NHS
South Sefton
Clinical Commissioning Group

Shaping Sefton

Our vision for community centred health and care

Staying **local**
& together

bootle

crosby

maghull

seaforth and litherland

Who we are

We are NHS South Sefton 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

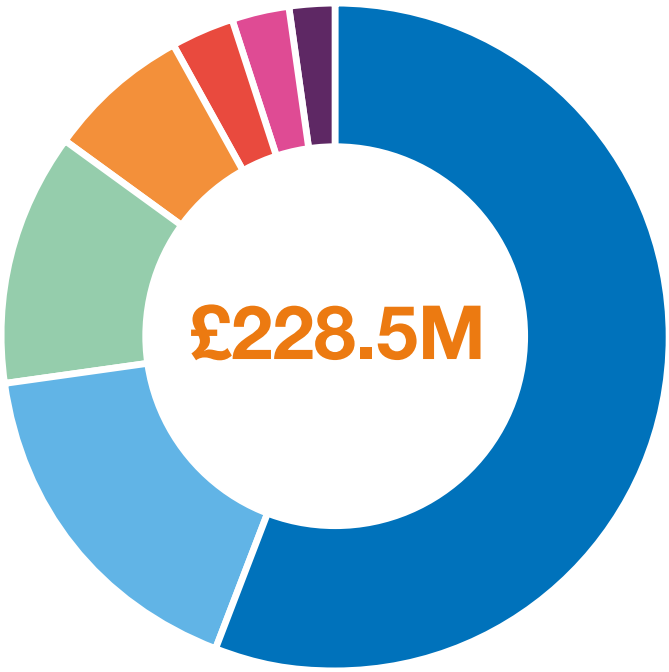
We are a membership organisation, bringing together the 32 GP practices in south Sefton. As we are led by local doctors and other health professionals, we are ideally placed to understand of the health needs of south Sefton residents.

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 under £230million to spend on commissioning health services for 155,213 south Sefton residents. The majority of this money, around 65%, was spent on hospital based care.

Here is a breakdown of how we spend our money.



Hospital healthcare	£134.9m
Community healthcare	£36.2m
Prescribing	£28.2m
Mental health*	£13.5m
Primary health care	£7.0m
Other programmes	£5.1m
Administration costs	£3.6m

* Excludes Community

We work closely with a wide range of partners who have a stake in ensuring the good health and wellbeing of all south Sefton 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 Southport and Formby 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 south Sefton 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

