

HEALTHY
LIVERPOOL
THE BLUEPRINT



**HEALTHY
LIVERPOOL**

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1

INTRODUCTION



Nadim Fazlani, Chair,
NHS Liverpool CCG

Katherine Sheerin,
Chief Officer,
NHS Liverpool CCG

In November 2014 NHS Liverpool Clinical Commissioning Group published **Healthy Liverpool: Prospectus for Change**. This document was the culmination of work which began in the summer 2013, when we embarked on Healthy Liverpool in response to the Mayoral Health Commission. The Prospectus outlined our vision for the future of health and care services in the city, and the principles on which change would be based.

The Mayor's Health Commission set out a vision for an integrated health and social care system for Liverpool, with prevention and self care at its core, for which Liverpool CCG has a mandate to lead and deliver, working in full partnership with all parts of the health and care system, along with patients and public.

In the 12 months since The Prospectus was published, a huge amount of work has taken place, involving partners across the health and care system.

In July 2015, 120 senior clinicians and leaders from 15 organisations gathered for the Healthy Liverpool Clinical Assembly for Hospital Transformation, where a landmark agreement to work together towards a "Single-Service, City-Wide Delivery" model around a Centralised University Hospital Teaching Campus was reached.

We have engaged with primary, community and social care providers to agree a compelling vision and new model for community services, which will be the cornerstone of Healthy Liverpool's transformational, whole-system changes.

The CCG has already approved significant investment to realise our ambitions for Liverpool to become the most active city in the country, and to drive digital care and innovation.

Alongside intensive and sustained clinical engagement, we have continued discussions with the people of Liverpool. Throughout the summer people had the opportunity to provide their views on our "case for change", and will soon be asked to get involved in informing detailed plans for Healthy Liverpool projects and programmes.

This document – The Blueprint – sets out how we will deliver transformational change across five areas:

- Living Well
- Digital Care and Innovation
- Community Care
- Urgent and Emergency Care
- Hospital Services

Within individual programme areas we are already seeing implementation of significant

pieces of work, which you will read about in this document.

The publication of The Blueprint represents a key point in our five-year journey. We now have a clearly defined programme to deliver ambitious and measurable transformation with targets formed by extensive engagement from clinicians, leaders, patients and the public, and are moving to full mobilisation to deliver the aims and ambitions of Healthy Liverpool.



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HEALTHY LIVERPOOL VISION


Like many health economies, Liverpool faces significant system-wide challenges including:

The need to improve clinical standards and reduce variations in quality and access.

Tackling inequalities and improving health outcomes.

Ensuring that the city is able to maintain a clinically and financially viable health and care system which is sustainable for the long-term.

Liverpool will have a health and social care system that is **person-centred**, supports people to stay well and provides the very best in care.



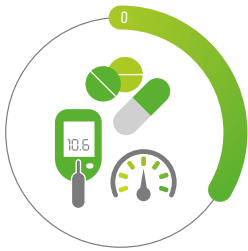
The findings of the 2013 Mayoral Health Commission concluded that such is the extent of the poor health outcomes of the people of Liverpool, and the relentless pressures on budgets and resources, that only a whole-system and comprehensive approach to the transformation of health and care could successfully address these challenges. The Commission's vision was for an integrated health and social care system for Liverpool, with prevention and self care at its core.

NHS Liverpool Clinical Commissioning Group, as the body responsible for the vast majority of health commissioning in the city, took up the challenge of delivering the recommendations of the Mayoral Health Commission. Healthy Liverpool will realise this vision for improved health and wellbeing and a sustainable health and care system.

3

THE CASE FOR CHANGE

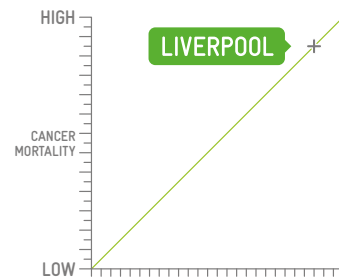
POOR HEALTH



30% of people in Liverpool live with one or more long-term conditions.



