NHS
Southport and Formby
Clinical Commissioning Group

Shaping Sefton

Our vision for community centred health and care

together
with you

ainsdale and birkdale

central southport

formby

north southport

Who we are

We are NHS Southport and Formby Clinical Commissioning Group (CCG) and we are responsible for planning and buying the majority of local health services. This process is called ‘commissioning’.

The range of services we are responsible for commissioning includes:

- **Community based services** – like district nursing, community matrons and blood testing
- **Hospital care** – including routine operations, outpatient clinics, maternity services and accident and emergency care
- **GP out of hours services** – to ensure people still have access to a doctor when their surgery is closed in the evenings, weekends and bank holidays
- **Mental health services** – we commission many mental health services apart from very specialised care and treatment

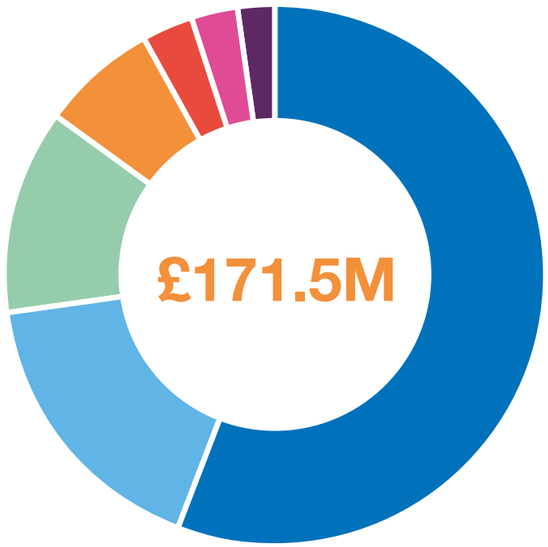
We are a membership organisation, bringing together the 19 GP practices in Southport and Formby. As we are led by local doctors and other health professionals, we are ideally placed to understand of the health needs of Southport and Formby residents.

Our members work together in four GP practice localities, so they can really concentrate on addressing the differing needs of the communities they serve.

What we do

In 2014-2015 we had a budget of just over £170million to spend on commissioning health services for 122,585 Southport and Formby residents. The majority of this money, over 60%, was spent on hospital based care.

Here is a breakdown of how we spend our money.



Hospital healthcare	£95.6m
Community healthcare	£29.6m
Prescribing	£21.3m
Mental health*	£11.8m
Primary health care	£5.8m
Other programmes	£4.5m
Administration costs	£2.9m

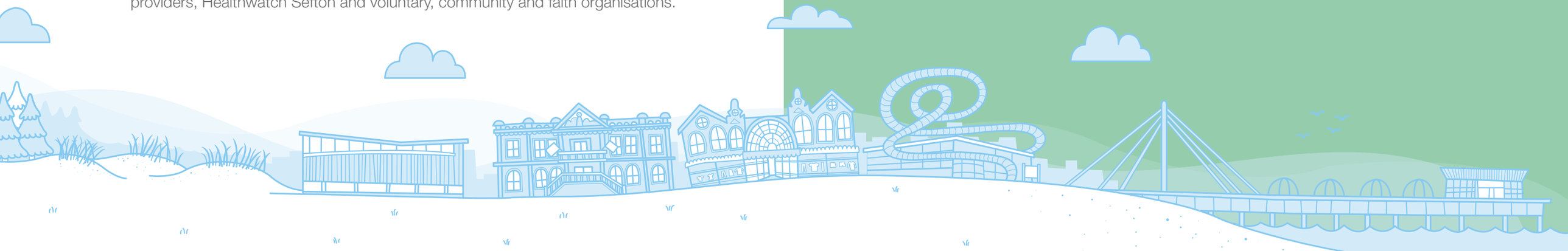
* Excludes Community

We work closely with a wide range of partners who have a stake in ensuring the good health and wellbeing of all Southport and Formby residents. This includes Sefton Council and its Health and Wellbeing Board, other NHS commissioners and service providers, Healthwatch Sefton and voluntary, community and faith organisations.

Shaping Sefton - our vision for future healthcare

> We want all health and care services to work better together – to be more joined up – with as many as possible provided in our local communities, so it is easier for you to get the right support and treatment first time, to help you live a healthy life and improve your wellbeing

We call this community centred health and care



Our 5 year strategy

Working with our partners from NHS South Sefton CCG, we have developed a Sefton wide 5 year strategy for improving healthcare. Our blueprint for transforming healthcare begins to describe what we need to do to move the vision of our 5 year strategy into reality. These documents focus on the challenges we face locally and they were shaped by the views of local people and a wide range of other partners across the borough.

