SOUTH SEFTON
PRIMARY CARE NETWORK

Primary Care Network of the Year

South Sefton Primary Care Network

January 2025

Dr Craig Gillespie, Clinical Director and Rachel Stead, Strategic PCN Manager

South Sefton wins PCN of the Year

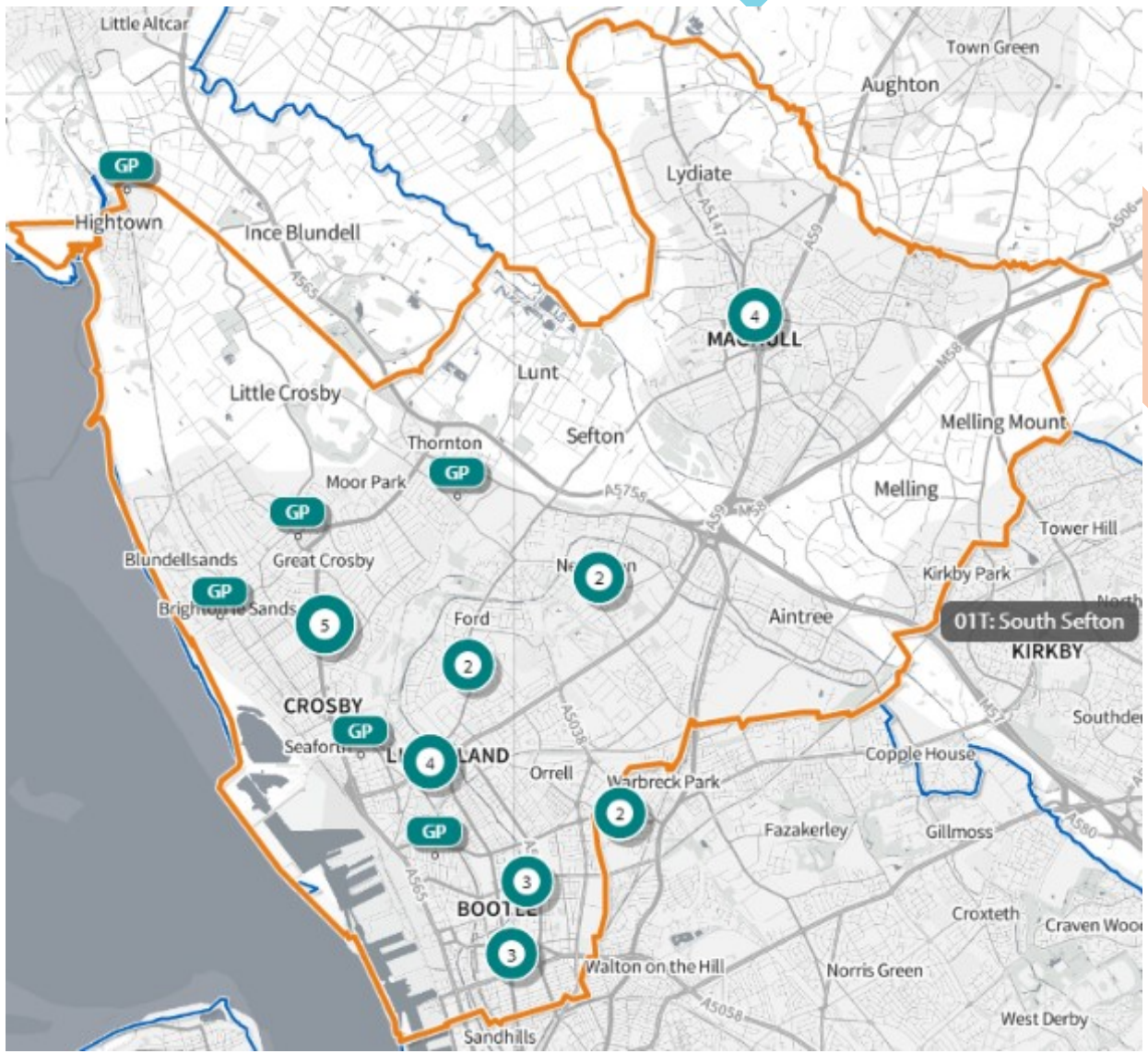
South Sefton Primary Care Network has won at the prestigious General Practice Awards 2024. This award recognises SSPCN's outstanding contribution to collaborative general practice, improving health outcomes and partnership working to deliver integrated, patient-centred care for its patients.