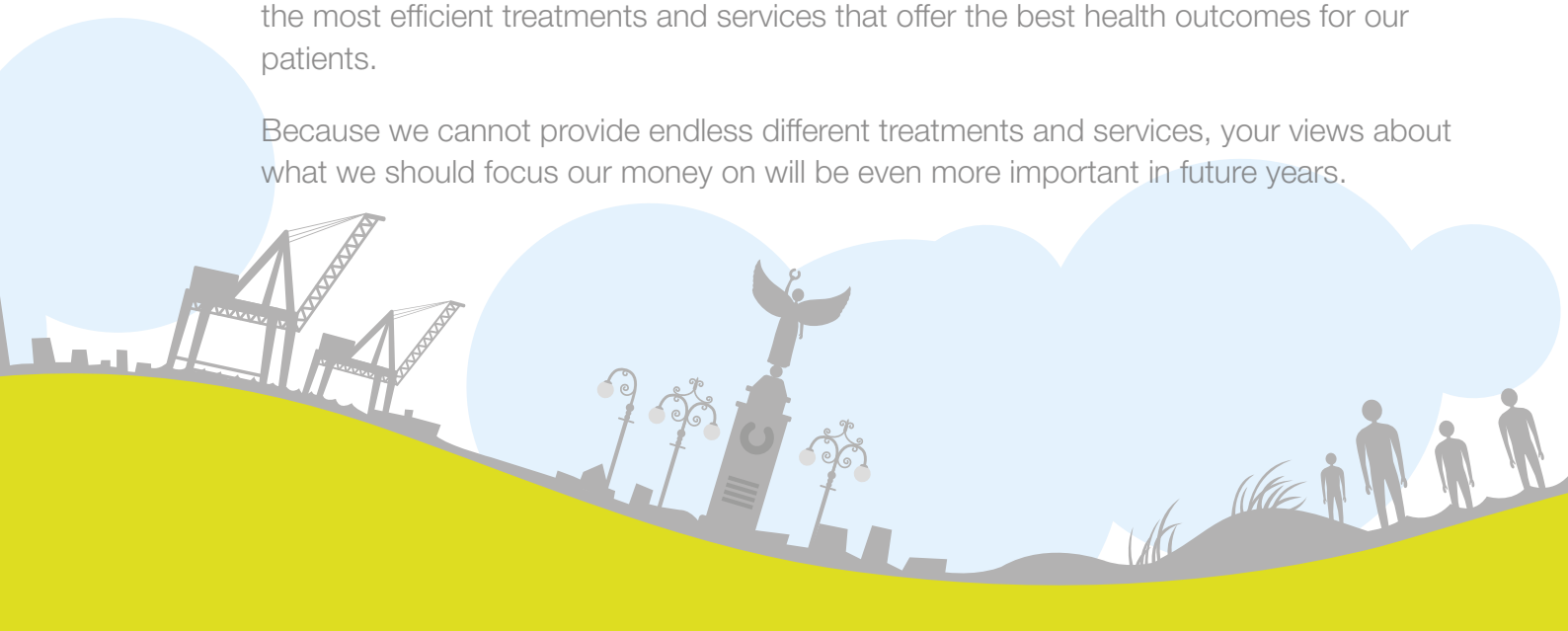
The NHS faces many challenges ahead. Like all public sector organisations we are working in tighter financial times. At the same time demands on health and social care are increasing, and locally there are a number of reasons why this is the case.

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 – Bootle, Crosby, Maghull and Seaforth and Litherland – 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 south Sefton residents, no matter what their age or differing health needs.