93,000 people in Liverpool are affected by mental health issues.



Liverpool has one of the highest cancer mortality rates in the country.

HEALTH INEQUALITIES



The difference in life expectancy between areas of the city can vary by more than 10 years.



Men in Liverpool live 3.1 years less and women 2.8 years less than the England average.



You are 2.5 times more likely to die of cardiovascular disease if you live in Picton ward than if you live in Mossley Hill ward.

The case for change is compelling. As a city, we experience amongst the highest levels of poor health and health inequalities – both within the city and compared to the rest of the country.

Within our health and care system there remain unacceptable levels of variation between services, and access to services needs to be improved.

Improvements in medicine mean that we are living longer, but not necessarily living well in our later years.

Although some lifestyle improvements have been achieved, such as reducing smoking rates, poor lifestyles remain a major challenge and this is the biggest issue we face as a city. These challenges are represented visually:

AGEING POPULATION



By 2021 there will be 9% (5,700) more people living beyond the age of 65 with the biggest growth in those aged 70-75 and 85+.



Almost 26,000 older people have a long-term illness that limits their day-to-day activities a lot.



By 2021 there will be a 10.7% increase in the number of people living with dementia.

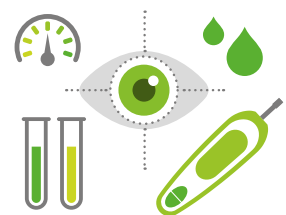
ACCESS AND VARIATION



The number of patients with Chronic Obstructive Pulmonary Disease offered rehabilitation varies between 24% and 79% in the city.



People with a learning disability are 58 times more likely to die before the age of 50 and 4 times more likely to have a preventable cause of death.

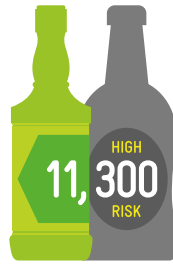


The number of people with diabetes receiving the recommended care processes to manage their condition varies between 20% and 80% depending on where they live in Liverpool.

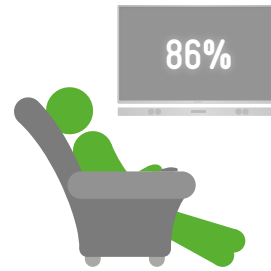
LIFESTYLE



Over half of adults in Liverpool are overweight or obese.



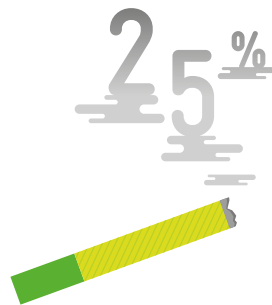
An estimated 11,300 people in Liverpool drink at high risk levels.



86% of people in Liverpool are not active enough to maintain good health.



424 deaths could be prevented each year by 30 minutes of activity per day.



25% of adults in Liverpool smoke.

4

HEALTHY LIVERPOOL OUTCOMES

We have set ambitious targets for change, which require Healthy Liverpool to be bold in its plans and for the whole health and care system to come together with a common cause, to transform services and to inspire and empower many more Liverpool people to improve their own health and wellbeing. More detailed information on outcomes is available at the end of this document.

HEALTHY LIVERPOOL OUTCOMES FOR TRANSFORMATION:

24.2%

To deliver a 24.2% reduction in avoidable mortality (years of life lost).¹

71%

An increase from 65% to 71% in the measurement of the quality of life for people with long-term conditions.²

15%

A 15% reduction in avoidable emergency hospital admissions. Equivalent to a reduction of 1659 emergency admissions by 18/19.

TOP 10

To deliver a patient experience in our hospitals that puts us in the top 10 of CCGs nationally.

TOP 5

To provide a community-based care experience that puts us in the top 5 of CCGs nationally.