Our vision

To improve health and wellbeing for people living in South Sefton and enable a sustainable, resilient health and care system

Introduction

- South Sefton PCN formed on 1 April 2022 bringing together Bootle, Crosby and Maghull PCN with Seaforth & Litherland.
- Made up of the 19 GP Practices of South Sefton, who care for 161,000 patients (some via subcontract).
- PCN operates a neighbourhood structure, each with clinical leadership to align with integrated care teams.
- Neighbourhood priorities established via close collaboration with practices and partners, and data in to action
- Around 100 PCN staff - either directly employed, hosted or seconded.



South Sefton PCN Strategy on a page

Context

- NHS Long term Plan
- GP Forward View
- Network DES
- Sefton Partnership
- ICS & Place Strategy
- HWBB Strategy
- Programme Delivery Group
- Fuller Stocktake
- Health Select Committee - Future of General Practice
- Sefton PCN Collaborative

Key risks

- Clinical systems interoperability
- Workforce
- Estates
- General Practice access
- PCN 'scope creep' and continuity of the contract
- Commitment to integration across organisations
- ICB changes: placed based support is vital

PCN Vision and Objectives

South Sefton Primary Care Network aims to be at the heart of the integrated health and social care system for primary and community care

Strategic priority 1: Integrate Primary Care	Strategic priority 2: Expand the primary care workforce	Strategic priority 3: Work at scale
• Enhanced Health in Care Homes • Enhanced Health at Home • Primary Care mental health hub • Tackling health inequality • Integrated Care Teams	• Maximising benefit of Additional Roles Reimbursement Scheme • Unified Learning Environment	• Medicines Management Hub • Acute home visiting service • Admin Hub • Proactive Care team • Estates plan

Strategic Enablers

Governance arrangements
PCN Structure
Workforce Plan
Communications and engagement (via place)
Systems and digital innovation
Financial management
Risk management
Business Intelligence (via place)
Estates
Quality and performance

Impact

Improved access for patients via a wider range of services

Continuity of care for patients via integration – they tell their story once and have a joined up team approach

Quality of care increases.

Services are levelled up, reducing health inequality

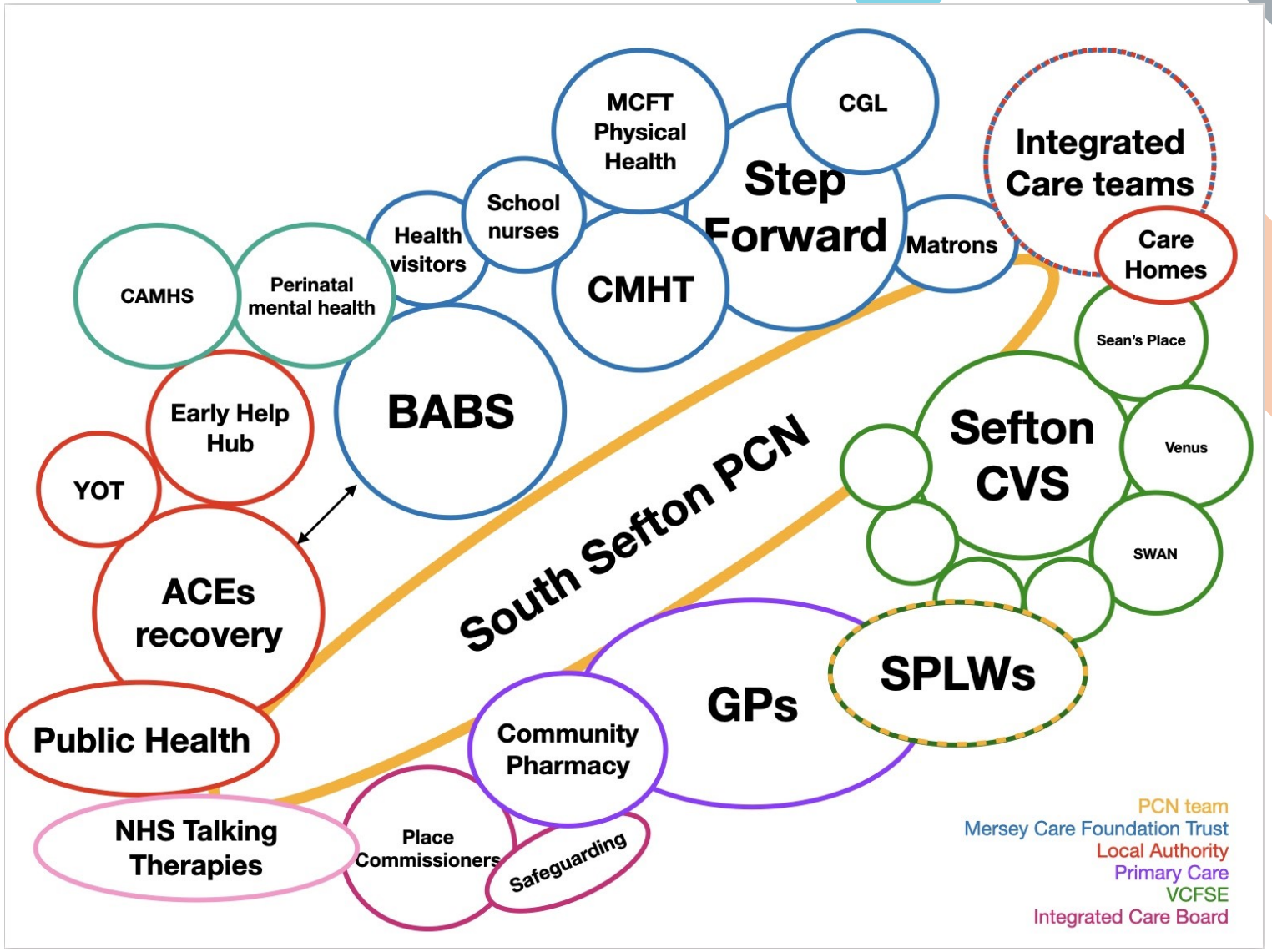
Primary care staff are retained through better training, portfolio careers and increased MDT support

