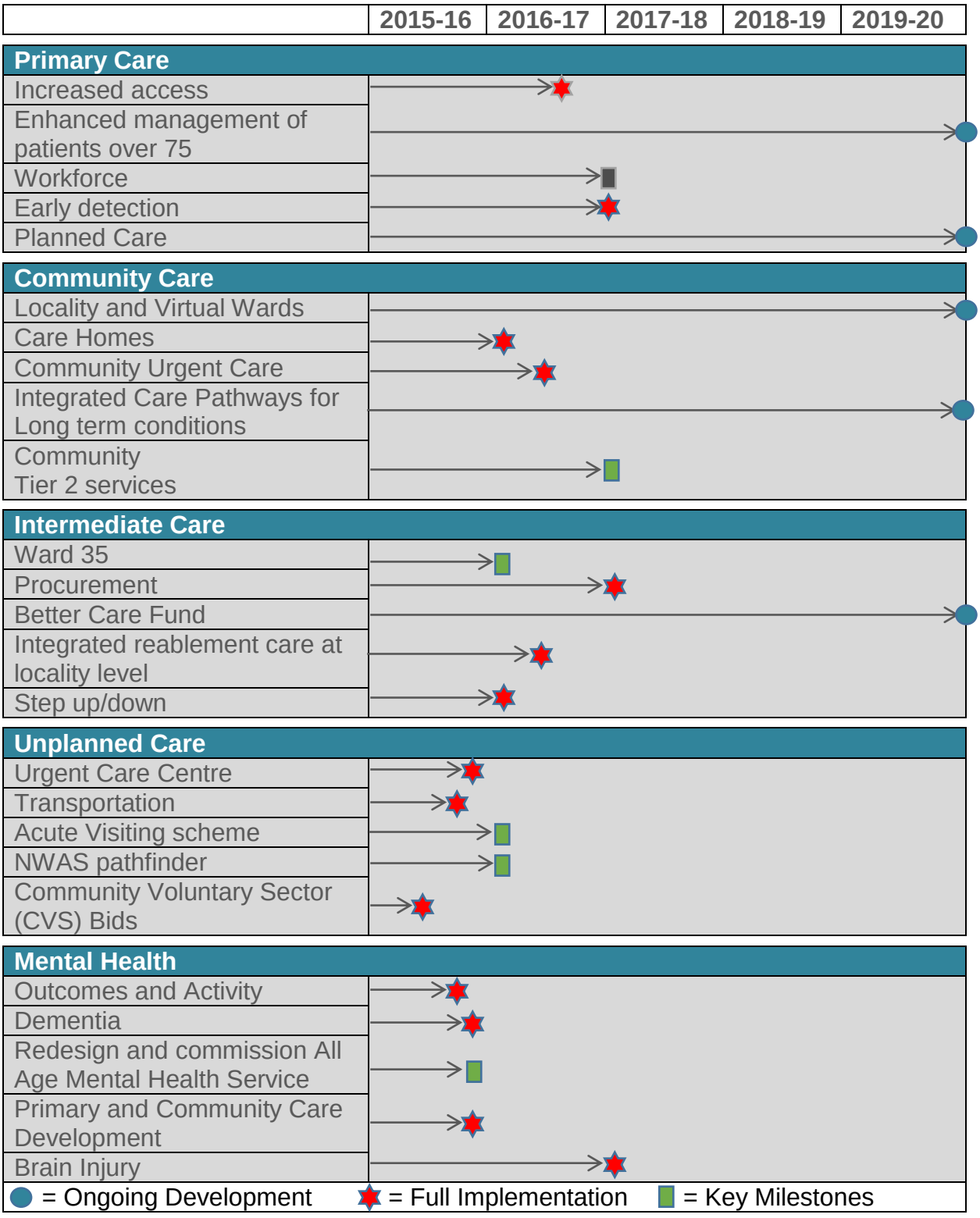
ID Number	Priority Area	Responsible Lead	Date due for completion	Actual completion date	R A G
MH01	**Outcomes and Activity** Agree a suite of measureable outcomes with Mersey Care	*Malcolm Cunningham*	*Dec 15*		
MH02	**Dementia** Shift provision of dementia care from current provider to integrated locality model	*Kevin Thorne*	*Mar 16*		
MH03	**Redesign and commission All Age Mental Health Service** To incorporate Child and Adolescent mental health services (CAMHS)	*Gillian Bruce*	*Phase one Mar 16*		
MH04	**Primary and Community Care Development** Undertake training analysis and map workforce development	*Geraldine O'Carroll*	*Mar 16*		
MH05	**Brain Injury** Move to new contracting arrangement following review by Cheshire and Merseyside Clinical Network	*Geraldine O'Carroll Martin McDowell*	*Mar 17*		

South Sefton Mental Health - Timeline



TIMELINE

Key workstream delivery schedule for South Sefton CCG:



ACTION, DELIVERY & TIMELINES SOUTHPORT AND FORMBY CCG

PRIMARY CARE

Scope and Rationale

The aim of the Primary Care work stream is to develop a population-based approach to primary care and support them to improve access to primary care and enhance quality of service.

Outcomes

- Better patient experience
- Reduce A&E attendances
- Reduction in referrals
- Reduction in admissions
- Increased prevalence rates
- Reduction in re-admissions
- Reduced length of stay
- Reduced number of admissions from care homes
- Increased quality and provision of primary care diagnostics and monitoring

Priority Projects/Activities

- Increased access
- Enhanced management of patients over 75
- Workforce
  - Succession Planning
- Early detection:
  - CVD – increased uptake of Health Checks
  - Hypertension – recording, management and treatment
  - Atrial Fibrillation (AF) Management – improve case finding and management
- Planned Care
  - Increase use of Choose and Book utilisation

Contribution to Strategic Priorities

- Unplanned Care
- Long term conditions

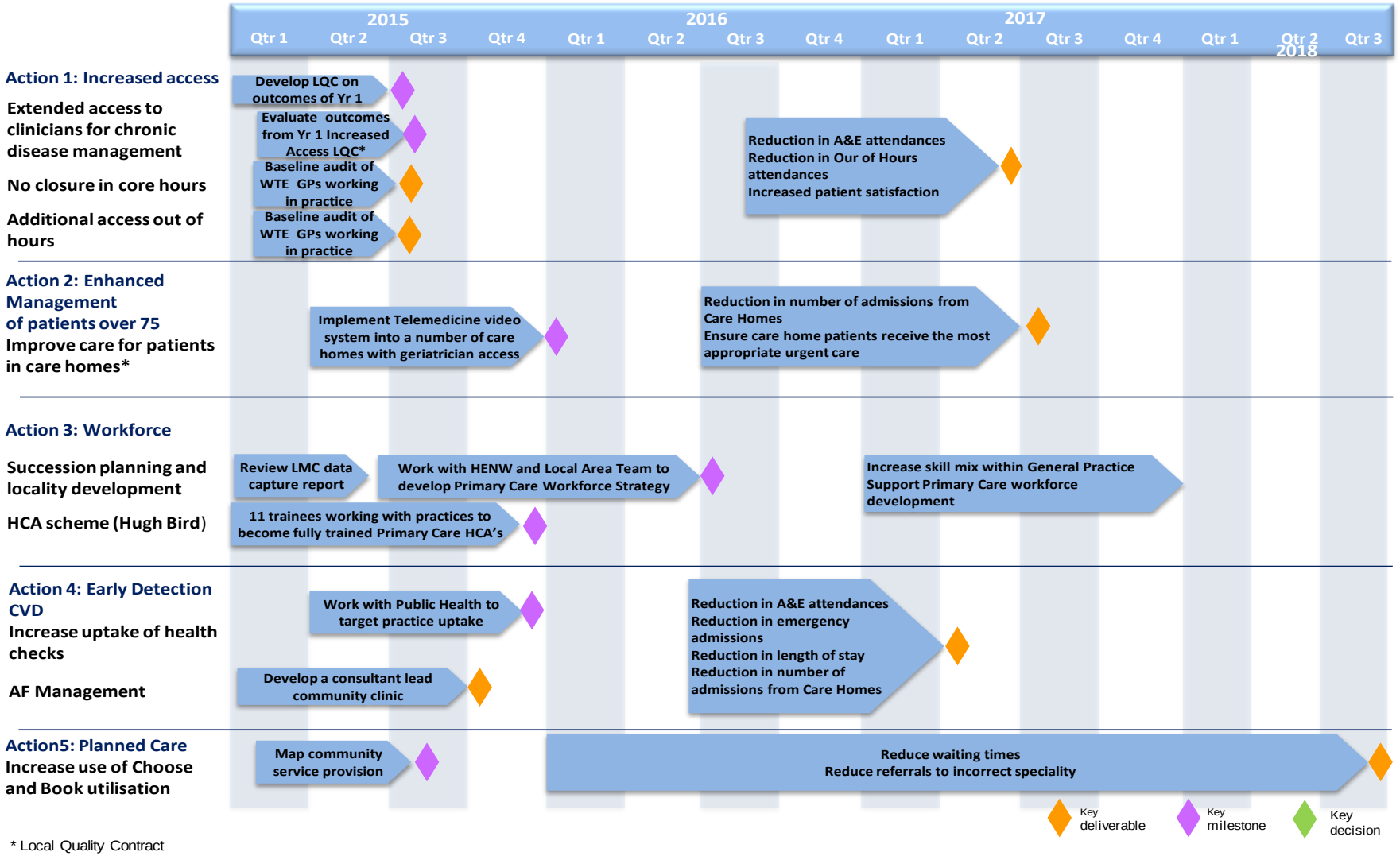
Workstream name: Primary Care	***Date:*** *09 Feb 15*
Senior Manager Lead: *Angela Parkinson*	***Updated****:*

Programme Aim

We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

ID Number	Priority Area	Responsible Lead	Date due for Completion	Actual completion date	RAG
PC01	**Increased access** Extended access to clinicians for chronic disease management. No closure in core hours, additional access outside of core hours. Link to quality scheme	Angela Parkinson	Aug 15		
PC02	**Enhanced management of patients over 75** Improved care for patients in care homes by offering more intensive health treatment Link to quality scheme	Moira McGuiness	Sept 15		
PC03	**Workforce** Succession planning and locality development HEE data capture LMC report	Angela Parkinson	Mar 17		
PC04	**Early detection** CVD Increased uptake of Health Checks. Hypertension – recording, management and treatment Atrial Fibrillation (AF) Management – improve case finding and management	Sharon Forrester	Mar 16		
PC05	**Planned Care** Increase use of Choose and Book utilisation for both acute and community services	Terry Hill	Sept 15		

Southport and Formby Primary Care - Timeline



* Local Quality Contract

Scope and Rationale

We will commission services that better link together right across health and social care – from hospital 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.