Community centred health and care brings together eight priority health and transformational programmes, wrapped around our GP practices and their patients:

primary care | community care | urgent care | mental health | care for older and more frail people intermediate care | cardiovascular disease | respiratory disease

Having a single strategy makes it easier for everyone in Sefton to work together – with the likes of the council and others - and better join up or 'integrate' our plans and services whenever we can, so we can work more efficiently in this challenging time.

Importantly, it means we have the potential to achieve more for Sefton residents than we could do individually, as there is greater strength in working together.

> **Shaping Sefton** will help us to achieve our vision for improved health and wellbeing

We know that if we are to improve health and wellbeing for everyone in Southport and Formby we must transform the way services currently work, so they are better equipped and organised to meet the needs of our residents now and in the future.

Shaping Sefton brings together organisations from across health and social care to look at how we can respond to our local challenges by creating services that work more closely together, so each person's care is better coordinated and tailored to their individual needs – meeting our vision for community centred health and care.

Working closely with Sefton Health and Wellbeing Board, we are leading a development programme with the highly respected and independent King's Fund that is helping providers to come together and think differently about how they can better organise services in the future around this vision.

Why things need to change

The NHS faces many challenges ahead. Like all public sector organisations we are working in tighter financial times. At the same time demands on health and social care are increasing and locally there are a number of reasons why this is the case.

Here are just two:

- We have a growing number of older residents with more complex health conditions, and this is much higher than the national average
- We know that residents living in some parts of the borough can expect to live unacceptably shorter lives than their neighbours in more affluent areas of Sefton

Together, these factors mean we need to prioritise the money we have, spending it on the most efficient treatments and services that offer the best health outcomes for our patients.

Because we cannot provide endless different treatments and services, your views about what we should focus our money on will be even more important in future years.

What we want in the future

We know that health services need to work differently if we are to meet the future needs of our local population whilst at the same time improve the quality of care they offer.

So, based on all that we know about health and healthcare locally and based on what people have told us we want:

- To spend less of our money on hospital based care, so we can spend more on services that are based closer to people's homes in places like GP practices, clinics and other community centres. A range of different health and social care services will be wrapped around our GP practice localities and their patients. This will make it easier for you to access healthcare, as well as improving your experience of the support you receive
- Health and care services to be more joined up, so you don't have to tell your story over and over again to all the different organisations involved in your care because they work better together. We expect hospitals, community services, GP practices and even social care will work together more seamlessly using up to date technology, so your care is more effective
- Hospitals to concentrate on providing you with the most effective care should you be seriously ill, along with any specialist services you may need – some of these could also be delivered by hospital staff in community clinics, so they come to you
- More support so you can better manage your health and wellbeing to prevent you from becoming ill. If you have a long term condition like diabetes or asthma, we want to provide services that help you stay as well as possible for as long as possible
- You to have the confidence to care for minor illnesses and ailments yourself – known as self-care - through better information and advice that is easier to find, which could be from the internet, over the phone, or your local chemist

Community centred health and care

We know from speaking to local people that they really value the care they receive from GP practices and community services, provided close to where they live. We believe there are great benefits in wrapping services around our local communities, so we are developing a locality model of care that mirrors our GP practice localities – Ainsdale and Birkdale, Central Southport, Formby and North Southport – to really focus on the needs of these four distinct communities. We see a variety of professionals from across health and social care playing a greater role in these locality teams.

We believe this model is capable of making improvements in all the priority areas we have set out in our 5 year strategy and our blueprint for transforming services, benefiting all Southport and Formby residents, no matter what their age or differing health needs.

primary care | community care | urgent care | mental health | care for older and more frail people intermediate care | cardiovascular disease | respiratory disease

Community centred health and care

Our vision
5 year strategy

Shaping Sefton
Community centred health and care

Central to our vision for community centred health and care are two of our most important transformational programmes

Community services

This is the name for a wide range of services that includes district nursing, community matrons, blood testing, footcare, diabetes clinics, wound care and speech and language therapies.

In the future, we see these services working much more closely with our GP practices. We also expect these services to be more joined up, so collectively they can better respond to each patient's individual needs. We also want them to work more closely and effectively with hospitals, so when a patient moves between these different services, their experience is seamless.