A CLEAR SET OF MEASURES OF SUCCESS FOR HEALTH AND SOCIAL CARE INTERVENTION HAVE ALSO BEEN DEVELOPED:

87

Reduction in the number of permanent admissions to residential and nursing care homes from 767.3 to 612.9 per 100,000 people by the end of 15/16. Equivalent to a reduction of 87 permanent admissions to care homes.

196

Increase the % of patients still at home 91 days after discharge to reablement services from 78.9% to 83% by the end of 15/16. Equivalent to an extra 196 people still at home 91 days after discharge.

214

Reduction in the number of delayed transfers of care from 2664.5 per 100,000 population to 2602.7 per 100,000 population by the end of 15/16. Equivalent to a reduction of 214 delayed days in hospital.

QUALITY OF LIFE

Increase in the levels of carer-reported quality of life.

912

Based on expected prevalence levels, increase in recorded cases of dementia from 54% in July 2013 to 70% by March 2016, equivalent to finding an extra 912 people with the condition.

1. 'Potential Years of Life Lost' (PYLL) is a count of the number of years between the age a person under 75 dies and the age of 75. These are summed for the population who die in a 12 month period and reported as a rate per 100,000 patients. A higher rate means more people die younger. Liverpool is going to reduce this value by 24.2% by 18/19.

2. This is a measure of the average EQ-5D score for people responding to the GP survey. EQ-5D asks patients to score themselves 1-5 against 5 questions relating to quality of life, mobility, self-care, usual activity, pain/discomfort, depression/anxiety. A % between 0-100 is attached to each response combination, 100 being good and 0 being poor quality of life. The % reported is the average score for people responding to the survey.

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HEALTHY LIVERPOOL PROGRAMMES

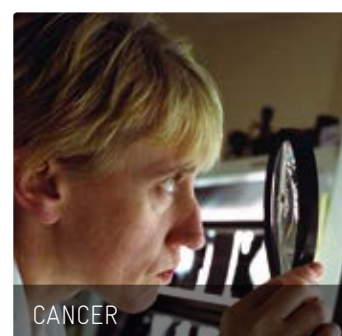
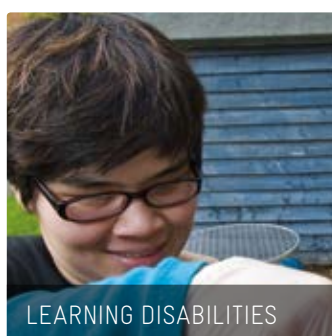
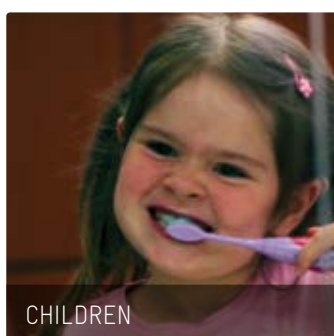
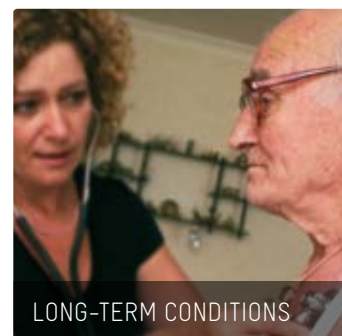
The changes planned in Liverpool are substantial and represent significant transformation in the way health and social care is organised and delivered. This transformation also extends to key enablers including workforce, estate, technology, systems and finance.

A new model of care will transform the whole health and social care system in Liverpool leading to improving outcomes for patients and new ways of working. Five core transformation programmes have been established:

- **Living Well:** Supporting people to become healthier and more active
- **Digital Care and Innovation:** Ensuring all our services make best use of developing technologies
- **Community Care:** Improving capability and capacity in primary care, community care and social care
- **Urgent and Emergency Care:** Developing robust and effective rapid response services
- **Hospital Services:** Ensuring our hospital services are the best they can be

Six clinical areas have been prioritised, informed by where we believe we can make the greatest impact in transforming services and health outcomes.