Outcomes

- Improved support for frail elderly
- Reduce A&E attendances
- Reduction in admissions
- Improve health outcomes
- Reduce inequalities
- Admission avoidance
- Long Term Condition support
- Discharge Support
- Increase the number people dying in their preferred place of care by 1%
- Increased use of clinical pathways

Priority Projects/Activities

- Further develop Integrated Community Services
  - Enhance skills of CERT
  - Review treatment rooms
  - Develop SPA
  - Develop Geriatrician model
- Implement developed care pathways
  - Diabetes
  - Cardiology
  - Respiratory
  - Dementia
  - End of Life
  - Frail elderly
- Review of community tier 2 services
- Reduce unplanned admissions for children with:
  - Asthma
  - Epilepsy
  - Diabetes
  - CF

Contribution to Strategic Priorities

- Unplanned Care
- Frail Elderly

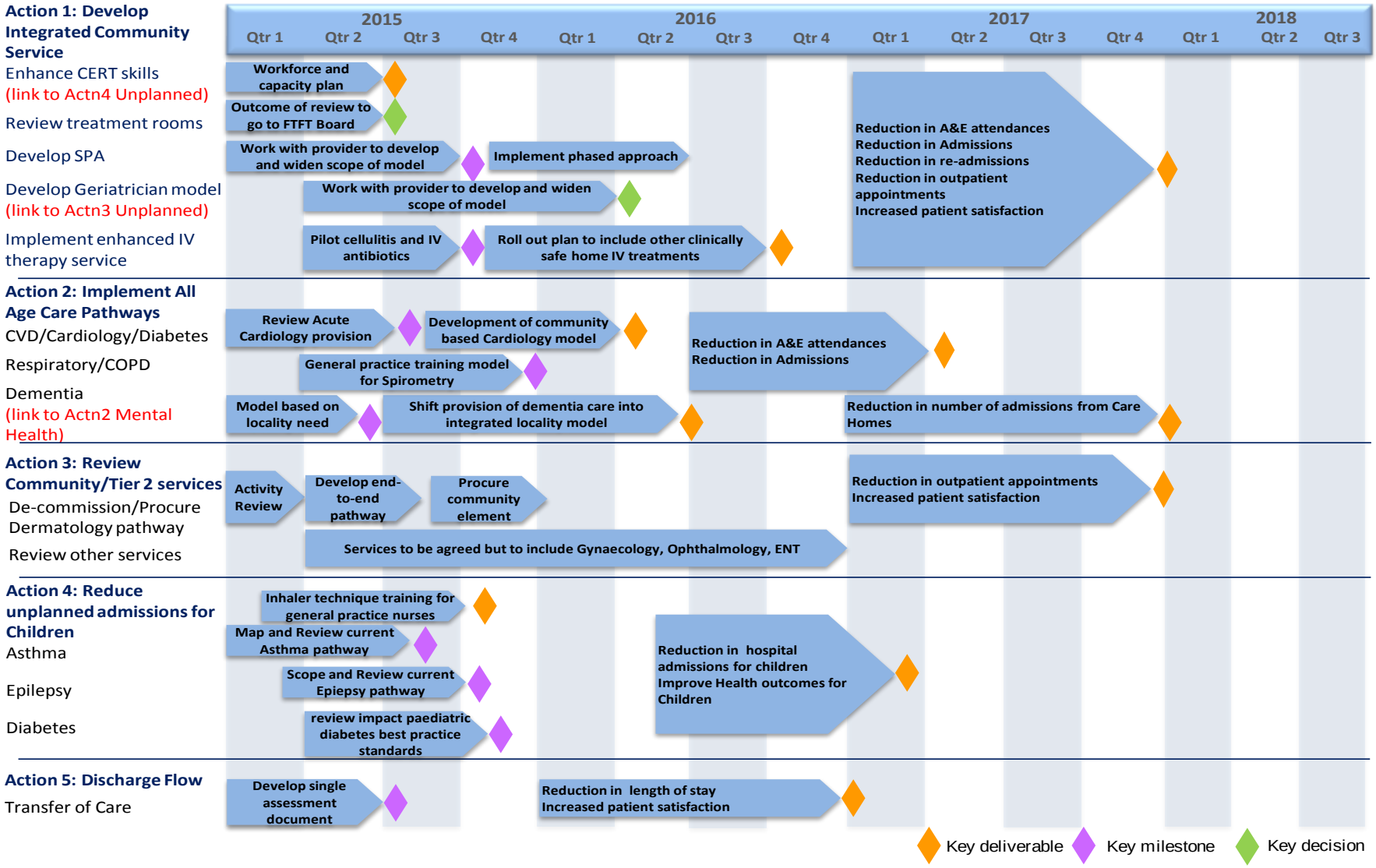
Workstream name: *Community Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Billie Dodd*	***Updated****:*

Programme Aim

We will commission services that better link together right across health and social care – from hospital 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.

ID Number	Priority Area	Responsible Lead	Date due for Completion	Actual completion date	RAG
CC01	**Develop Integrated Community Services** • Enhance skills of Community Emergency Response Team (CERT) • Review treatment rooms • Develop Single Point of Access (SPA) • Develop Geriatrician model • Implement enhanced IV therapy service	Billie Dodd	Phase one - June 15 Phase two – Apr 16		
CC02	**Implement Developed All Age Care Pathways** • CVD /Cardiology / Diabetes • Respiratory • Dementia and Frail elderly	Sharron Forrester Terry Hill Jenny Kristensen Kevin Thorne	Jan 16		
CC03	**Review of Community/Tier 2 services and activity** • De-commission • Procurement	Billie Dodd	Phase one Dermatology Apr 16		
CC04	**Children** Reduce unplanned admissions for children with: • Asthma / Epilepsy / Diabetes	Jane Uglow	Apr 16		
CC05	**Discharge flow** Transfer management of discharge from acute into community	Mel Wright	Sept 15		

Southport and Formby Community Care - Timeline



Scope and Rationale

The Intermediate Care aim is to have ONE point of access, ONE assessment, ONE care planning process. This will be enabled by commissioning co-ordinated care for patients via integrated services and being responsive to patient's needs.

Outcomes

- More integrated, efficient and effective intermediate care
- Reduce hospital admissions
- Reduce re-admissions
- Reduce length of stay
- Ensure decisions about long term care are not made in an acute setting

Priority Projects/Activities

- Tender Intermediate Care bed provision
- Better Care Fund
  - Integrated approach with local authority for care transition
- Integrated care at locality level to ensure timely discharge
- Increase use of appropriate use of step up / step down beds
- Stroke:
  - Development of Intermediate care beds in nursing homes

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

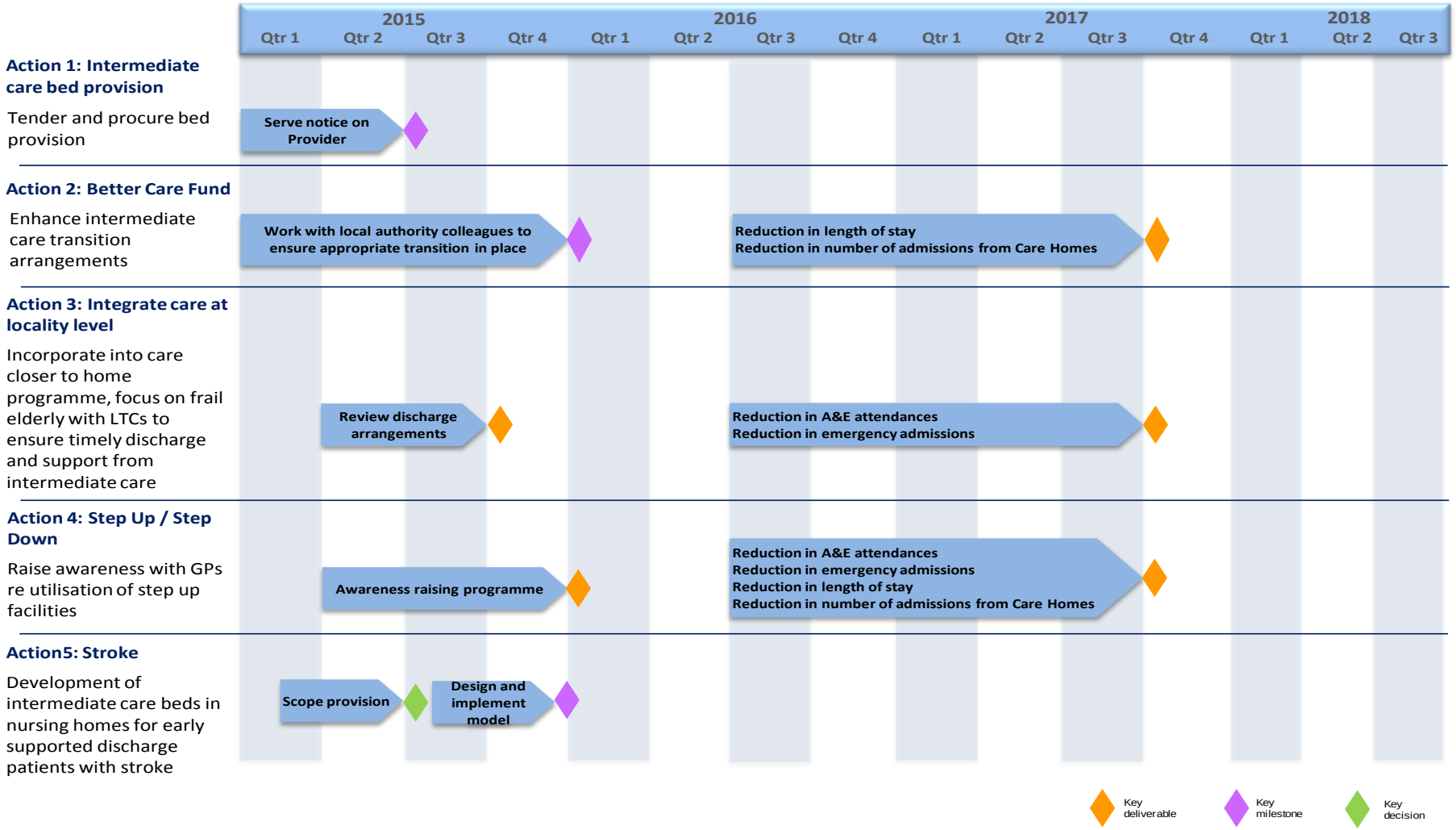
Workstream name: *Intermediate Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Melanie Wright*	***Updated****:*