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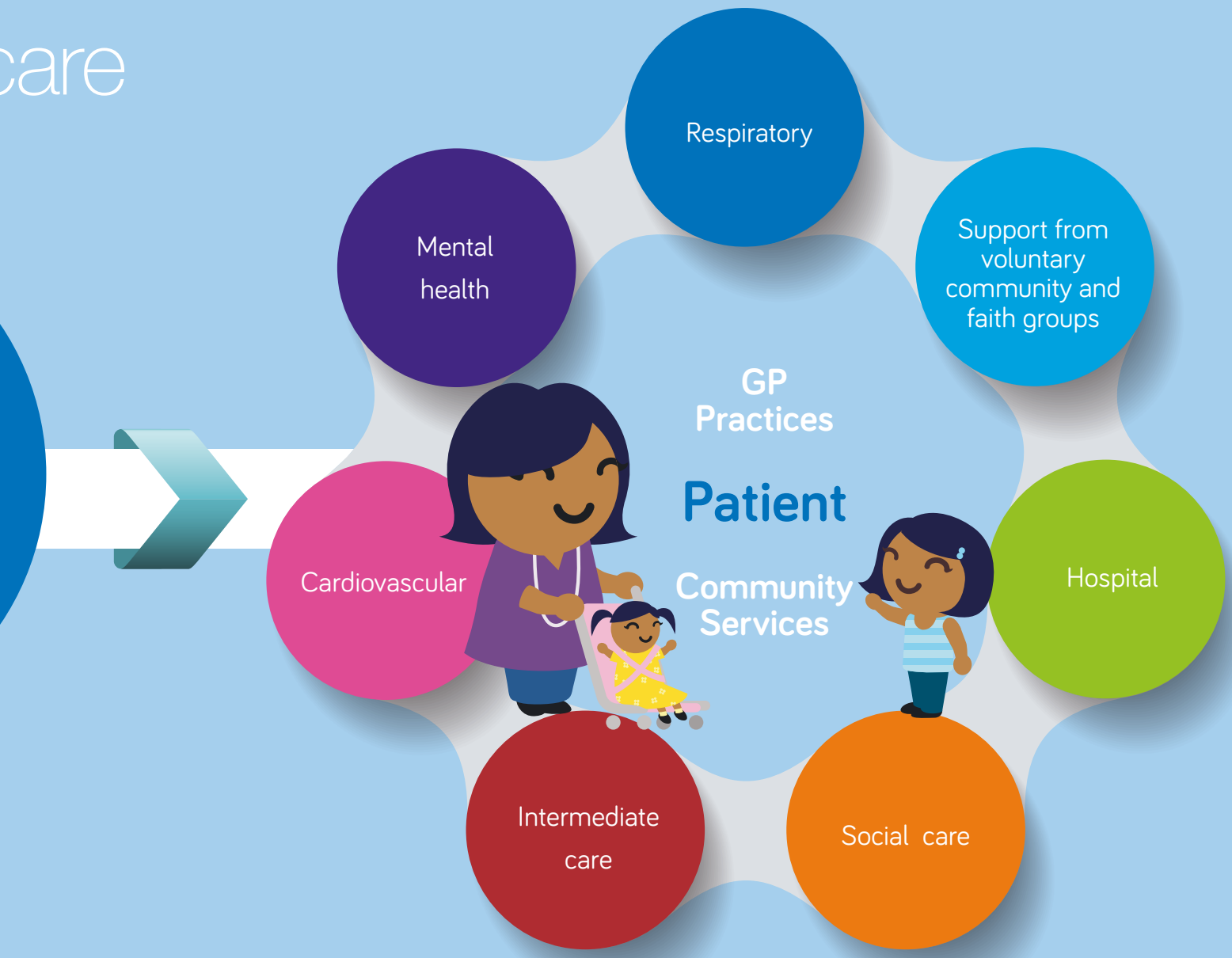
Community centred health and c

Our vision
5 year strategy

Shaping Sefton
Community centred health and care

care


Respiratory
Mental health
Support from voluntary community and faith groups
GP Practices
Patient
Community Services
Cardiovascular
Hospital
Intermediate care
Social 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 114 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?

An example of how we are already working towards this community centred approach is our **Virtual Ward** programme, which has two elements – an established **proactive** 12 week intensive support service and a new community **urgent** care team, introduced at the end of 2014.

Proactive care

This proactive 12 week intensive support programme is now in its second year and is for those with long term conditions, particularly older patients, helping them to stay as well as possible, for as long as possible. It focuses on patients who are at most risk of being admitted to hospital and aims to address and improve their health, as well as their wider wellbeing. Pro-active care works to prevent the health of these patients from deteriorating, which can otherwise result in them needing urgent or emergency care. Doctors identify patients who will benefit from pro-active care and refer them to their locality pro-active care team. There are four teams, one for each of our GP practice localities. The teams bring together a wide range of health and social care professionals to coordinate and tailor support based on each patient's individual needs – this could be medical treatment provided by a nursing team, or help and advice about improving their lifestyle from a community health and wellbeing trainer, who works with patients and carers to access services such as befriending, reablement, community activities, welfare rights and social services. In October 2014, health and wellbeing trainers helped their patients to set up a new support group in Seaforth and Litherland. It provides people with the chance to socialise, share their experiences and better manage their ongoing conditions. A second support group is now being established, also led by a former pro-active care patient, along with their carer.

In 2014-2015, over 1,000 people benefited from this service. Over 200 of these were already diagnosed with dementia. However, a further 68 people were supported to gain a dementia diagnosis, which meant they and their carers could also benefit from more appropriate services and support.