The delivery of these priorities will ensure that people in the greatest need receive the best care and support. The priority clinical workstreams are:



6

HEALTHY LIVERPOOL DESIGN PRINCIPLES

The Healthy Liverpool model of care has been informed by a core set of design principles:

Person-centred

Proactive

Eliminating avoidable variation in quality

Local care where practicable, central when necessary

Improving access to services in the community

Integrated across health, social care and the voluntary sector

Making the best use of digital technology

7

LIVING WELL PROGRAMME



Dr Maurice Smith,
Living Well
Clinical Director

“Leading an active life is one of the single most powerful actions we can take as individuals to improve and maintain our overall health and wellbeing, and yet so many of us are living sedentary lives.

“This isn’t an issue unique to our city – inactivity has become a global epidemic – but we’ve made tackling it a cornerstone of Healthy Liverpool, because the potential benefits of raising physical activity levels are huge. For example, we know that it offers us a real opportunity to improve outcomes for diseases such as diabetes, heart disease and cancer, which all present major challenges locally.

“We’re working to understand more about what will inspire the population, on both a group and individual basis, to engage in daily physical

activity. We hope to use these findings to help spark a social movement around being active. We want to help people find a realistic, sustainable approach which suits their lifestyle. It doesn’t need to involve hitting the gym or running a marathon – anything which gets you moving more on a regular basis is important. Even using the stairs instead of the lift can make a difference.

“It’s about embedding physical activity into the fabric of our daily lives, so that we can all start to reap the benefits of moving more.”

Our vision is for Liverpool to be the most active Core City in England by 2021, inspiring and enabling people who live and work in Liverpool to be active every day for life.

Our aim is that by 2021 an additional 1 in 3 of us – 118,000 people in Liverpool – will be doing at least 30 minutes of activity, one day a week. This would equate to at least 80% of the Liverpool adult population undertaking a level of activity that will be beneficial to their health.

- We will work with the city's schools to embed activity as a core part of school life, not just as a PE lesson.
- We will work with the city's employers to roll out workplace activity programmes to enable people to get active during their working day.

Our aim is that by 2021 an additional 1 in 3 of us – 118,000 people in Liverpool – will be doing at least 30 minutes of activity, one day per week.

“We want the inactive to become active; the semi-active to become more active; and the active to maintain their activity levels.”

7.1 LIVING WELL AIMS

Living Well is central to the success of Healthy Liverpool and is built upon two objectives:

- To prevent people falling into ill health, through supporting them to adopt positive lifestyles;
- Promoting self care; supporting and empowering people with long-term conditions to better manage their health, in partnership with clinicians and carers.

The Living Well priority for Healthy Liverpool over the next two years is to increase physical activity levels for a substantial number of people who are either currently inactive or moderately active.

We have a set of ambitious objectives:

- We aim to create a large-scale social movement in Liverpool, with people in the city getting active for their own benefit, but also driven by a collective sense of pride around Liverpool aiming to become the most active major city outside London.
- We will be using existing expertise and creating new community assets to support people with activity programmes, mentoring and other forms of support to encourage people to get active.
- We will be investing in physical assets, in both indoor and outdoor environments, to maximise the potential for physical activity and sport.
- We will deliver schemes to encourage mass participation in physical activity schemes, including supporting major events, ongoing programmes and a large-scale social marketing campaign to motivate and inspire people to get active.
- We will integrate physical activity and sport into health care, as a prescription for better health.

7.2 WHY CHANGE?

Physical inactivity has become an epidemic and is now perceived to be the greatest threat to our physical and mental health. Only 14% of people in Liverpool are doing enough activity to benefit their health. Half of the population of Liverpool do not take part in any regular sport or active recreation in a typical week.

According to Sport England, the health cost of physical inactivity in Liverpool is currently £10.8m per year, based on five of the most common conditions – diabetes, breast cancer, colon cancer, coronary heart disease and hypertension.