Programme Aim

Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.

ID Number	Priority Area	Responsible Lead	Date due for completion	Actual completion date	RAG
IC01	**Intermediate Care Bed Provision** Tender above service	Mel Wright	01/04/16		*Not yet started*
IC02	**Better Care Fund** Work with local authority to enhance intermediate care transition arrangements Better Care Fund initiative	Mel Wright	Ongoing		
IC03	**Integrated care at locality level** Incorporate into care closer to home model with particular focus on frail and elderly with long term conditions, ensure timely discharge and support from intermediate care Better Care Fund initiative	Mel Wright	*01/04/16*		
IC04	**Step up/down** patient flow - appropriate increase in use of step up beds particularly requested by GPs - Awareness raising exercise with GPs	Mel Wright	*TBC*		*Not yet started*
IC05	**Stroke** Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Sharon Forrester	*31/03/16*		

Southport and Formby Intermediate Care - Timeline



UNPLANNED CARE

Scope and Rationale

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

Outcomes

- Reduced emergency admissions
- Reduced readmissions
- Reduced A&E attendances
- Reduced non-elective admissions
- Increased availability of ambulances
- Increase number of adults making healthy lifestyle choices
- Increase people's feeling of involvement and confidence to be involved
- Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking)
- Reduce hospital admissions

Priority Projects/Activities

- Primary Care Engagement
- Development Ambulatory Care Sensitive Conditions pathways:
  - CVD – Heart Failure reconfiguration
  - Diabetes – In reach diabetes nurse
- Implement Rapid Access Geriatrician Service
- Review role and function of Chronic Care Co-ordinators
- Development of bids from Community Voluntary Sector

Contribution to Strategic Priorities

- Primary Care Transformation
- Frail Elderly
- Unplanned Care

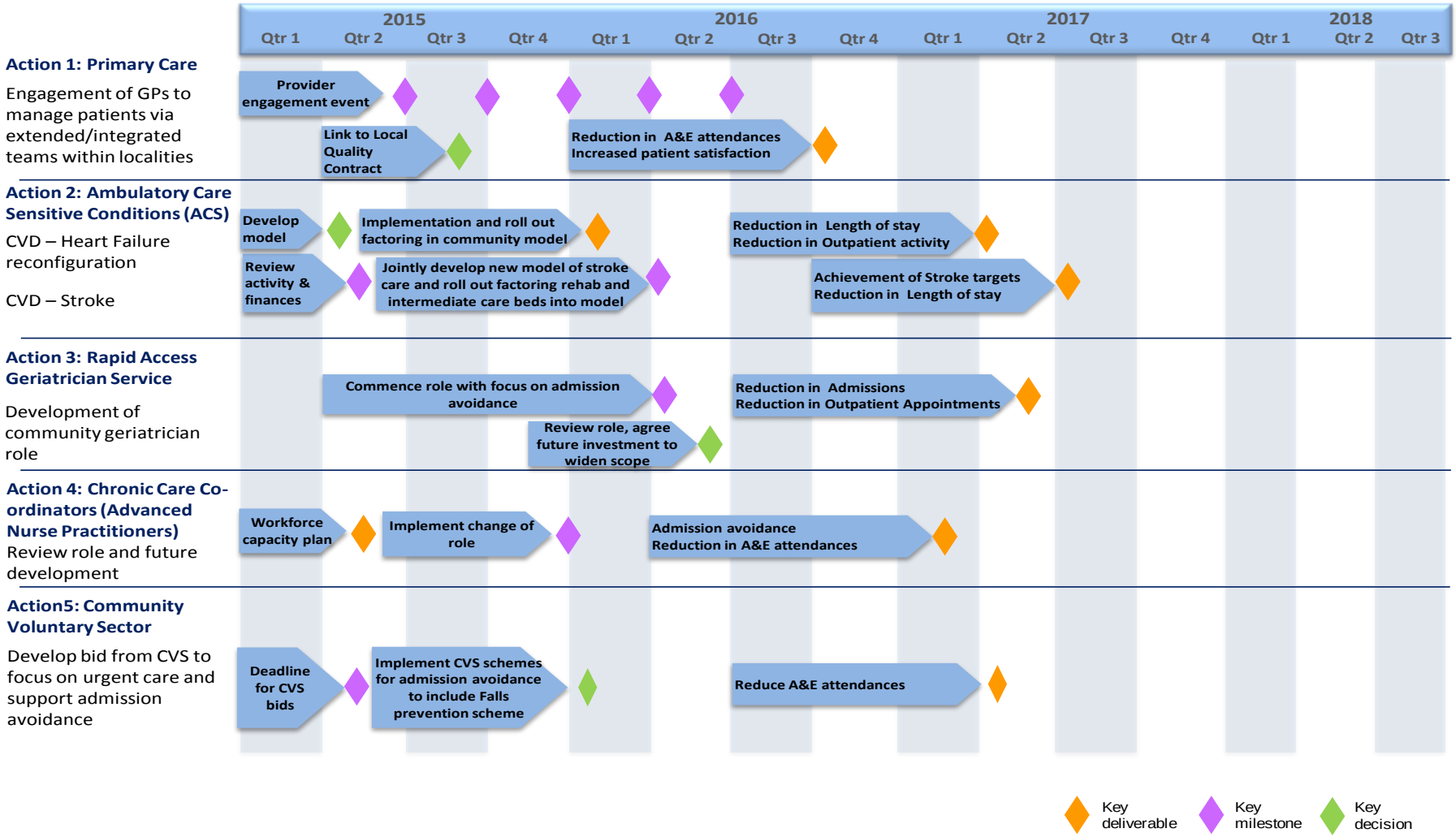
Workstream name: *Unplanned Care*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Billie Dodd*	***Updated****:*

Programme Aim

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

ID Number	Priority Area	Responsible Lead	Date due for completion	Actual completion date	RAG
UC01	**Primary Care** Engagement of GPs within Primary Care to support practices to manage patients via extended/integrated primary care teams within localities	Billie Dodd Angela Parkinson	Aug 15		
UC02	**Ambulatory Care Sensitive Conditions (ACS)** CVD • Heart Failure - reconfiguration • Stroke – link with network Diabetes • In reach diabetes nurse	Sharon Forrester Terry Hill	*Jun 16*		
UC03	**Raid Access Geriatrician Service** Further development of geriatrician role to support community teams	Billie Dodd	Operational Jun 15		
UC03	**Chronic Care Co-ordinators** Review of role and future development	Billie Dodd	*Apr 16*		
UC05	**Community Voluntary Sector (CVS)** Development of the bids from CVS to focus on urgent care to support patients to avoid admission	Geraldine O'Carroll	Jun 15		

Southport and Formby Unplanned Care - Timeline



Scope and Rationale

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care.

Outcomes

- Dementia diagnosis
  - 75% of identified population by 2015/16
  - 90% of identified population by 2018/19
- More people independently managing dementia
- Reduce Tier 4 placements
- Improve response times
- Reduce waiting times
- Early Identification
- Improve patient experience

Priority Projects/Activities

- Outcomes and Activity
  - Develop suite of measurable outcomes with Provider
- Dementia
  - development of integrated locality model
- Commission All Age Mental Health Service
  - To incorporate Child and Adolescent mental health services (CAMHS)
- Brain Injury
  - Move to new contracting arrangements following review by Cheshire and Mersey Clinical Network
- Primary and Community Care Development
  - Training analysis

