Southport and Formby PCN	**9th March 2023**
Complete Care Community Programme Tranche III – Expression of Interest	

Southport and Formby Primary Care Network Complete Care Community:
Complex Lives- fewer snakes, more ladders.

Introduction

Southport and Formby Primary Care Network (PCN) covers a coastal population of mixed demographic but with undoubted inequality located in areas of Central Southport (Figure 1). The Chief Medical Officer's Annual Report 2021-Health in Coastal Communities highlights the issues facing coastal populations and in Southport we recognise the impact of deprivation, physical and mental illness, substance misuse, homelessness, low quality housing, migrant population and seasonal employment are having on health outcomes. Our intended focus on inequality in Southport and Formby PCN is the population segment that experiences many of these risk factors requiring disproportionate support but still suffer poor outcomes - those living with **Complex Lives**.

The **Complex Lives** population cohort defines those who represent some of the most marginalised and complex individuals in our services. Cheshire and Merseyside ICB (System P) identify people with Complex Lives as those who experience:

- A mental health condition and
- One or more physical health conditions

Plus, one or more of the following indicators

- Homeless
- Substance use
- Alcohol use
- History of offending
- High frequency of A and E presentations
- History of Looked After Children
- Victim of Domestic Violence

Or three or more of the above indicators regardless of mental or physical health conditions.

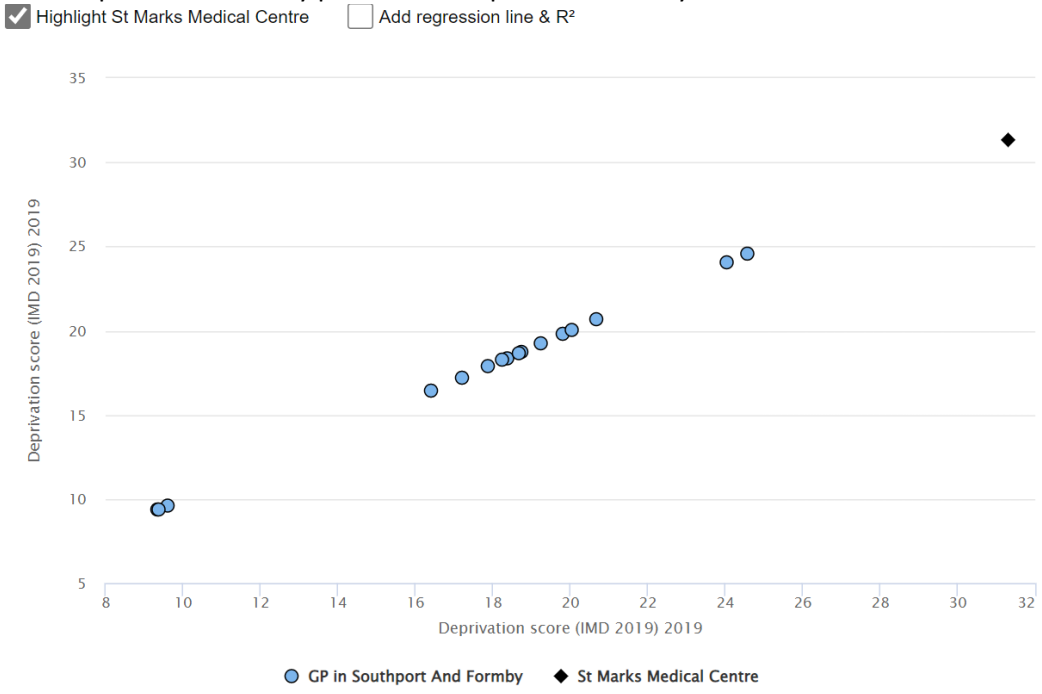
The impact of such determinants is not lost on practitioners on the ground locally and this cohort is comprised of:

- 555 individuals [0.4% of the population in North Sefton]
- 96% are identified as British-white.
- 37% are from the most deprived quintile in Sefton [Cambridge, Dukes and Kew Wards]
- 103 Complex Lives clients are living with someone under 18.
- 97% have a long-term illness [asthma, chronic liver disease, diabetes, epilepsy, coronary vascular disease, chronic kidney disease, atrial fibrillation, heart failure]
- 71% of complex clients go to A and E each year [22% general population]
- 46% of complex clients are admitted into hospital from A and E [9% general population]
- In terms of specific issues [intersections within the data] 190 complex clients have a substance misuse issue
- 50 Complex clients have an alcohol and substance use relationship.
- 21 Complex clients have an offender-alcohol relationship.