If we were able to surpass our ambitions and get every adult in the city to undertake 30 minutes of activity a day for at least five days a week we estimate this would prevent:

- 424 deaths a year;
- 146 coronary heart disease emergency admission a year;
- 2,452 new diabetes cases;
- 55 cases of breast cancer;
- 43 colorectal cancer cases.

Our ambition to get people active enough to realise health benefits requires a significant step-change, with many more people valuing activity as an intrinsic part of daily life. Therefore the key aims of the strategy are to enable the inactive to become active; the semi-active to become more active; and the active to maintain their activity levels.



“Inspiring people to integrate activity into daily life.”

When we refer to physical activity, this doesn't have to mean joining a gym or participating in sport. The activities that will make a difference include: walking; active travel, such as getting off the bus a stop early; taking the stairs rather than the lift; gardening; dancing; chair exercise; swimming; cycling and even housework. Doing more of these everyday things will make a difference.

7.3 DELIVERY

The aim for Liverpool to be the most physically active Core City is a long-term aspiration. However, over the next two years we have set ourselves realistic but stretching targets, which are underpinned by nearly **£3 million new investment**.

Over the next two years (2015/6 and 2016/17) the programme will:

Year 1: Engage 10,000 people in the city, resulting in at least an additional 5,000 people undertaking at least 30 minutes of activity, one day a week.

Year 2: Engage 30,000 people, resulting in an additional 15,000 people undertaking at least 30 minutes of activity, one day a week.

The key deliverables designed to achieve these targets are:

Insight and Social Marketing

The objective is to inspire people to value and integrate physical activity into daily life by encouraging a Liverpool social movement. This will be supported by a large-scale social marketing campaign, media and commercial partnerships, to: raise awareness of the compelling benefits of physical activity; motivate people to take action; and to let them know what support is available, both in terms of structured programmes and 'do it yourself' activity.

Bespoke behavioural insight has been commissioned to provide local intelligence and to understand motivations and barriers at an individual, community and city-wide level. This insight will inform a bold and Liverpool-centric campaign to create and sustain a city-wide social movement to get and stay active.

The aim is to launch this campaign in May 2016, but we will also carry out work in 2015/16 which raises awareness of the compelling benefits for getting active – improving health and saving lives.

Living Well Champions

In order to achieve the desired step-change activity across all parts of the city, we will develop a network of champions who can empower and support people and groups. This includes targeting people who work for the NHS, the city's largest employer. The NHS has made a commitment to set a national example in the support it offers its own staff to stay healthy, including helping them to be more active.

We will also be investing in champions and projects designed and delivered through a network of voluntary organisations that understand the particular needs of their communities and the areas of the city they work in. This will in part be delivered through Liverpool CCG's Community Grant scheme.

Quality indoor and outdoor environments

We will be investing in schemes to improve access to quality indoor and outdoor assets, to maximise opportunities for people to access a range of activities and sport. This will be achieved through developing a number of Liverpool City Council-led initiatives, including Access to Schools; Open Spaces and Parks; and Lifestyles centres.

Mass Participation

Alongside the city-wide campaign to generate a social movement for activity, we will be delivering mass participation activity schemes, focused for the first two years on maximising walking and cycling opportunities. These schemes will be consumer-focused and will incorporate incentives to motivate people and families to participate. Planned mass participation schemes include:

Active Travel – Embedding a 'moving' culture into the lives of Liverpool residents, encouraging people to walk and cycle over other forms of transport. This is arguably the most practical, sustainable and cost-effective way to increase physical activity on a daily basis.



“The activities that will make a difference include walking and cycling.”