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

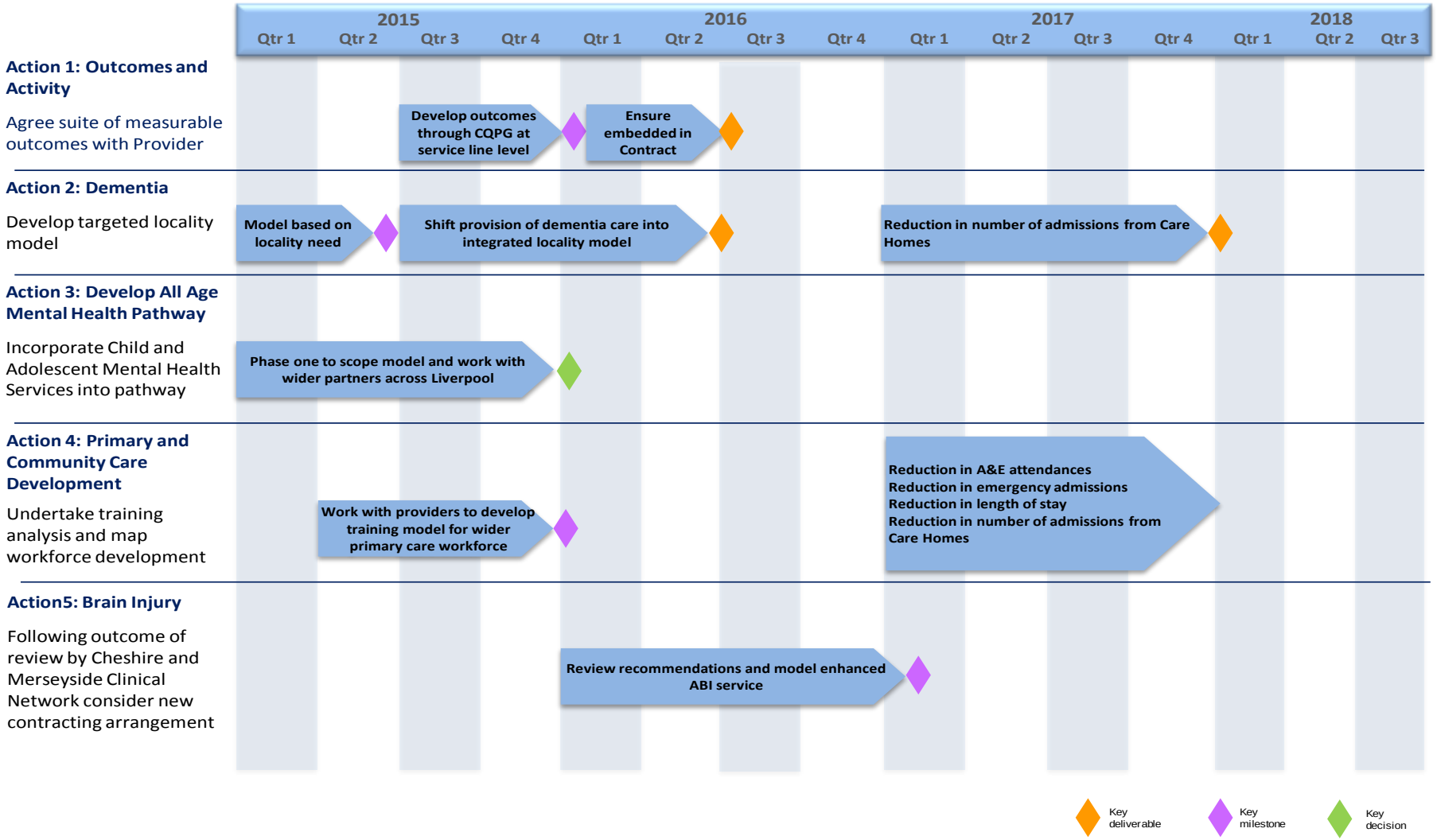
Workstream name: *Mental Health*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Geraldine O'Carroll*	***Updated****:*

Programme Aim

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care.

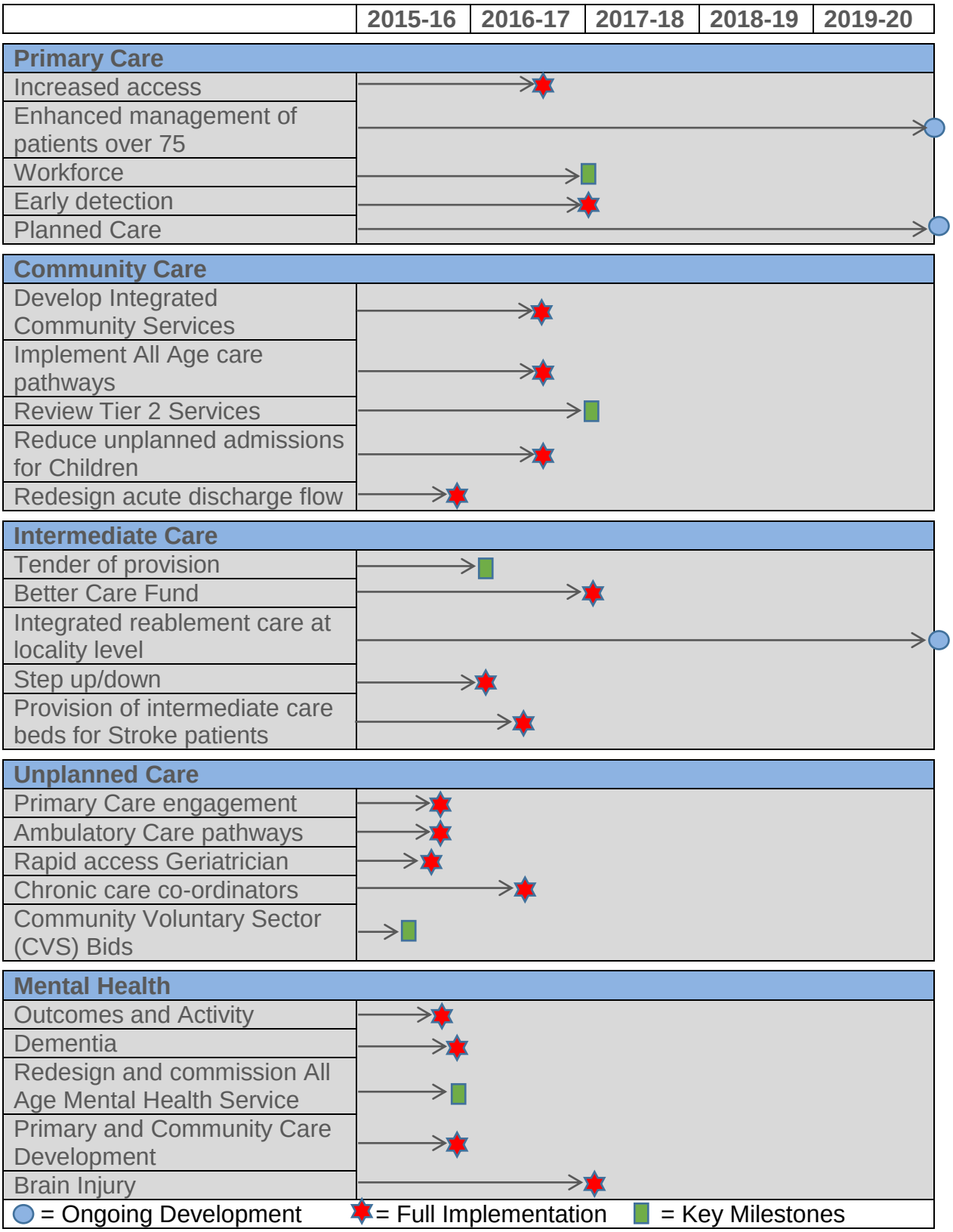
ID Number	Priority Area	Responsible Lead	Date due for completion	Actual completion date	RAG
MH01	**Outcomes and Activity** Agree a suite of measureable outcomes with Mersey Care	*Malcolm Cunningham*	*Dec 15*		
MH02	**Dementia** Shift provision of dementia care from current provider to integrated locality model	*Kevin Thorne*	*Mar 16*		
MH03	**Redesign and commission All Age Mental Health Service** To incorporate Child and Adolescent mental health services (CAMHS)	*Gillian Bruce*	*Phase one Mar 16*		
MH04	**Primary and Community Care Development** Undertake training analysis and map workforce development	*Geraldine O'Carroll*	*Mar 16*		
MH05	**Brain Injury** Move to new contracting arrangement following review by Cheshire and Merseyside Clinical Network	*Geraldine O'Carroll Martin McDowell*	*Mar 17*		