Services already working in North Sefton to support those with Complex Lives often do so through the focus of their own lens, concentrating on one of the component data sets outlined above rather than as part of a collaborative system. One of the key issues for us remains that "silo working" remains apparent with each service providing its own "ladder" for that person. Those with Complex Lives cannot successfully navigate between services successfully, nor are services attuned to the requirements of other services who work with exactly the same cohort. Decisions made in one service area set in motion a series of unintended consequences for other services working with the same client which can disrupt both the social and clinical recovery of the client and as such undermine the work of other organisations as well as erasing the real efforts made by the client who is '*lost*' without a map to navigate by.

Local attempts to offer fully co-ordinated care for those with complex lives to date remain embryonic. Historically, although there are well established third sector organisations (including most prominently, Light for Life) who have long provided support to those experiencing homelessness, Southport and Formby CCG had not commissioned specifically targeted services for homeless. St Marks Medical Centre in Central Southport has higher deprivation (Figure 1) and has a current register of **90 patients** experiencing **homelessness**. Together with Light for Life, the practice currently provides an informal weekly clinic for homeless patients **StreetSeen@StMarks** This is provided without funding by NHS commissioners and is staffed by GP, practice mental health nurse and allied staff when required. The current challenges identified in providing this service include resource, enhancing relationships with mental health and substance misuse services and training / sustainability longer term.

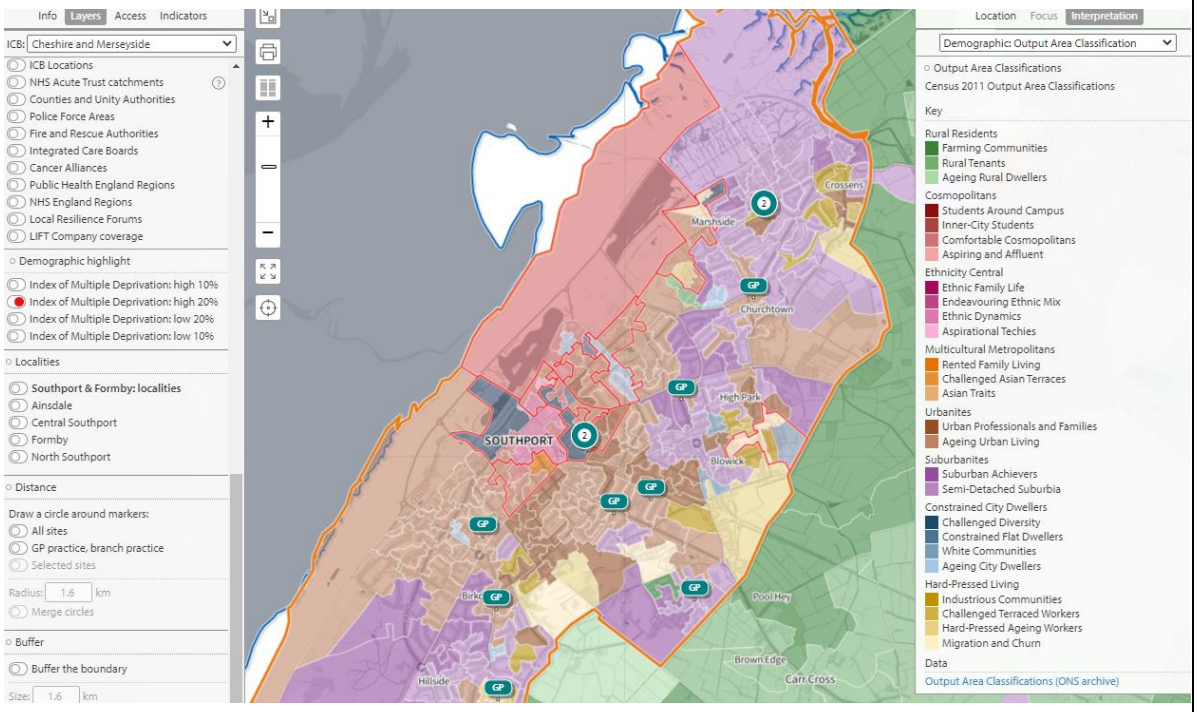
Figure 1: Deprivation score by practice Southport and Formby PCN