Primary care becomes sustainable

More effective population health management

Partnerships

- Why we think we won
- Relationships across Sefton place
- Critical to delivery of an effective PCN
- Collaborate to sustain
- High trust enables innovation



Adverse Childhood Experience Group Programme - Participant Video

https://youtu.be/yql35ezExyQ?si=KhPNRW-9kqJua4t3

South Sefton Access Service

- Acute Respiratory Infection Hub launched 14 February 2023
- Increased scope to include wider range of acute minor illnesses for patients aged 2+.
- Treated just over 35,000 patients
- Working with Local Pharmacy Committee to maximise benefit of Pharmacy First.

Integrating Care - Enhanced Health at Home

Enhanced Health at Home supports the aims of the Sefton strategy by establishing a team focused on integration of services with the Sefton partnership to enable older patients who want to live at home to remain to do so, maintaining high quality of life, and appropriate support to retain independence.

1. Patients have a regular named team that operate a ‘no wrong door’ policy
2. Patients are contacted proactively and regularly by Care Co-ordinators and Social Prescribing Link Workers
3. Patients remain well, and avoid in-patient admissions or re-admission through proactive medication reviews, acute visiting service, etc.

Learning disability health checks

- Expanded PCN team to support practices in visiting patients at home who have not attended surgery for their annual learning disability health check.
- Having time to visit patients at home, or at day centres is improving uptake of health checks.
- Recently, a nurse associate, Sarah after several attempts, made contact with a patient who not been seen for some time and discovered them living in extremely poor home conditions. The patient had not eaten a meal for days, and they were acutely unwell. Sarah went out to buy the patient a meal. She was able to liaise with the practice safeguarding lead to arrange urgent referral and made arrangements with a several other agencies to ensure appropriate intervention.

Working at scale - Medicines Hub

- Discharge hub
- Care Plans for Care home residents (320 completed Q1 and Q2)
- Impact and Investment Fund
- Structured Medication Reviews
- Outreach clinics via VCF organisations
- Specialist clinics in development (eg Women's health hubs)
- ICT MDTs including Virtual Wards, Enhanced Health at Home and Enhanced Health in Care Homes
- Quality Improvement in General Practice

Impact on safety

In the first half of 22/23

- Responded to 9,500 medicines queries, including 400 calls to secondary care and 1700 calls to patients
- 6600 post hospital discharge summaries
- 822 Structured Medication reviews for patients at risk of harm from their combinations of medication
- 2267 medication reviews for patients at risk of gastric bleed
- 924 reviews of controlled drug prescribing
- 1006 medication reviews for new patients in Sefton

Impact on cost

Medicines hub is forecast to deliver £1.2m prescribing cost savings in 2022/23 for Sefton

Impact on workload

For GPs: "*The support from the hub has been magnificent and they are all so professional their expertise is valued by all GPs. We cannot stress the amount of time it has saved our clinicians*"

For secondary care: 1.8 WTE Pharmacists supporting intermediate care and virtual ward teams

Impact on patients

A patient was admitted to hospital for a very short stay with no time for a hospital pharmacist to review discharge medication. The medicines hub noted that doses of two medications appeared to have been reduced inappropriately. A hub pharmacist queried this with the ward doctor who confirmed the discharge information was incorrect. If the hub pharmacist had not identified this, it is probable the patient would have required re-admission.