Southport and Formby Mental Health - Timeline



TIMESCALES

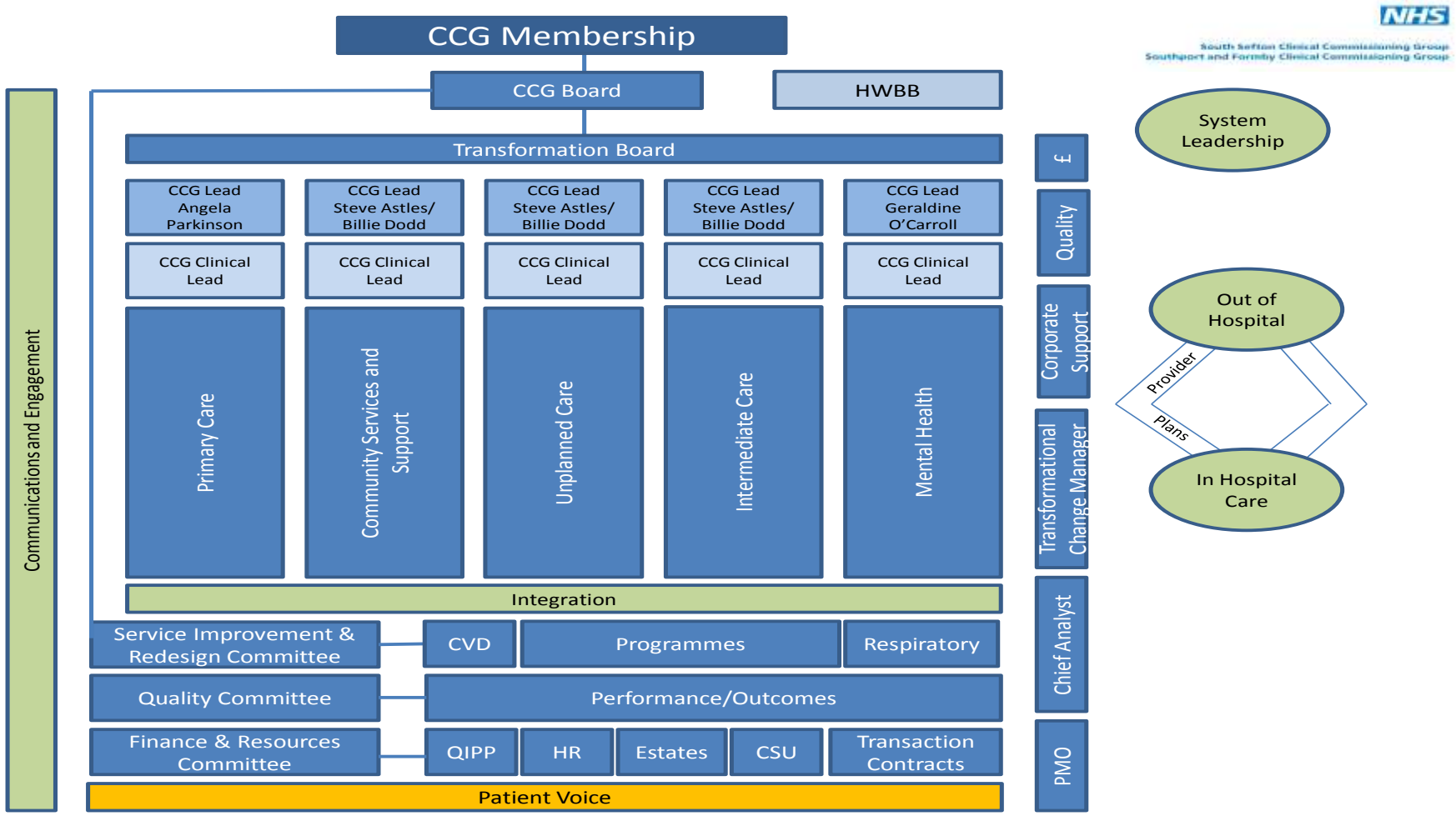
Key workstream delivery schedule for Southport and Formby CCG:



APPENDIX ONE
PROPOSED GOVERNANCE STRUCTURE

DRAFT GOVERNANCE STRUCTURE FOR DELIVERY

These transformation programmes will be managed, progressed and implemented through the individual multi agency gateway groups which will report formally into the Transformation Board.



Joint\management\transformation governance structure v5 060515.ppt

APPENDIX TWO
INITIATIVES, BENEFITS AND MEASURES
SOUTH SEFTON CCG

PRIMARY CARE

INITIATIVE	QUALITY BENEFIT	MEASURE
Increased access and patient choice	Extended access to clinicians. No closure in core hours, additional access outside of core hours.	Reduce A&E attendances
Collaboration across practices	Better patient access Care closer to home	Better patient experience
Co-commissioning – greater involvement	Co-ordination of service provision	Better patient experience
Workforce Planning and Development • **Work with HEE to develop a Primary Care workforce strategy** **Heath Care Assistant scheme in collaboration with Hugh Bird College**	Informed and empowered Workforce Succession Planning	Better patient experience Reduction in referrals Reduction in A&E attendances
Primary Care Infrastructure Fund	Potential to provide a wider range of services closer to home	Better patient experience Reduction in referrals
IT Data sharing / Interoperability	Holistic approach to patient care	Better patient experience
Early detection CVD • **Increased uptake of Health Checks.** • **Hypertension – recording, management and treatment** • **Atrial Fibrillation (AF) Management – improve case finding and management**	Prevention of multiple long term conditions Better patient outcomes Better management of patients with long term conditions	Reduce A&E attendances Reduction in admissions Increased prevalence rates Better patient experience
Early detection	Joint commissioning of rehabilitation facilities with Public Health and third sector Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Reduce A&E attendances Reduction in admissions Reduction in re-admissions Reduced length of stay Reduced number of admissions from care homes
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment	Reduced number of admissions from care homes

	Reduction in hospital acquired complications Maintain function level of patients Improve End of Life care	Reduced length of stay Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1%
Children • **obesity – supporting primary care and public health** • **Reducing variability within primary care by optimising medicines use**	Better Quality of Life Reduced morbidity Eradicating prescribing errors between secondary and primary care Support patients to get the best from their medicines	Reduction in referrals Reduction in admissions
Diabetes • **Prevention – Impaired Glucose Regulation (IGR)** • **Prevention – Increased awareness** • **Identify pilot areas to further develop pathways for IGR screening** • **Dashboard due to be rolled out to all practices to support practices to case find, identify and understand variation at practice level** • **Education – for both health professionals and patients**	Early intervention can prevent, delay or reverse the onset of diabetes Evidence of clinical and cost effectiveness for lifestyle interventions Offer of support every step of the way, take small steps, Provide assistance with willpower, coping strategies and practical support.	Reduction in referrals Reduction in admissions Better patient experience
Respiratory • **Primary care education programme covering Asthma and COPD all ages** • **Roll out inhaler technique across all localities** • **Review all at risk patients across all four localities**	Understand the impact the disease process regarding the quality of life of these patients and the importance of self management. Identifying the early detection of COPD. Increased self management	Reduce A&E attendances Avoid hospital admissions Better patient experience

Cancer • **Cancer Research UK – two posts in Merseyside and Cheshire undertaking practice visits** • **Programme of screening uptake** • **Embedding best practice via Macmillan GPs**	Increased awareness Earlier diagnosis Increased screening uptake Management of late effects of cancer and cancer treatments	Reduce A&E attendances Avoid hospital admissions Better patient experience
Planned Care • **Choose and Book utilisation** • **Choose and Book addition of community services**	Increased patient choice Reduce DNAs Increased	Reduce waiting times Reduce referrals to incorrect speciality Reduce referrals to secondary care Reduction in unplanned admissions
End of Life • **Access to Community geriatrician team to support Primary Care Team in complex cases** • **Collaborative working with Public Health to raise awareness of 'Dying Matters'** • **Raise public awareness around care planning** • **Develop bereavement frameworks to effectively and efficiently provide bereavement support and signposting to avoid future psychological distress and morbidity** • **TRANSFORM Education programme**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Promote public awareness of dying, death and bereavement improve the quality of end of life care	Increase the number people dying in their preferred place of care by 1% Reduction in unplanned admissions

COMMUNITY CARE SOUTH SEFTON

INITIATIVE	QUALITY BENEFIT	MEASURE
Locality and Virtual Wards • **Enable direct telephone access for professionals and patients** • **Improve internal coordination including permanent role of dedicated virtual ward manager** • **Develop the community matron model** • **Facilitate improved integration across all disciplines through electronic and face-to-face mechanism including effective virtual ward round** • **Improve pro-active care program impact** • **Shared care planning for top 2% at risk including palliative and care home patients using standardised template** • **Access to all respective virtual ward staff to the common care record** • **Mobile working for all virtual ward staff** • **Electronic managed referrals into the virtual ward** • **Continuity and relational coordination of staff aligned to specific GP practices** • **Align health visitors and district nurses to practices** • **Streamline treatment room workflow and task shift to enable efficiency** • **Community Navigators (Health Trainers) in partnership with Public Health– focus on prevention and healthy living**	Identification and case management of 'at risk' patients within the community Outcomes for the frail elderly and those with long-term conditions will be improved Co-ordination of care Integration of care Proactive nursing Re-ablement Common patient record and IT system	Reduction in unplanned/emergency admissions Reduction in re-admissions Reduced length of stay Better health outcomes

Care Homes • **Community matron for each locality to support care homes along with primary care** • **Promotion and support of NWAS/SSCCG care plan along with advanced care planning facilitated via care home facilitator (6 steps programme) and advanced care plan lead (new post)** • **Standardisation of care home protocols** • **Community geriatrician in-reach to care homes** • **Tele-medicine video support for care homes to community matrons, UCT, on-call geriatrician and remote nursing support** • **Quality dashboard working in conjunction with the LA** • **Ongoing support by meds management** • **Care home improvement collaborative**	Extended access to clinicians. Co-ordination of service provision Potential to provide a wider range of services closer to home Holistic approach to patient care Better patient outcomes Better management of patients with long term conditions Improved care for patients in care homes by offering more intensive health treatment Reduction in hospital acquired complications	Reduced number of admissions from care homes Reduced length of stay for care home admissions Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1% Reduction in A&E attendances Avoid hospital admissions Better patient experience

Community Urgent Care
• **Acute GP home visiting scheme**
• **Integration of all community urgent care providers including the following**
  ○ **NWAS pathfinder step down to UCT and GP OOH**
  ○ **Integration and assimilation of CRT and cellulitis to UCT**
  ○ **Acute trust front door community urgent care coordinator**
• **Urgent care team input into care homes directly**
• **Increase number of community based**
	Improved access to primary care
	Care closer to home
	Reduced exposure to hospital acquired infections
	Co-ordinated response to urgent care
	Patients able to live more independently
	Patients stay at home longer
	Emotional, physical and social care needs assessed together
	Common patient record and IT system
		Reduced number of admissions from care homes
		Reduced length of stay for care home admissions
		Reduction in Hospital acquired infections
		Reduction in A&E attendances
		Avoid hospital admissions
		Better patient experience

intermediate care beds • **Single entry and coordination for intermediate care** • **Rotation of therapists through acute trust, CICT, ward 35** • **Patient alert system to community matrons, specialist teams, acute trust front end coordinator** • **Ratified pathway development for 14 ambulatory care conditions** • **Mobile access to EMIS for all staff** • **Consolidation of SPC including scoping health and social integration**		