To further compound efforts, there is systemic misunderstanding of people living with Complex Lives are often labelled by services as "difficult" or said to "not engage". In some circumstances, the same individuals are "mandated" to engage in services that they view as "for others and not for them". In the clinical context, arriving at an appointment is a 'win'; making an appointment with probation is a 'win'; keeping an appointment and remaining on a prescription with drug services is a win; not sleeping on the streets is a 'win'. If only one of the above 'wins' changes into a 'fail', the client 'slips down the snake' and all the accrued social and clinical currency previously invested in

and with the client simply spills out of their pockets. In short, the current strategic and operational landscape has "*too many snakes and not enough ladders"*. It is the aim of this demonstration programme to start to remove the snakes and put in more ladders.

Map 1: SHAPE ATLAS EXTRACT: Southport and Formby PCN area, showing Output Classification Areas Red borders indicate areas where IMD is high 20% confined to specific areas and surrounding affluence which is mainly represented in one practice population (largest in PCN at 16,257 patients January 2023).



Aims

Our aim as a proposed demonstrator site is to develop a collaboration of stakeholders and patients with Complex Lives. This collaboration will test and document how partner agencies can re-calibrate their focus, language and attitudes, to improve service delivery for the complex lives population. We aim to do this through service user engagement and co-design and in a in a way that allows other sectors nationally to titrate our findings and meet exactly their own local need with no or minimal additional expenditure.

Objectives

If we accept that there are currently more "snakes" than "ladders" in the Complex Lives health journey, then our objectives must logically follow.

It is currently difficult for General Practice alone to make any headway with this cohort in terms of health outcomes since many of the "snakes" are not within its gift to influence or change. Instead, there is a need for cross sectoral collaboration. Indeed, fragmentation of services working with the Complex Lives cohort is at the heart of a lack of progress. As such one of the principal objectives to make progress is to remove the institutional barriers that impede progress.

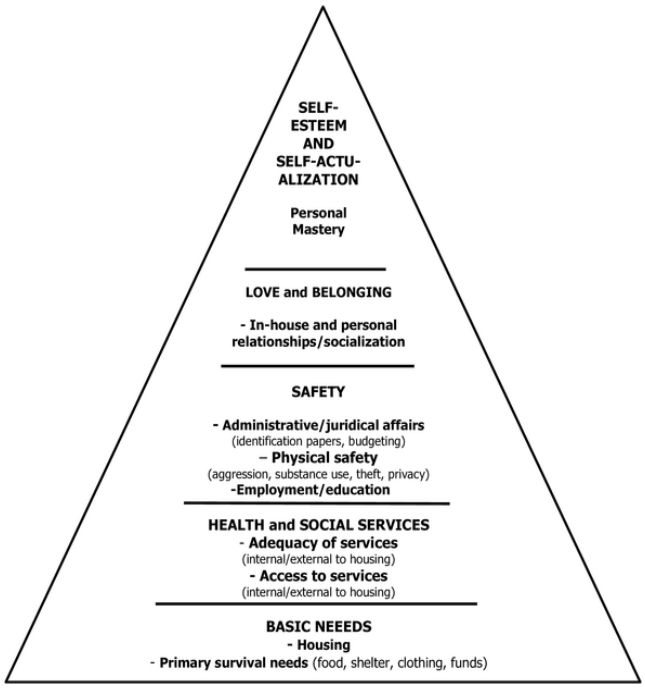
Our objectives are:

1. Identify people living Complex Lives.
2. Engage with this population, listen and understand the issues that mean most to people
3. Engage with relevant stakeholders (see below)
4. Form a leadership team of key stakeholders to provide strategic oversight of the programme.
5. Form a wider stakeholders group to facilitate change.
6. Co-design a common framework and operational map for those with Complex Lives
7. Begin to Identify measurable outcomes e.g. admission rates, emergency presentations
8. Disseminate a model as learning progresses.