Patients and health professionals tell us they greatly value the proactive care team.

Former pro-active care patient – "I am now back to running my home efficiently and joining in various outings, lunches and I have joined the University of the Third Age. Not bad for an 84 year old!"

GP – "My patient felt isolated due to family issues, her medical conditions, isolation and depression were impacting on her ability to undertake activities on a daily basis. Occupational therapy provided aids around the home which enabled her to cook again, take a bath alone, and to stand from sitting without support. Physiotherapy helped build strength in her legs resulting in increase of confidence. A health trainer helped build her confidence, motivation and even accompanied her to support groups and craft classes. Counselling was organised along with advice and support sorting financial issues out. My patient found the programme really beneficial, to the point where she is pursuing training with a view to employment. I hardly ever see her now."

Community urgent care team

This team was established at the start of winter 2014 and provides a rapid response to patients who need urgent healthcare but who do not need to go to hospital. For patients, this means more appropriate care, often in their own home. Being admitted to hospital can be distressing for some patients and may also not provide people with the most effective care for their condition. So, the team works alongside community intermediate care to continue to monitor and manage patients in their own home whenever possible. The urgent care team also works closely with GP practices, ambulance crews, hospitals, the pro-active care team and other community based services to identify, care and monitor patients. Over the winter, the team responded to patients with a range of worsening conditions including mobility problems, infections, dehydration and shortness of breath. Over the coming year we plan to widen the care provided by the team, so it can deal with chronic obstructive pulmonary disease (COPD), intravenous cellulitis treatments, heart failure deterioration and specialist palliative care.

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

Care Homes Innovation Programme

We call this our CHIP initiative and it involves all 34 care homes in south Sefton. This evidence based scheme aims to ensure that care home residents enjoy the best quality of life within their usual place of residence whenever possible. CHIP encompasses a wide range of initiatives including direct access to an urgent care team and expert community geriatrician. In the year ahead we will also be introducing a new telemedicine video system that will connect care homes with round the clock medical support.

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.

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

There are around 14,500 people in south Sefton who have been diagnosed with two of the most common breathing conditions - chronic obstructive pulmonary disease, better known as COPD and asthma. We know the real number is likely to be much higher because many more people will not as yet have had their condition detected.

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. From speaking to local residents and carers we know this is what they want too.

What we are doing

Improving inhaler techniques for patients

This project was initially devised by our Bootle locality due to the high numbers of respiratory patients regularly being admitted to hospital as a result of their condition worsening. Over 500 of their patients were identified as needing an inhaler review and around 100 of these were housebound. Just over 208 patients were initially reviewed. More than half of these were found to have poor inhaler technique and nearly all showed vast improvements during a follow up, greatly helping them to better manage their condition. We are now rolling out this project across our other three GP localities.

Self management course

Our new respiratory self management course was developed as a direct result of what patients and carers told us would make a difference to them. We worked closely with a patient representative to design the course and the first 6 week programme took place in early 2015, led by Sefton CVS on our behalf. For some, this was the first time they had been given such helpful information about managing their conditions.

Breath well bus captures unidentified need

Our first Breathe Well Bus roadshow took place in Bootle in December 2014, offering shoppers a free lung health check. The respiratory team took to the streets to give people advice about looking after their lungs and to spot any problems they may have, no matter how small, as early as possible. More than 80 people had a lung health check over the two days, with over 50 of these identified for the first time as having a lung problem, resulting in them being referred for further tests.

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 south Sefton.

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

Cardiac rehabilitation

We have been working with Aintree Hospital, Liverpool Community Health and the council's Active Sefton team to improve rehabilitation services for cardiology patients. This includes greater choice of community venues, which are more accessible. There will be earlier access to a local rehabilitation programme for patients who have had a recent cardiac event or cardiac surgery to improve their quality of life. It is also crucial that this programme is bespoke and tailored to the needs of the individual, with achievable personal goals and expertise to help them to adopt positive long term lifestyle changes.