Integrated Care Pathways for LTCs
• **For the following conditions**
  ○ **Diabetes**
  ○ **Heart Failure**
  ○ **COPD**
  ○ **Palliative care**
  ○ **Dementia & Frailty**
• **Consultant community hot clinics**
• **Consultant oversight for specialist nursing teams**
• **Develop role and opportunity of GPSI**
• **Seamless step-up step down**
	Improved access to clinician
	Care closer to home
	Reduced exposure to hospital acquired infections
	Patients able to live more independently
	Patients stay at home longer
	Holistic approach to patient care
	Better patient outcomes
	Better management of patients with long term conditions
		Reduction in admissions
		Reduction in re-admissions
		Reduced length of stay
		Improve health outcomes
		Reduce Inequalities

Diagnostic Services • **Urgent bloods wait time to 24h for domiciliary, treatment room and UCT**	Develop more community specialty services to streamline intervention Ensure only appropriate conditions are referred to secondary care	Reduce A&E attendances Better patient experience Care closer to home Reduce referrals
End of Life • **develop a locality based structure for all staff**	Extended access to clinicians.	Increase number of people

delivering palliative care • **ensure that those who wish to die in the community in their PPC have the support they require** • **improve access to EOL beds in the community for those where it is not possible to support their needs in their own home** • **commission additional bed capacity for EoL patients** • **support and improve integration of all EOL services to ensure that patients are able to die in their PPC** • **support an integrated programme of education for all of those delivering EOL care in the community** • **ensure that all EOL care in the community is of high quality and supported by the necessary expertise regardless of where this take place ie, private home, care home**	Care closer to home Co-ordination of service provision Holistic approach to patient care Improve the quality of end of life care Appropriate increase in use of step up beds Promote awareness of dying, death and bereavement	dying in usual place of residence Reduced LoS Admission avoidance Reduction in unplanned admissions Increase in reablement
Cancer • **to develop the virtual ward Macmillan coordinator role (vacant)** • **to scope the information and support needs of patients in South Sefton and recognise existing services to develop a directory/programme for survivorship** • **to improve the cancer knowledge of existing staff including primary care so that patients can/may receive their long term cancer follow up in the community (see primary care)**	Increase awareness of Macmillan's services Communicate campaign messages Involve local people Improve the lives of people affected by cancer across the Sefton	Admission avoidance Reduction in unplanned admissions

Respiratory • **Develop patient led self-care pilot programme** • **Review current respiratory pulmonary rehab programme and develop new programme with Public Health and SCVS** • **Commission enhanced Home Oxygen Therapy Service** • **Set- up MUR programme to train local pharmacies correct inhaler technique**	Early detection Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
CVD • **Telehealth – consultant hotline pilot** • **Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.**	Increased access to clinician Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Diabetes • **Review of community diabetes care** • **Work with current Acute Provider to explore benefits of joint clinics for patients with diabetes and kidney injury** • **Implementation of a primary care pathway for diabetes footcare, scope and potential cost and provider implications** • **Gestational diabetes – clinical pathway out to consultation outlining support before and during pregnancy**	Early detection Increased access to clinician Increased self management Care closer to home Holistic approach Reduce morbidity	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Children • **Review children's community nursing team with a view to commissioning an integrated children's nursing model in 16/17** • **Reduce unplanned admissions for children with LTC: asthma, epilepsy, diabetes, CF**	Increased access to clinician Care closer to home	Admission avoidance LTC support Discharge Support Reduce A&E attendances

• **Review community paediatric services** • **Review children's therapies** • **Replicate inhaler technique pilot for children** • **Palliative care review** • **End of Life review** • **Review complex children's nursing care**		
Development of community/Tier 2 services • **Ophthalmology community assessment service (OCAS)** • **ENT** • **Dermatology**	Care closer to home	Reduce outpatient activity

INTERMEDIATE CARE

INITIATIVE	QUALITY BENEFIT	MEASURE
Enhanced intermediate care and reablement (BCF initiative)	Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Step up/down – patient flow (CC2H)	Appropriate increase in use of step up beds particularly requested by GPs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Integrated care at locality level building on virtual ward and care closer to home (BCF initiative)	Focus on Frail and elderly with LTCs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting

UNPLANNED CARE SOUTH SEFTON

INITIATIVE	QUALITY BENEFIT	MEASURE
Acute Visiting Scheme	Support for care home patients More patients being treated at home rather than being conveyed to hospital	Reduction in unnecessary attendances to hospital
Ambulatory Care Sensitive (ACS) Conditions • **CVD Heart failure – reconfiguration of acute heart failure team to work alongside consultant in AED** • **Respiratory – in reach of Community team**	Development of zero-stay ambulatory care condition pathways This would offer appropriate fast track diagnosis and treatment in an assessment area and discharge to the community to prevent admission Consultant reviews Initiation of treatment	Admission avoidance Reduction in admissions Admission avoidance Reduction in admissions
NWAS pathfinder acute visiting scheme	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings More patients being treated at home/in the community rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances Reduce emergency admissions
Explore ambulance transportation requirements to support Walk in Centre as part of new model of care as an alternative to A&E	Reducing conveyance to A&E Referring to Primary Care/OOH if required	Reduction in non-elective activity
Integrated Discharge Team	Better patient and carer experience Reduction in hospital acquired complications Prompt and pro-active identification of end of life care	Increased discharges to home Reduced time from discharge to home Reduced patients in long term care Reduced length of stay
111 programme implementation	Provide advice for patients and appropriate use of services	Reduce A&E attendances

Review of Walk in Centre and impact of closure of Darzi practice – development of Urgent Care Centre	More patients being treated in the community rather A&E	Reduce A&E attendances
Self care/management • **easily accessible support for the self management of conditions delivered as part of the virtual ward and health and wellbeing board via the better care fund** • **Patient education**	Disease prevention Minor illness Improved signposting Targeted education Tailored self-care plan Assistive Technologies	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Development of the Community Voluntary Sector (CVS) - Bids from CVS to focus on urgent care to support patients to avoid admission	Ensure services are used appropriately and community Engagement and commissioning	
Proactive case management	To support self-care and early disease management	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Proactive case finding	To support self-care and early disease management	Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of

		unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Additional Community Geriatricians	To support the Community teams	Reduction in unplanned admissions Reduced Length of Stay
Cancer **Develop acute oncology to include outpatient clinic access for cancer of unknown primary 2/52 clinic, side effects of treatment**	Better patient and carer experience To support early diagnosis	Reduction in unplanned admissions Reduced Length of Stay

MENTAL HEALTH

INITIATIVE	QUALITY BENEFIT	MEASURE
Primary Care development and education	Raise awareness and understanding	Patient satisfaction Survey
Dementia	Holistic care for patient Improved screening Services wrapped around patient Access to voluntary services Develop service to meet patient need Extend memory services Enhance Alzheimer's Society Support Review use of anti psychotic drugs for Dementia	75% of identified population by 2015/16 90% of identified population by 2018/19
Child and Adolescent Mental Health Services (CAMHS)	Improve access and understanding of CAMHS services Ensure seamless transiton Increased patient experience	Reduce Tier 4 placements Improve response times
Brain Injury	Co-ordinated care for patient	Better patient experience
Outcomes and Activity Information	Introduction of Payment by Results (PbR) is a major organisational change for both providers and commissioners Financial modelling and profiling of risk to be undertaken	To be agreed with Mersey Care NHS Trust
Children • **Review ADHD and ASD pathways** • **Develop Children's IAPT service**	Improve access to services Increased patient experience	Reduce waiting times Early Identification Better patient experience
Cancer • **Psychological support via Aintree cancer pathway**		Better patient experience

APPENDIX TWO
INITIATIVES, BENEFITS AND MEASURES
SOUTHPORT CCG

PRIMARY CARE		
INITIATIVE	**QUALITY BENEFIT**	**MEASURE**
Collaboration across practices	Better patient access Care closer to home	Better patient experience
Co-commissioning – greater involvement	Co-ordination of service provision	Better patient experience
Workforce Planning and Development **Heath Care Assistant scheme in collaboration with Hugh Bird College**	In collaboration with NHS England/HENW Succession Planning	
Primary Care Infrastructure Fund	Potential to provide a wider range of services closer to home	Better patient experience Reduction in referrals
IT Data sharing / Interoperability	Holistic approach to patient care	Better patient experience
Increased access and patient choice	Extended access to clinicians. No closure in core hours, additional access outside of core hours.	Reduce A&E attendances
Early detection CVD • **Increased uptake of Health Checks.** • **Hypertension – recording, management and treatment** • **Atrial Fibrillation (AF) Management – improve case finding and management** • **Community cardiology services – review acute cardiology provision**	Prevention of multiple long term conditions Better patient outcomes Better management of patients with long term conditions Rapid access to diagnostics	Reduce A&E attendances Reduction in admissions Increased prevalence rates Better patient experience Reduced LoS
Early detection	Joint commissioning of rehabilitation facilities with Public Health and third sector Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Reduce A&E attendances Reduction in admissions Reduction in re-admissions Reduced length of stay Reduced number of admissions from care homes
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment	Reduced number of admissions from care homes

	Reduction in hospital acquired complications Maintain function level of patients Improve End of Life care	Reduced length of stay for care home admissions Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1%
End of Life • **Access to Community geriatrician team to support Primary Care Team in complex cases** • **Collaborative working with Public Health to raise awareness of 'Dying Matters'** • **Raise public awareness around care planning** • **Develop bereavement frameworks to effectively and efficiently provide bereavement support and signposting to avoid future psychological distress and morbidity** • **TRANSFORM Education programme**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Promote public awareness of dying, death and bereavement improve the quality of end of life care	Increase the number people dying in their preferred place of care by 1% Reduction in unplanned admissions
Children • **obesity – supporting primary care and public health**	Better Quality of Life Reduced morbidity	Reduction in referrals Reduction in admissions
Diabetes • **Prevention – Impaired Glucose Regulation (IGR)** • **Prevention – Increased awareness** • **Identify pilot areas to further develop pathways for IGR screening**	Early intervention can prevent, delay or reverse the onset of diabetes Evidence of clinical and cost effectiveness for lifestyle interventions Provide assistance with willpower, coping strategies and practical support.	Reduction in referrals Reduction in admissions Better patient experience