The design principles would include:

- ✓ Placing those with lived experience at the centre of change with their needs as a focus (Adapted Maslow Hierarchy of need, Fig1 below)
- ✓ Addressing inequality with proportionate redirection of resource where it is apparent this is required
- ✓ Developing a common purpose and shared language and understanding amongst stakeholders
- ✓ Challenge silo working and break down organisational barriers, being bold and disruptive where necessary.
- ✓ Using the principles of Asset Based Community Development (Cormack McConnell)
- ✓ Incorporating a “No wrong door” approach and an aim to “Make Every Contact Count”.
- ✓ An acceptance that additional funding is unlikely to be available but rather a new way of working is most certainly within our gift.
- ✓ Recognising that our Primary Care Network is not solely about General Practice but more about a collaboration of services from a range of sectors working to address the health of our population.

Fig 1. Adaptation of the Maslow hierarchy of needs to a homeless population.



Fleury MJ, Grenier G, Sabetti J, Bertrand K, Clément M, et al. (2021) Met and unmet needs of homeless individuals at different stages of housing reintegration: A mixed-method investigation. PLOS ONE 16(1): e0245088. https://doi.org/10.1371/journal.pone.0245088
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0245088

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005217/cmo-annual_report-2021-health-in-coastal-communities-summary-and-recommendations-accessible.pdf
2. System P: Complex lives patient cohort: NHS Southport and Formby CCG
3. https://www.southportandformbyccg.nhs.uk/media/3455/sf-foi-55535-the-homeless-population.pdf

Key stakeholders identified

Organisations are identified by their potential to link the domains of defined complex lives:

- Southport and Formby Primary Care Network
- Change Grow Live [CGL: Community Addictions Service]
- Neighborhood Policing Team (Merseyside Police)
- HALT [Hospital alcohol specialist team]
- Homelessness services Clinical Psychologist [Mersey Care]
- Sefton Council
- Sefton Housing Options Team
- Local Probation service
- St Marks GP practice
- Light for Life [Commissioned service for homelessness presentations]
- Southport and Formby NHS Trust
- Crisis Café in Southport [late night provision for clients to use if required]
- Social Prescribing Link Workers (Sefton CVS)

- DWP
- Migrant Sefton
- Sexual Health Service
- Hepatitis C Service

Demonstrate:

Strong overall PCN maturity

Southport and Formby PCN are a maturing PCN, established in April 2021 with the membership of all 17 GP practices in the area joining this new network. We work closely with the GP Federation, Southport and Formby Health Ltd who plan and operationalise PCN services, supported by a strong leadership group who represent the practice members and we benefit from a strong governance framework for clear decision making.

We have identified the key challenges and issues for our population that require attention in our developing clinical strategy. These are to address: health inequalities; capacity and access in general practice, mental health, challenges associated with our frail and elderly patients such as isolation, equitable access and care for those who are housebound or living in a care homes, improving our Long-Term Conditions prevalence through targeted work and prioritising prevention.

In addressing these challenges, we have clear aims to:

- Improve resilience in General Practice
- Build a stronger and more sustainable general practice service across the Primary Care Network footprint
- Facilitate collaborative working between all Primary Care Network practices
- Engage with local health and care providers to develop place-based care to assist in the transformation of local services to improve the health and wellbeing of the Primary Care Network population
- Work with Patient Participation Groups to improved patient access, experience and quality
- Reach out to strengthen and develop working relationships with non-NHS community groups
- Develop signposting with Primary Care Network practices to streamline the patient journey to enhance more achievable and sustainable outcomes
- Further develop digital technology as a primary resource for practices and patients
- Continue to work in collaboration with the local GP Federation to build and strengthen relationships

As a PCN we have a robust infrastructure through Southport and Formby Health Ltd to include finance, human resources, governance and communications. They also provide employment to teams such as our EHCH, Pharmacy, Enhanced Access staff. We also work in partnership with local voluntary sector organisations to deliver services such as social prescribing and Cancer care navigators and are integral in the development of the integrated care team working with our community services provider and key stakeholders across Sefton.