Impact – Working with Voluntary & Community Partners

MYA - Space

Open Space Project/Art Therapy

Priority Area: Anxiety and Depression

The project has been very successful for the young people who have been involved. With improvements being made in different areas such as confidence, self-esteem, relationships, knowledge understanding, supporting one another and overall having positively achieved what they have sent out to do. Throughout the process, young people have learnt new skills and gained new interests making them have a more positive outlook for life in the future. They have addressed issues and came up with solutions along the way, creating a self-support and help strategies. In the shape of a magazine for young people about young people putting issues in the "SPOTLIGHT".

"This project has really helped me express how I feel, and I know I have people who I can share my thoughts with and they can help me."

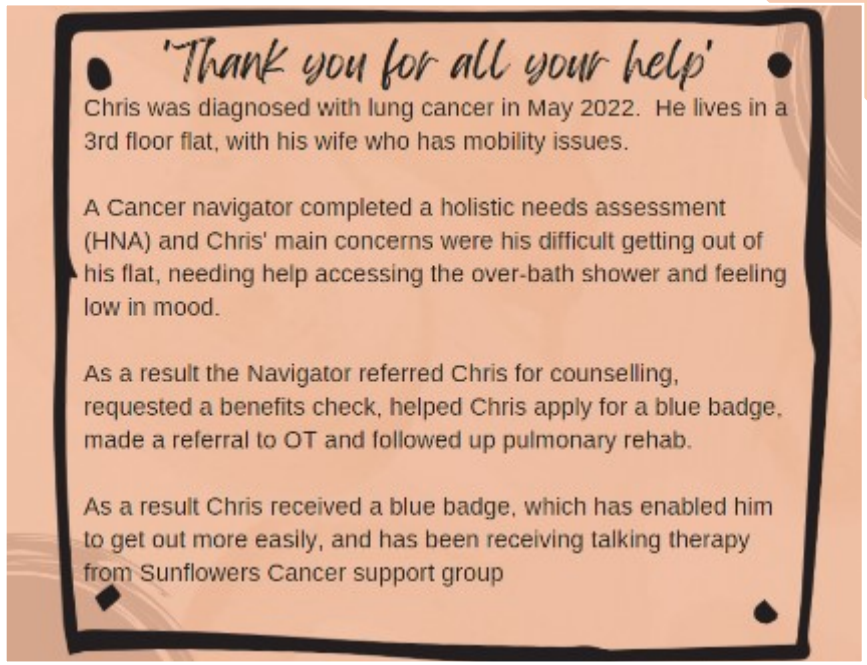
"I would definitely, recommend this project to other people ...I know that other people my age are struggling with problems and how I can help them."

62 young people have gained support with their mental health and wellbeing relieving pressure in primary/community care whilst engaged within this project.

After young people completing our MYA outcome star looking at: Motivation, Resilience, Skills, Aspirations, Belonging, improvements were made in all areas such as:

- Motivation improved by 98%
- Resilience improved by 95%
- Skills improved by 100%
- Aspirations improved by 92%
- Belonging improved by 97%

PCN Winter Access Community Grants



PCN funded Cancer Navigators

Future Plans

- Completed ‘EvoGP’ consultation – consulting member practices and system partners about how general practice in south Sefton should evolve
- Vision for further collaboration is wide and deep
- Recommendations will become the strategic plan for the next PCN period

PCN Strategic planning / connectivity with health & care system

Core General Practice

Retains list-based practice and autonomy
Partnership model and multi-practice providers co-exist
Underpinned by PCN services

Complex Patients – continuity essential, seen by own GP	Unwell patients – would benefit from continuity where possible	Generally well patients – would benefit from quick access

Amber patients may be seen in if access more important than continuity

Prioritised to seen in Acute & Minor illness Hub / EAS

Existing PCN services (Pharmacist Hub, EHCH / EHAH / Mental Health team / LD / SSAS)

Central services responding to key risks eg nurse workforce, health inequality

New specialist primary care PCN services to be agreed

Enabled through SSPCN Ltd

Future Plans

- Existing services are business as usual, developing a strong track record of effective delivery
- Ready for investment and opportunities for further system collaboration.


GENERAL PRACTICE
AWARDS 2024
Winner
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Thank you