What we are doing

Traditionally all these different services have worked quite separately and independently from each other, so people's care has not been as joined up as it could be, which can sometimes be confusing and difficult for patients and carers. We think these services can provide more effective care if they work better together, and this will also make it simpler for people to get the support they need. So, over the next 18 months we will be reviewing community services to see how they can be better organised and to also work much closer with social care and hospital services.

Primary care

This programme focuses on improving the quality of the services provided by your GP practice. We know that primary care needs to adapt and respond to the changing needs of our local residents if it is to remain effective in the future.

Our partners from NHS England are the main commissioners of GP practices. In addition we, as CCGs, have a duty to ensure that the quality of services provided in local GP practices continually improves. So, we work closely with NHS England to influence how these services develop in the future based on what we know local people need. We have a CCG primary care quality strategy developed with our member GP practices and informed by views gained from our partners, patient groups and voluntary and community organisations.

What we are doing

Whilst NHS England is the lead commissioner of these services, we can also commission a number of practice based quality schemes to support our wider 5 year strategy. Our member practices can choose to sign up to a range of schemes including reviewing A&E patients, blood testing and ankle brachial pressure indicator testing. Our improving access scheme has led to over 128 extra patient appointments per week in its first year. We are also hoping to introduce a scheme to improve the care of older and more frail patients.

What does this mean for you?

We are already working towards our Shaping Sefton approach of community centred health and care. We are developing a number of **proactive** and **urgent care** services that are working together more effectively than before and they are beginning to make a difference to our patients.

A good example of how we are already beginning to wrap care around our patients and GP practice localities is our **Children's community nursing team**

Following a successful pilot we are continuing the children's community nursing team, which works between hospital and primary care. It aims to provide better support in the community to prevent the need for hospital, as well as working with young patients on the ward to get them well and back home as quickly as possible. As a result more children are being treated at home rather than having to spend time in hospital and last year the team treated 571. We tested a new direct referral system for GPs to this service in the year, and we are now planning to extend this system to more of our GP practice over the coming months.

You will find some more examples over the next few pages.

Care for older and more frail patients

Working as part of our model of community centred health and care, there are some important schemes that we believe are helping us to provide more effective support for our older and more frail patients, which we believe will also improve their experience of care.

What we are doing

Community Emergency Response Team

Now in its second year, the nurse led, multi-disciplinary Community Emergency Response Team (CERT) provides care to some of our most vulnerable, older patients. CERT acts as a bridge between hospital and primary care, working with those patients who need extra support but who do not need to be in hospital. GPs refer patients whose condition may be deteriorating to CERT to give additional, more appropriate care. CERT also works with hospital patients, so they do not stay on the wards any longer than they need to and get home quicker. This service has continued to show good results for our patients and is contributing to reducing the need for people to be admitted to hospital when they can be cared for more comfortably, safely and appropriately in their own home or in another community setting.

Formby GP care home pilot

This 12 month pilot involved paying care home residents two visits a week by a local doctor with the aim of keeping them as well as possible, for as long as possible. A GP carries out a weekly 'ward round' at care homes in the area to assess patients and spot early any changes in their conditions. Care home populations are rising, with more vulnerable patients with increasingly complex needs. Four in five care home patients have memory problems or dementia and many have several long term conditions. Regular, proactive GP visits mean that health problems are spotted at an earlier stage, and can often be treated in the home. In this way, emergency admissions to hospital due to a sudden health crisis can be prevented. The Formby pilot is already proving beneficial for both residents and staff and the results will inform future service developments.

Care home medicines project

This is the second year of the project, which carries out an annual medication review for care home residents. The scheme aims to improve the quality and safety of care for these patients. Through more regular monitoring of patients' medicines we can ensure they are taking the most appropriate ones for their condition at the right time. In 2014-2015 we reviewed over 700 patients, the scheme helped prevent people from needing hospital treatment on 47 occasions. Around £85,000 was also saved through better and more effective prescribing. In addition, pharmacists also provide advice to nursing home staff around the safe management of medicines, and act as a bridge between nursing homes, primary care and hospitals – all with the aim of improving the treatment and experience for this vulnerable group of patients.

Connected Communities

This project was developed by two of our GP localities - Ainsdale and Birkdale and Central Southport. Evidence suggests that social isolation amongst the elderly can impact gravely on wellbeing and quality of life, with demonstrable negative health effects. Connected Communities aims to improve older peoples quality of life and help them to better manage their health. Connected Communities provides a link between health professionals and residents who have been identified as possibly being socially isolated. The service provides support, information and advice about services and social activities available near to where they live. In its first nine months 103 individuals had been referred to service and a number of these have been supported to attend 205 social or health and wellbeing activities. Others were signposted and introduced to other support services and agencies.