The PCN continues to develop and will be measuring maturity through use of the maturity matrix.

Strong support in situ from local Place/Locality

This programme supports the strategic objectives at ICB and Sefton Place level. These include:

- Improving Health & Wellbeing in Cheshire & Merseyside Strategy, 2021-25 includes objectives for tackling health inequalities, improving outcomes and access to services.

- Five-year aspirations for C&M include reducing harm from alcohol, providing integrated, high quality mental health and wellbeing services for all people who require it.

Sefton Partnership aims to "deliver a confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future." This programme would support these aims by breaking down organisational barriers and improving outcomes for patients with complex lives.

A PCN with known/established interest in using analytical support tools

The PCN benefits from a clinical Digital Lead who has enabled the PCN to establish PCN wide data sharing agreements to support data collection, retrieval, and analysis. Southport and Formby Primary Care Network are tackling health inequalities in relation to high deprivation levels in central Southport practices masked by surrounding affluence as well as our ageing and vulnerable populations with the life expectancy in Southport and Formby significantly higher than that of our neighbours in South Sefton. Conversely, for our areas of high deprivation the mortality rate is significantly lower. Please see excerpt from SHAPE ATLAS above.

Reducing-healthcare-inequalities-Core20PLUS-infographic.pdf (england.nhs.uk)

It is proposed to use data sets from Fingertips, CIPHA and local practice data to facilitate and develop our Complete Care Community.

A PCN which can demonstrate strong local workforce planning

As a PCN we are developing and refining our workforce strategy to enable us to deliver the Network DES services as well as supporting our practices to deliver services, increase capacity and access. We are aiming to maximise our ARRS budget to increase workforce across primary care, working differently to deliver services at scale where possible and to embed in practices where possible. We have a detailed estates plan that we are progressing for a PCN hub to create a positive PCN team culture and support staff recruitment and retention.

Embedded use of social prescribers and Care Co-ordinators

We have co-designed the social prescribing service with Sefton CVS and Brighter Living Partnership utilising the skills and experience that exist within our community and vibrant voluntary sector that began it's inception in 2019. This partnership approach has been a key driver of success. The increasing maturity of the partnership means that we have increased resource to meet demand where the deprivation and consequent health inequalities are the highest.

There are now 11 social prescribing link workers (SPLWs) across Southport and Formby transforming healthcare for people. This includes Cancer Care link workers who support patients with new cancer diagnosis and the service is delivered through partnership with Southport Macmillan / Southport and Formby Cancer information & Support centre.

Good existing/maturing Local Authority links

We have established relationships with Sefton Local Authority and are keen to develop and strengthen these relationships. They are a key stakeholder in this programme to agree common language and purpose to address health inequalities.

Furthermore, many of the proposed stakeholders have strong links with the local authority. The non-statutory services are commissioned at least in part by the local authority to deliver services to the complex lives' cohort. Services have established reporting and commissioning frameworks with the Local Authority. As such the links with the local authority are well established and can be regarded as secure.

Good existing/maturing third sector and NHS Community Provider Sector links

We have a good relationship with Mersey Care NHS Foundation Trust, our Community Services and Mental Health provider. We are working with the Trust to develop population-based Community Integrated Care Teams locally. We also partner Mersey Care in the provision of Mental Health Practitioner roles through the PCN Additional Roles Reimbursement Scheme (ARRS). We aim to strengthen these relationships through this programme.

We have strong relationships with our third sector through our Social Prescribing programme that uses the rich community assets in Sefton to benefit our patients. We continue to work closely with them to consider new ways of working.

There is already a real recognition that people with Complex Lives are well known to different health and community-based agencies many of whom are formally commissioned by the Local Authority or through the relevant health pathway. The proposed stakeholder organisations and agencies have a strong track record of delivering services to this 'shared' cohort in Sefton as they present with a range of social and clinical related issues.

These services well established, operating within Sefton for many years (in some cases over 30 years). However, despite this investment, the inequality faced by this cohort remains at best in a 'holding pattern' with little overall evidence of improvement and resilience despite their involvement in numerous services. We recognise this as an issue and collaboration and engagement between services is at the very core of this proposal which seeks to address this issue.