Beat the Streets – A scheme designed around a ‘real world walking game’ concept where people compete for points by walking or cycling around their local area: to work, to school or as part of a daily routine. As part of the challenge, schools and businesses will compete to accumulate the most points, which brings a range of rewards. Beat the Streets is designed to ‘nudge’ people to try walking and cycling for a period of six weeks, at the end of which it is anticipated that a significant proportion will continue to incorporate regular walks and bicycle rides into their daily lives. This programme has evaluated well elsewhere in the UK. The concept will be tested initially in the north and east wards of Liverpool, which have some of the country’s lowest levels of physical activity.

Bounts – A scheme that rewards residents for making positive lifestyle choices. Bounts is like airmiles for physical activity, using an app to check-in at healthy venues like gyms, or with instructors and coaches outdoors. People build up points which can be redeemed for rewards. Again, we will test this concept for Liverpool.

Back to Sport Programme – A city-wide programme offering people opportunities to return to sport, using existing local facilities and clubs. This programme will be supported by Sport England and the 12 national governing bodies of sport that are currently designing a bespoke offer for Liverpool. The sports are: athletics, badminton, boxing, cycling, football, gymnastics, hockey, golf, netball, rugby union, swimming and tennis.

Community Grants – the CCG’s Community Grants programme will be enhanced to include a specific physical activity element to support local groups to provide sustainable activities based on local needs and interest.

The programme will also look at how physical activity can be **embedded into clinical pathways**, and **extensions to the School Sport Pathway Programme**.





ACTIVITY FOR BETTER HEALTH

'Active Me' is an inclusive sports programme aimed at disabled people in Liverpool who experience barriers to physical activities and sport.

Ann-Marie, 32, first attended the Active Me project in April 2014, with her then support worker. Anne-Marie was morbidly obese and spending a lot of time alone. Her mental health issues meant she was relying on anti-depressants to face each day.

The first time Ann-Marie attended an Active Me session, she was very anxious and shy. Ann-Marie was encouraged to attend the next week's session where activities would be broken down into smaller chunks, so that she felt more confident joining in.

A few weeks later Ann-Marie had made new friends and had already attended a number of weekly sessions. She gained in confidence while improving her fitness at the same time. With the support of the activator running the sessions she embarked on the Walk for Health scheme, where twice a week she took part in a 3 to 5k walk, and was given the opportunity to understand the importance of preparing and cooking healthy meals.

To date Anne-Marie has lost five stone in weight. She cooks and prepares healthy meals, has reduced the amount she smokes and is an active gym member. She also no longer requires a support package.



ACTIVITY ON PRESCRIPTION

Exercise for Health is a GP referral scheme for people living with long-term conditions.

Bill, 82, who takes part in activities at Lifestyles Garston, said: "After starting the scheme with instructor Wendy, I was given a programme to suit my needs.

"When I first started the scheme I felt down - I didn't always want to leave the

house - but since coming here I have made some great friends and now we all have a laugh and a social after our workout.

"I go out feeling great and ready to take on any challenge put in my way. Since I have joined Lifestyles Garston, my life has changed for the better. I feel much fitter and am enjoying life."