Case study – Mr and Mrs S met Connected Communities staff in October 2014 at a flu clinic. They were told about the project and their daughter was particularly keen for them to get involved as she lives away from them, causing her genuine anxiety. Mr and Mrs S are both in their 90s and have been married for nearly 70 years. Both have health or social care problems. They were given some information at the flu clinic about activities near them and by the time they had a home visit from the Connected Communities team, they had already begun to try some out. As a result of getting involved in Connected Communities they now attend a shared reading group, as well as taking part in leisure activities and luncheon clubs.

Their daughter said: "It was wonderful for me to see how animated my mother in particular became at your visit, and I am so pleased that they now to go to the Ainsdale Community Centre on a regular basis and have contact with other people. Thank you for all you help and concern."

Intermediate care

This is sometimes called a ‘halfway home’ service for people who do not need hospital care but who need some additional support to help them recover fully from illness or injury. Intermediate care brings together a range of services to promote faster recovery from illness, prevent unnecessary urgent admission to hospital, prevent premature admission to long term residential care, or to support timely discharge from hospital – all with the aim of maximising people’s independent living. We are working closely with Sefton Council to improve intermediate care.

What we are doing

During 2014-2015 we reviewed current services and began work to draft a blueprint for how these might be improved in the year ahead. We want future services to give increased focus on ‘step up’ care, for those people who may not have been admitted to hospital but who need additional support for their condition. We expect future intermediate care to be largely provided in a person’s own home but these services will need to be flexible so that some people with additional needs can be treated in a community based intermediate care setting when they need it, working even more closely with the CERT team.

Mental health

We believe that improving mental health is just as important as improving physical health.

This is an area we will give greater focus to in the year ahead, so we can make quicker progress to bring it in line with our other areas of priority. We know this will mean transforming mental health and dementia services so they can more effectively deal with the challenges of our ageing population, unacceptable inequalities in health and wide variations in the quality of and access to these services.

As well as continuing to develop services this year, we carried out a major review of mental health and dementia care and this will to shape how we move forward in 2015-2016.

What we are doing

Mental health task group

This task group was clinically led by a GP and its initial aim was to gain a thorough understanding of current services and how effective they are in supporting our patients. The group also looked at what works and what does not, based on evidence and best practice, to identify a vision for mental health and dementia care that we can begin to introduce in the year ahead.

These are the task group's recommendations for future mental health and dementia services:

- Embedding prevention in all services starting from primary care, in line with our model of community centred health and care
- Earlier diagnosis and intervention that result in people being less dependent on intensive services
- When people become ill, recovery and care takes place in the most appropriate setting to enable people to regain their wellbeing and independence
- Services that work seamlessly and more cohesively together

Alongside this we will continue to work with providers to shape services, so they are more responsive to the needs of our patients and carers, and which are work more closely with our GP practice localities.

Respiratory health

This programme covers a range of conditions and the two that affect Southport and Formby residents the most are chronic obstructive pulmonary disease, better known as COPD and asthma.

Respiratory conditions are the cause of thousands of emergency hospital admissions each year and we know that many of these could have been prevented if patients had more support to better manage their condition. We also know that many people are suffering from poor respiratory health but will not as yet have had their condition detected.

What we are doing

Joining up services for improved care

We have begun to review respiratory services to determine how they might work better together through our Care Closer to Home programme, making it easier for patients to get the right, more streamlined care and support that they need in a more timely way.

Respiratory training programmes

We have been developing an extensive training programme that will support practices to better manage their COPD and asthma patients. It is initially focusing on three practices with the highest emergency hospital admissions for these conditions before being rolled out to others across Southport and Formby.

Identifying undetected need

During the year ahead we plan to adopt an initiative developed by our colleagues in NHS South Sefton CCG to help identify the high numbers of people living with an undetected respiratory disease. The 'breathe well roadshow' offers people a free lung health check and advice about breathing problems. In two days of the roadshow being in Bootle, more than 80 people had a lung health check, with over 50 of these identified for the first time as having a lung problem, resulting in them being referred for further tests.