Cancer • **Cancer Research UK – two posts in Merseyside and Cheshire undertaking practice visits** • **Programme of screening uptake** • **Embedding best practice via Macmillan GPs**	Increased awareness Earlier diagnosis Increased screening uptake Management of late effects of cancer and cancer treatments	Reduce A&E attendances Avoid hospital admissions Better patient experience
Respiratory • **Primary care education programme covering Asthma and COPD all ages** • **Roll out inhaler technique across all localities**	Understand the impact the disease process regarding the quality of life of these patients and the importance of self management. Identifying the early detection of COPD. Increased self management	Reduce A&E attendances Avoid hospital admissions Better patient experience
Planned Care • **Choose and Book utilisation** • **Choose and Book addition of community services** • **Choice**	Increased patient choice Reduce DNAs Increased	Reduce waiting times Reduce referrals to incorrect speciality Reduce referrals to secondary care Reduction in unplanned admissions

COMMUNITY CARE		
New pathways of care introduced (CC2H)	**For diabetes, cardiology, respiratory, dementia, End of Life, Frail Elderly fully in place by April 2015**	**Reduce A&E attendances Reduction in admissions Improve health outcomes Reduce inequalities**
End of Life • **Commission TRANSFORM hospice based community team** • **Equitable and speedy access to EoL beds** • **Ensure that services are developed which provide holistic care regardless of the need. (eg dementia, LTC, cancer, frail elderly)** • **Access to a full compliment of staff within the community to prevent hospital admission** • **Seamless 24/7 access to care** • **Full integration of provider services** • **Audit of quality of Gold Standards Framework (GSF) registers** • **All care homes to complete Six Steps to Success programme or GSF care homes** • **All people identified as being EoL will be registered on GSF register, regardless of diagnosis or capacity** • **Mobile working for all community and SPCS staff** • **OOH – integration and improved handover processes of DN night service to OOH services and day DN services** • **Sharing of relevant information, including**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Improve the quality of end of life care Appropriate increase in use of step up beds Promote awareness of dying, death and bereavement	Increase number of people dying in usual place of residence Reduced LoS Admission avoidance Reduction in unplanned admissions Increase in reablement

care plans • **Evaluate care home provision with a view to supporting equitable and sustainable EoL care across care homes**		
Community Emergency Response Team	Improved access to primary care Care closer to home Reduced exposure to hospital acquired infections Co-ordinated response to urgent care Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together Common patient record and IT system	Reduced number of admissions from care homes Reduced length of stay for care home admissions Reduction in Hospital acquired infections Reduction in A&E attendances Avoid hospital admissions Better patient experience
Children • **Evaluate children's community nursing team** • **Reduce unplanned admissions for children with LTC: asthma, epilepsy, diabetes, CF** • **Review community paediatric services** • **Review children's therapies** • **Replicate inhaler technique pilot for children** • **Palliative care review** • **End of Life review** • **Review complex children's nursing care** • **Develop community audiology service**	Increased access to clinician Care closer to home	Admission avoidance LTC support Discharge Support Reduce A&E attendances
Diabetes • **Review of community diabetes care** • **Implement generic agreed pathways in collaboration with West Lancashire CCG** • **Implementation of a primary care pathway for diabetes footcare, scope and potential cost**	Early detection Increased access to clinician Increased self management Care closer to home Holistic approach	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances

and provider implications • **Gestational diabetes – clinical pathway out to consultation outlining support before and during pregnancy**	Reduce morbidity	
CVD • **Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.**	Increased access to clinician Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Cancer • **Support community based Macmillan centre providing:** ○ **info and support** ○ **Survivorship** ○ **In-reach into Southport & Ormskirk Hospital** ○ **Wellness and Activity co-ordinator** • **Potential for new community recovery and support pathways for breast patients following service changes at Southport and Ormskirk Acute Trust**	Increase awareness of Macmillan's services Communicate campaign messages Involve local people Improve the lives of people affected by cancer across the Sefton	Admission avoidance Reduction in unplanned admissions
Respiratory • **Develop patient led self-care pilot programme** • **Review current respiratory pulmonary rehab programme and develop new programme with Public Health and SCVS** • **Commission enhanced Home Oxygen Therapy Service**	Early detection Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances

INTERMEDIATE CARE		
Enhanced intermediate care and reablement (BCF initiative)	Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Step up/down – patient flow (CC2H)	Appropriate increase in use of step up beds particularly requested by GPs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Integrated care at locality level building on virtual ward and care closer to home (BCF initiative)	Focus on Frail and elderly with LTCs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting

UNPLANNED CARE		
End of Life • **Speedy diagnostic and access to treatment to negate the need for transfer to a secondary care setting** • **Acute hospital to attain GSF accreditation and undertake national TRANSFORM programme** • **Appropriate and timely discharge**	Care closer to home Improve the quality of end of life care Promote awareness of dying, death and bereavement	Reduce A&E attendances Reduce LoS Admission avoidance
Ambulatory Care Sensitive (ACS) Conditions **CVD** • **Heart failure – possible reconfiguration of acute heart failure team to work alongside consultant in AED based on Aintree model** • **Stroke – link with Cheshire and Merseyside networks to explore the possibility of 3 hyper Acute Stroke Units across Cheshire and Merseyside to address and improve inconsistences of the quality of care** **Diabetes** • **In-reach diabetes nurse to identify and appropriately discharge in-patients with diabetes who no longer need to be in a hospital setting**	This would offer appropriate fast track diagnosis and treatment in an assessment area and discharge to the community to prevent admission Access to Consultant reviews Timely initiation of treatment	Reduction in admissions Admission avoidance Reduce LoS Better patient experience
Cancer **Develop acute oncology to include outpatient clinic access for cancer of unknown primary 2/52 clinic, side effects of treatment**	Better patient and carer experience To support early diagnosis	Reduction in unplanned admissions Reduced LoS

NWAS CERT pathfinder	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings More patients being treated at home/in the community rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances Reduce emergency admissions
Self care/management • **easily accessible support for the self management of conditions delivered as part of the virtual ward and health and wellbeing board via the better care fund** • **Patient education**	Patients will: • have knowledge of the condition and/or its management • adopt a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters • actively share in decision-making with health professionals, significant others and/or carers and other supporters • monitor and manage signs and symptoms of the condition • manage the impact of the condition on physical, emotional, occupational and social functioning • adopt lifestyles that address risk factors and promote health by focusing on prevention and early intervention • have access to, and confidence in the ability to use support services	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Development of the Community Voluntary Sector (CVS) - Bids from CVS to focus on urgent care to support patients to avoid admission	Ensure services are used appropriately and community Engagement and commissioning	Reduce A&E attendances Better patient experience

111 Programme implementation	Provide advice for patients and appropriate use of services	Reduced attendance in A&E
Proactive case management	To support self-care and early disease management	Increase number of adults making healthy lifestyle choices Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Proactive case finding	To support self-care and early disease management	Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Community Geriatrician	To support the Community teams	Reduction in unplanned admissions Reduced LoS

MENTAL HEALTH		
Primary Care development and education	Raise awareness and understanding	Patient satisfaction Survey
Dementia	Holistic care for patient Improved screening Services wrapped around patient Access to voluntary services Develop service to meet patient need Extend memory services Enhance Alzheimer's Society Support Review use of anti psychotic drugs for Dementia	75% of identified population by 2015/16 90% of identified population by 2018/19
Child and Adolescent Mental Health Services (CAMHS)	Improve access and understanding of CAMHS services Ensure seamless transiton Increased patient experience	Reduce Tier 4 placements Improve response times
Brain Injury	Co-ordinated care for patient	Better patient experience
Outcomes and Activity Information	Introduction of Payment by Results (PbR) is a major organisational change for both providers and commissioners Financial modelling and profiling of risk to be undertaken	To be agreed with Mersey Care NHS Trust
Children • **Review ADHD and ASD pathways** • **Develop Children's IAPT service**	Improve access to services Increased patient experience	Reduce waiting times Early Identification Better patient experience
Cancer • **Psychological support via Aintree cancer pathway**		Better patient experience

APPENDIX THREE
LOCALITY PLANS

South Sefton CCG
Transformation Programmes
Governance and Reporting Structure

Management and External Scrutiny

The programme structure addresses The three priorities to:

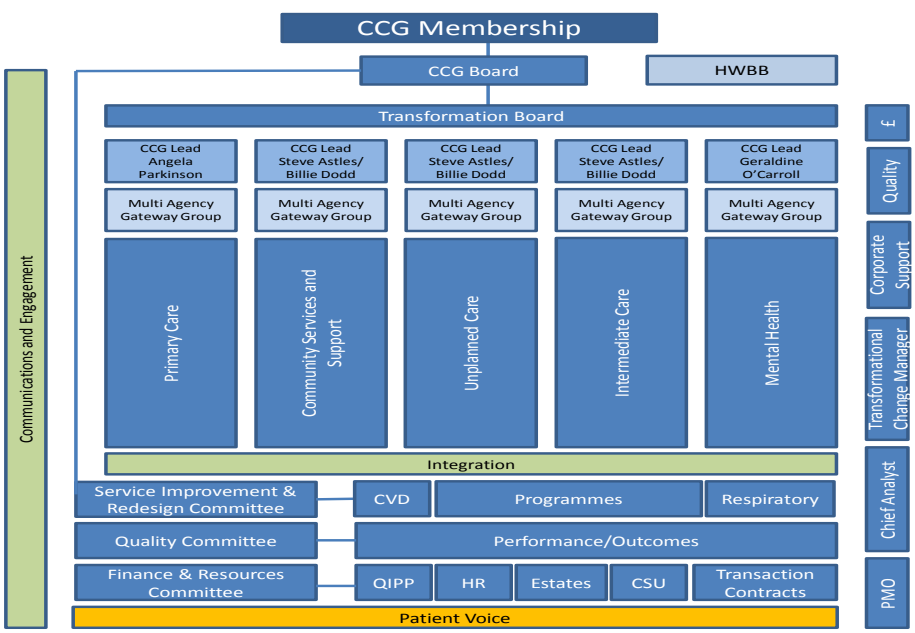
- Care for our older and Vulnerable residents
- Unplanned Care
- Develop and support Primary Care