LIVING WELL PROGRAMME PLAN OVERVIEW

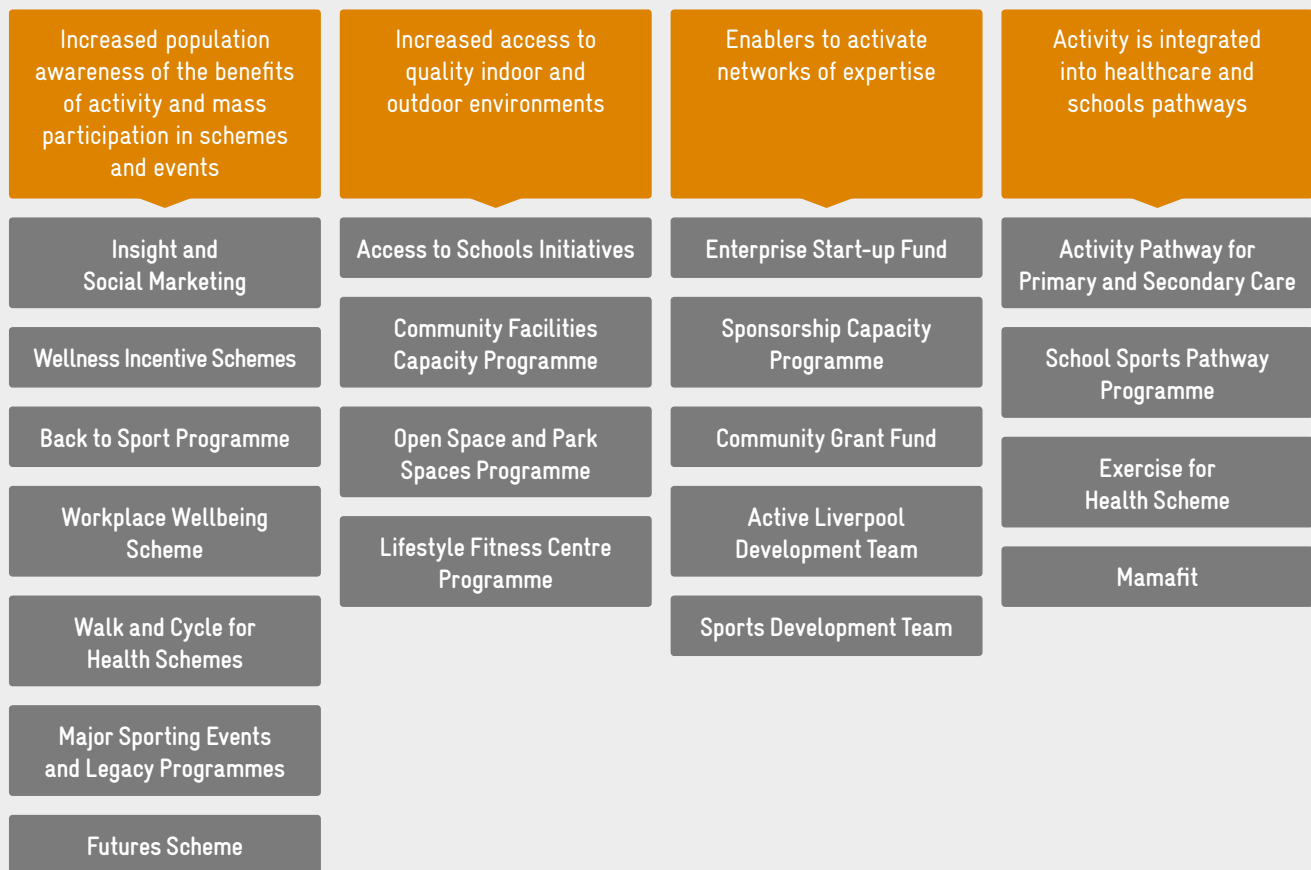
VISION AND OUTCOME AMBITION

‘A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care.’

Improved Health Outcomes	Deliver First Class Services	Delivering a Sustainable System
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LIVING WELL OUTCOME DOMAIN

Liverpool will be the most active Core City in England by 2021 by increasing participation in physical activity and sport (PAS) by 30%



Principles	Population approach, Person-Centred: Co-creation, Collaboration, Engagement: Access to Physical Activity Opportunities
Enablers	Digital Care, Estates, Proactive Care, High Quality Primary Care, Community Engagement, Workforce

8

DIGITAL CARE AND INNOVATION PROGRAMME



Dr Simon Bowers,
Digital Innovation
Clinical Director

“We’ve been focused on the benefits of digital innovation for a number of years now, and Healthy Liverpool gives us an opportunity to realise the enormous potential that technology can bring to both local health services and the people who depend on them.

“Further roll out of assistive technology will support even greater numbers of people to maintain their independence and take control of their lives. They will join thousands of residents across the city who have already benefited from devices to monitor their health, make everyday life simpler, and help them stay in touch with family and carers.