Cardiovascular disease

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

What we are doing

Improving cardiology services

During the year we have been working with Southport and Ormskirk Hospital, Liverpool Heart and Chest Hospital and Liverpool Community Health to improve local cardiology services. This has particularly focused on:

- Early access to essential diagnostic testing
- Timely referral to specialist interventions and treatments
- Ongoing community support to help people to better manage their own condition
- Early access to local rehabilitation services to improve longer term health outcomes

Atrial fibrillation and stroke prevention

People with an irregular heartbeat are at greater risk from stroke. As part of our work around stroke prevention we have been working with public health and wider health care professionals to identify patients who are living with an irregular heartbeat to improve management of their condition. This includes:

- Identifying more patients through the NHS health check programme for those aged 40 to 74
- Carrying out more opportunistic pulse checks in GP surgeries and clinics
- Using modern technologies such as hand held electrocardiogram machines to help clinicians diagnose atrial fibrillation more easily
- Installing specialist software – called GRASP AF - in practices to assist with the identification and management of patients with an irregular heartbeat
- Working with pharmacies and medicines management to optimise patients' medications to reduce their long term risk of stroke

Stroke care

We are working with Southport and Ormskirk Hospital and the Cheshire and Mersey Stroke Network to improve the quality of care for patients who have suffered a stroke. We aim to improve the quality of treatment for patients in the first 72 hours of having a stroke. We also want an excellent local rehabilitation service, which will support patients in making a better recovery and improve the quality of their lives. This also means putting improved assistance in place so patients can be discharged from hospital more quickly with support and ongoing therapy in their own homes.

Investing in our local communities

We believe that our voluntary, community and faith groups have an important role to play in **Shaping Sefton** and helping us secure better health and wellbeing for all our residents. For the second consecutive year, and together with NHS South Sefton CCG, we awarded around £1 million to local voluntary, community and faith sector organisations. We recognise the valuable role these groups play in achieving better health and wellbeing for our residents. This is reinforced by what local people consistently tell us, that these groups are important in providing them with support.

Through Sefton CVS, organisations were asked to submit bids for one off funding to support specific initiatives contributing to better health and wellbeing. There were 30 successful bids in 2014-2015 including Brighter Living Partnership, Parenting 2000, Expect Ltd and Sefton Children's Trust. These are exciting schemes, often designed and delivered by local people for others who live in their communities. Here are some examples of how these grants have been put to use so far:

Ainsdale Community Care

This organisation provides a luncheon club on site and also delivers hot meals through a home delivery service. It offers a variety of activities for older people such as Qigong, the name for Chinese yoga, a reading group, sequence dancing, cooking for beginners and art. Activities are designed to improve the overall wellbeing of older people living in the local area. It also signposts people to relevant services or raises awareness of other support organisations. Many of the older people are vulnerable and have long term conditions. In addition, most who attend live on their own, or are on their own during the day while other members of the household are at work. This year Ainsdale Community Care (ACC) has supported thousands of local residents.

Case study – One man had been living on two packets of chips a day and was vitamin deficient. His GP referred him to ACC and is now losing weight. He has transformed from an undernourished lonely figure to a far more vital, happy force with new friends and new interests. He plans to start a degree in theology and has commented about coming to ACC: "It's a wonderful place, always lots to do and lots of people to meet. The activities are really first class."

Navigate

This Southport based project is helping young people turn their lives around when faced with accommodation issues or problems with their lifestyle. Between September and December 2014, the project supported 19 young people giving advice on suitable accommodation and encouraged attendance at college while addressing any issues of risky behaviours.

Case study – "Before Navigate my situation was not the best. I was 7 months pregnant and living with my boyfriend in his dad's house. I could not go home at that point and I was not wanted at my boyfriend's either. I was in a bit of a mess and didn't know what to do next. I was going to be homeless with a baby on the way. I was trying to keep it under control but I came to college one morning and I just had a breakdown. I was told about the project from the student services at college and it seemed that it was the best option for me. I was so glad to have met Anne Marie from Navigate because I literally had no one else to help me. I am surprised and so grateful at how much support the Navigate project has given me. I can ask for help at any time and as a result I am on track with my course work and my attendance has improved as well. Navigate has given me the support that I needed at the time and I will continue to ask for help with any problems that I face in the near future.

Sefton Veterans

This is a new one stop shop for Sefton's military veterans that opened its doors in May 2014, offering advice and assistance on a range of issues including health, housing and employment by working with a range of specialist organisations to provide personalised support under one roof at the Bowersdale Resource Centre in Seaforth. The service is currently looking to identify a second base in the north of the borough. This free and confidential service is open to all military veterans and former reservists no matter what their age, or how long they have served in the armed forces – even if it was just for one day. The service also provides support to families in the armed forces community, as well as current serving personnel.