Executive Management Team Meets monthly and receives an overview report of activity, including any activity that requires authorisation

→ **Health and Wellbeing Board**

→ **Governing Body**

Governance



Blue-print Area

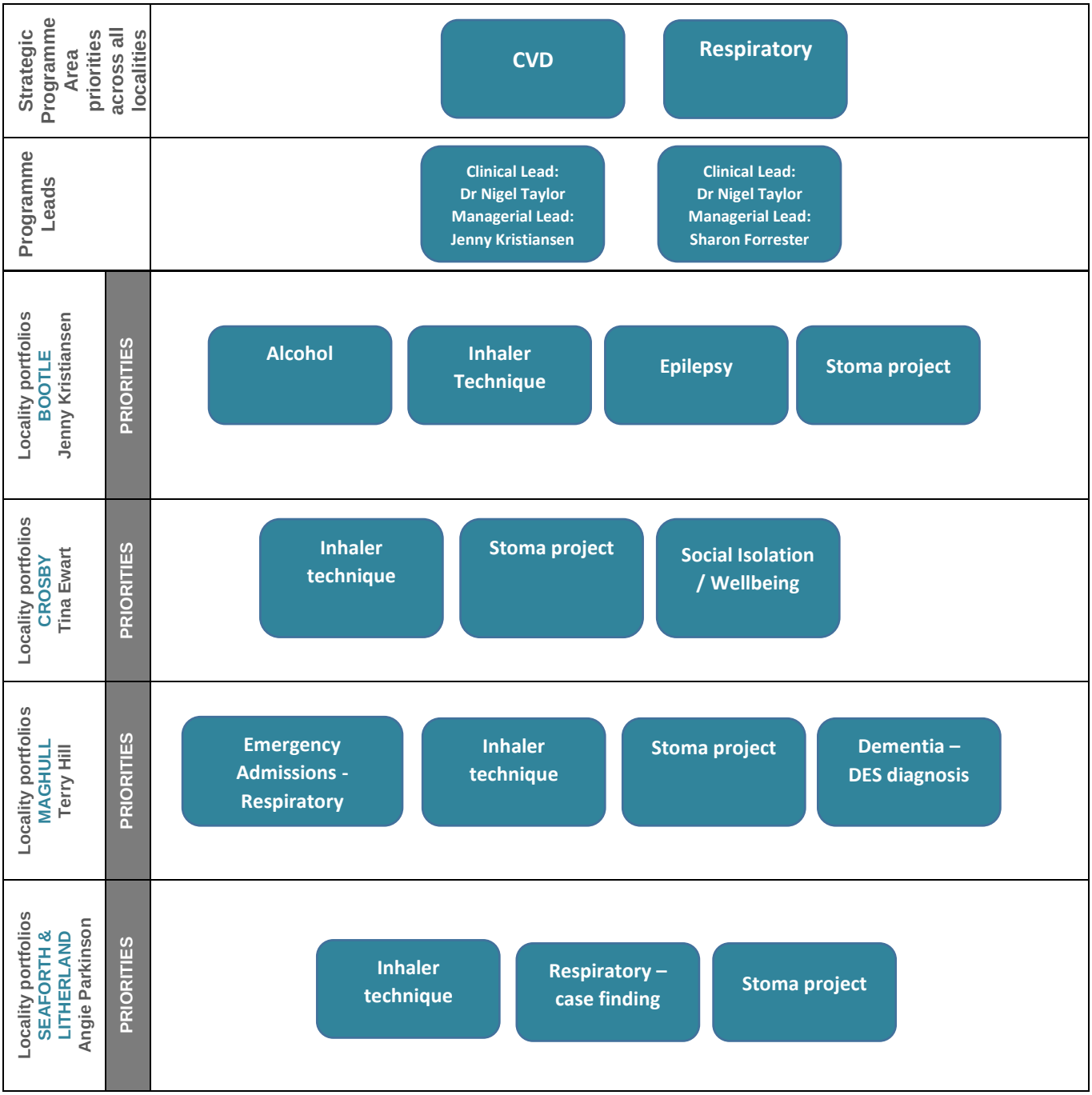
Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health

Blueprint Leads

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Clinical Lead: Dr Craig Gillespie Managerial Lead: Angela Parkinson	Clinical Leads: Dr Ricky Sinha (Transactional) Dr Paul Thomas (Transformational) Managerial Lead:	Clinical Lead: Dr Daniel McDowell Managerial Lead: Melanie Wright	Clinical Lead: Dr Andy Mimnagh Managerial Lead: Steve Astles	Clinical Lead: Dr Sue Gough Managerial Lead: Geraldine O'Carrol

Blueprint top 5 priorities across all localities

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Increased Access	Locality and virtual wards	Better Care Fund	Develop Urgent Care Centre	Dementia locality model
Enhanced Mngt of ptns over 75	Care Homes	Single entry co-ordination	Transportation review for WIC	Ageless service to include CAMHS
Workforce Succession Planning	Community urgent care team	Integrated care at locality level	Acute visiting Scheme	Primary and community training
Early detection	Integrated care pathways LTCs	Increased use of Step Up/Step down	NWAS pathfinder	Develop outcomes & activity dataset
Choose and Book utilisation	Review community tier 2 services	Stroke beds development	CVS bids	Brain Injury pathway


Strategic Programme Area priorities across all localities
CVD
Respiratory
Programme Leads
Clinical Lead: Dr Nigel Taylor Managerial Lead: Jenny Kristiansen
Clinical Lead: Dr Nigel Taylor Managerial Lead: Sharon Forrester
Locality portfolios BOOTLE Jenny Kristiansen
PRIORITIES
Alcohol
Inhaler Technique
Epilepsy
Stoma project
Locality portfolios CROSBY Tina Ewart
PRIORITIES
Inhaler technique
Stoma project
Social Isolation / Wellbeing
Locality portfolios MAGHULL Terry Hill
PRIORITIES
Emergency Admissions - Respiratory
Inhaler technique
Stoma project
Dementia – DES diagnosis
Locality portfolios SEAFORTH & LITHERLAND Angie Parkinson
PRIORITIES
Inhaler technique
Respiratory – case finding
Stoma project

Southport and Formby CCG
Transformation Programmes
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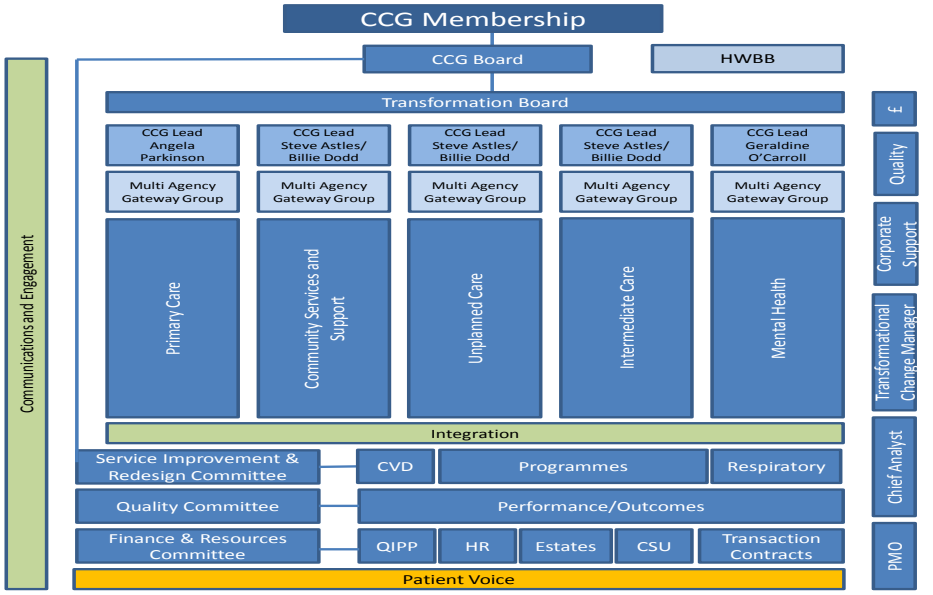

Blue-print Area

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health

Blueprint Leads

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Clinical Lead: Dr Niall Leonard Managerial Lead: Angela Parkinson	Clinical Lead: Dr Rob Caudwell Managerial Lead: Billie Dodd	Clinical Lead: TBC Managerial Lead: Melanie Wright	Clinical Lead: Dr Martin Evans Managerial Lead: Billie Dodd	Clinical Lead: Dr Hilal Mulla Managerial Lead: Geraldine O'Carrol

Blueprint top 5 priorities across all localities

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
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Strategic Programme Area priorities across all localities	CVD Respiratory
Programme Leads	Clinical Lead: Dr Nigel Taylor Managerial Lead: Jenny Kristiansen Clinical Lead: Dr Nigel Taylor Managerial Lead: Sharon Forrester
Locality portfolios AINSDALE & BIRKDALE Jane Uglow / Mel — PRIORITIES	Connected Communities CVD
Locality portfolios CENTRAL SOUTHPORT Sharon Forrester — PRIORITIES	Connected Communities CVD – CKD Exception rates Hypertension Tx Respiratory Mental Health
Locality portfolios FORMBY Moira McGuines — PRIORITIES	Mental Health / Depression CKD
Locality portfolios NORTH SOUTHPORT Sarah McGrath — PRIORITIES	Asthma Exception rates COPD Prevalence Mental Health Dementia CVD Improve coding