Better treatment for heart failure patients

We have been working with local services to improve heart failure treatment and management for our patients in south Sefton. We plan to provide specialist cardiology outreach services to support patients and community clinicians to manage patients more effectively, closer to home. Early specialist intervention is key to ensuring that patients remain at home and in control of symptoms which can often lead to a prolonged stay in hospital. We are also planning educational programmes for patients to enable greater understanding of their condition, to aid their self management and independence.

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

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 Southport and Formby 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 Feelgood Factory, 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:

Redi

During its 10 years of existence Ykids has come a long way and its Redi programme focusses on topics such as education and employment and offering young people support so they can build a positive future. The grant was used to continue nine different groups within the programme. Children and young people from different age groups were involved in a variety of activities from a drumming workshop, a sponsored charity run and writing a pantomime, to achieving a first aid certificate with St John Ambulance and working on an 'Art is Rubbish' project. By offering a range of activities, the project builds emotional resilience within the children and young people who attended. Overall, 61 children and young people took part from October to December 2014.

Case study – One young person aged 15 attending Redi Affex, for young women, has a difficult home life and is often living in different places. She is involved in risky behaviour, is self harming and struggling to find a place she belongs. Redi has provided a constant in her life through the upheaval and chaos. Whilst her behaviour can be challenging she is calming down and her scores on risky behaviour reduced at the end of the term.

Netherton Feelgood Factory

The organisation has been working to combat social isolation and to improve people's health and mental wellbeing, especially for older people. It offered 'Feelgood Fridays' from December and the members who are now attending are aged over 65. One of them has early onset dementia and the others have had mental health problems. One of them is now confident enough to attend follow-on activities and another has improved mental health because her GP has remarked there has been a positive improvement in their health.

Case study – "The Feelgood Friday has had a huge impact on my life, it has brought me out of myself. I never went to any groups before coming to the Feelgood Friday, now I attend quite a few groups at the Feelgood Factory." - BH, who is partially paralysed and semi housebound before attending Feelgood Friday.

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. 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.

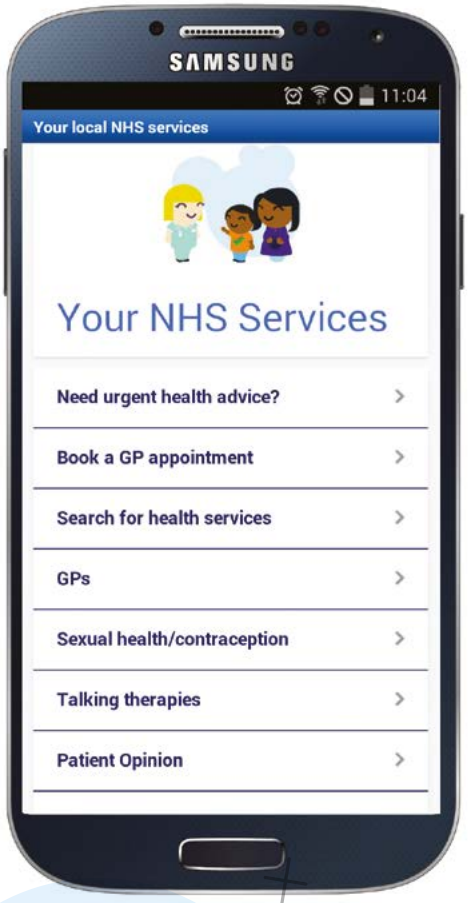
Case study – a former member of the parachute regiment said of the service: "Just over a year ago I was really down on my luck - I had no job, I was angry at myself and I was struggling to support my girlfriend and kids. A couple of guys I know told me about the Sefton Veterans Project. Because it is 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/southseftonccg
- **To download the app** - go to either Google Play or the iTunes App Store – then search for NHS SSCCG

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.southseftonccg.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.