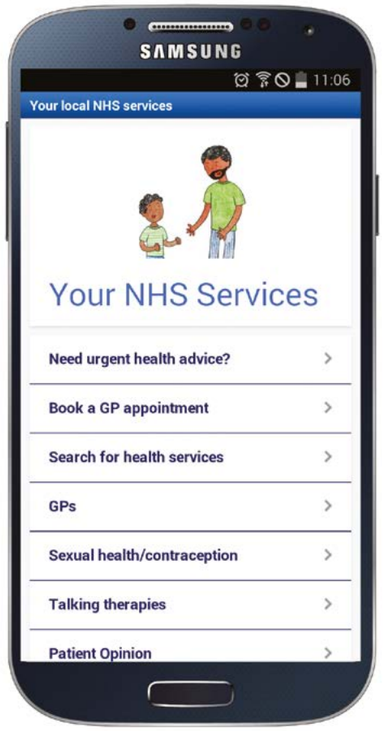
Case study – a former member of the parachute regiment said of the service: "Just over a year ago I was really down on my luck - I had no job, I was angry at myself and I was struggling to support my girlfriend and kids. A couple of guys I know told me about the Sefton Veterans Project. Because it is run by an ex squaddie I went to see them. I knew they would understand and I knew I could talk to them without being embarrassed or feeling like I was a loser or a waster. It was great talking to vets again. The project manager, Dave Smith, managed to find some funding and training for me. I now have a full time job and I can now hold my head up again and support my family."

Supporting you to better health and wellbeing

What we are doing

Find advice on digital TV and mobile app

We launched a new information system in spring 2014, making health advice and information available to our residents via an app for smartphones and digital interactive TV systems. Looking Local gives local information to help people live a healthy lifestyle, or to find their nearest health service. Some people can also book appointments at their GP practice using Looking Local.



- **Virgin media** - Press the HOME button on your remote control, choose INTERACTIVE, select “Local & Directory Enquiries”, select “Looking Local”, or Go to the Community Channel (233) and press the RED button
- **Online / Wii / mobile web** - www.lookinglocal.gov.uk/southportformbyccg
- **To download the app** - go to either Google Play or the iTunes App Store – then search for NHS SFCCG

VCF Direct

We have been working with Sefton CVS to develop a new online directory of services - currently known as VCF Direct - provided by voluntary, community and faith groups. This public directory can also be used by primary care professionals to help them signpost and directly refer patients to a wide range of support to improve their health and wellbeing. Take a look for yourself www.vcfdirect.org.uk

Examine Your Options

People have told us that it can be confusing when trying to choose the right service, first time when they are ill. Examine Your Options is our information campaign to help signpost people to help and advice on their doorstep. The campaign is also helping to raise awareness of our GP out of hours service and the range of expert medical support available in local high street chemists. You may have seen Examine Your Options posters in GP practices, libraries and other community venues, as well as displayed on the sides of buses and at train stations. You may have even looked for pharmacy opening times over the Christmas and New Year holidays, from our adverts in your local free newspaper.

How we have involved you so far

There are a number of different ways that we involve local people in our work – from tapping into the strong voluntary, community and faith networks, to carrying out more focused work with specific communities or groups of people affected by our work.

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We finalised our 5 year strategy for improving health and health services in the summer of 2014 and our blueprint for transforming services in early 2015. Alongside the views of our partners, these important documents were also informed by the experiences and ideas of patients, carers and other local residents gained from our Big Chats, Mini Chat and other engagement events and activities.

We began to discuss our vision with local residents for community centred health and care - wrapped around our patients and our GP localities - at Big Chat 4 in November 2014. People at the Big Chat broadly agreed with our Shaping Sefton model. They talked about some of the other services that they would like to see delivered closer to home in their communities, and about those which they felt should be provided on a wider footprint, or in hospital.

You will find more information about our Big Chats and Mini Chats on our website, along with details of some of the other ways we involve people in our work.

Tell us what you think

All the views we have gained so far from speaking together with patients, carers and other residents have helped us to further refine Shaping Sefton - our model of community centred health and care - but we want to know more about what you think as this work progresses.

So, tell us your views about **Shaping Sefton and our vision for community centred health and care**.

There are a number of ways you can do this:

- Telephone us - 0800 218 2333
- Email your experiences and thoughts – cmcsu.pals@nhs.net
- Join our mailing list to hear about all forthcoming events and opportunities - you can sign up from the home page of our website www.southportandformbyccg.nhs.uk

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