“However, while technology offers exciting benefits for the individual, it is also a fundamental part of our plans for the health system to work more collaboratively. For example, it will provide us with the means to integrate records across

health and social care, ensuring that a patient’s information can be accessed by all of the professionals who look after them. This has major benefits for speeding up diagnosis, improving safety, and delivering a better experience for patients.

“If we are to realise the Healthy Liverpool vision then the way in which we access, deliver and experience care services must be different. Technology will be at the heart of this change, and in Liverpool we’re leading the way in harnessing digital tools to make joined-up, person-centred care a reality.”

Our vision is that by 2020, we will support better health for people in Liverpool by maximising the benefits of digital technology and innovation.

8.1 DIGITAL AIMS

Our aim is to be one of the top ten most digitally advanced health and social care economies in Europe by 2020. We will transform the way services are delivered through a step-change in the use of digital technology and innovation.



Our aim is to be one of the top ten most digitally advanced health and social care economies in Europe by 2020.



Digital health records will enable people to take more control of their health.

Digital services in Liverpool have been at the leading edge for several years through existing programmes such as iLinks and More Independent (Mi). Our achievements include: scaling up of electronic patient record sharing, moving from 1 million shared records from 2008–2014 to 5.5 million in the last 12 months; and one of the largest deployments of telehealth in a single health economy in Europe, with 2,000 patients using this technology.

Our ambition is to empower people to take control of their own health and wellbeing, while ensuring professionals have access to the information they need to use technology to deliver safe and efficient 'seamless' care. We envisage a connected health and social care economy supported by integrated systems that empower people to make the right choices in an innovative, efficient, safe and secure way. We will enable the use of smartphones and other personal devices to open up better self care for people in a way that is convenient and complements other elements of their lives.

8.2 WHY CHANGE?

The use of digital technology allows us to deliver health and care services more efficiently, more quickly and to achieve better outcomes. Patients and professionals alike experience duplication in the health and social care system, with paper-based recording and computer systems across care providers making communication particularly difficult, and in some cases impossible. For professionals, access to shared information across care settings will be enormously beneficial, providing clinicians with access to clinically significant information at the point of care, improving efficiency and reducing costs and associated duplication.

For individuals, the ability to view and contribute to their own person held record and care plan

will help empower them to take better control of their health and wellbeing, confident in the knowledge that this information will be made available only to those practitioners involved in their care, with appropriate safety, monitoring and governance in place.

Technologies that allow the monitoring of patient vital signs, assist diagnosis, and state-of-the-art sensors to detect specific cells in the blood stream will form a new set of tools that allow clinicians to gain access to clinical data faster, enabling proactive care.

8.3 DELIVERY

Delivery of the digital care and innovation services of the future is based around four connected themes:

- **Integrated Health and Social Care Records**
- **Person Held Record**
- **Assistive Technology**
- **Predictive Analytics**

Integrated Health and Social Care Records - iLINKS

Integrated records will enable Liverpool health and social care practitioners to view information relevant to the person they are caring for safely and confidentially. Whether people are being treated by their GP, in a community-based service or in hospital, their shared digital care record will be accessible 24/7, with appropriate permissions and consent. This will save people being asked for information repeatedly, meaning that a person only has to tell their story once. It will also ensure that individual preferences about resuscitation, mental capacity and end of life care are understood by all practitioners caring for them. Liverpool has led the way nationally in information sharing; we will build on these solid foundations by truly integrating electronic health and social care records at scale.

Person Held Record

The person held record will enable people to take real control of their health, providing the means for truly person centred care. It will support data sharing and integration between health and social care providers, people and their circles of care. Liverpool is in a unique position, working with the Cabinet Office, to create a new identity authentication scheme,

which links social identities to an NHS identity so that the right information can be confidently shared.

This project will utilise the digital 'marketplace' to provide access to apps created by digital innovators in response to public need, enabling the CCG to support innovation at pace without needing to drive or fund this innovation directly.

Assistive Technology

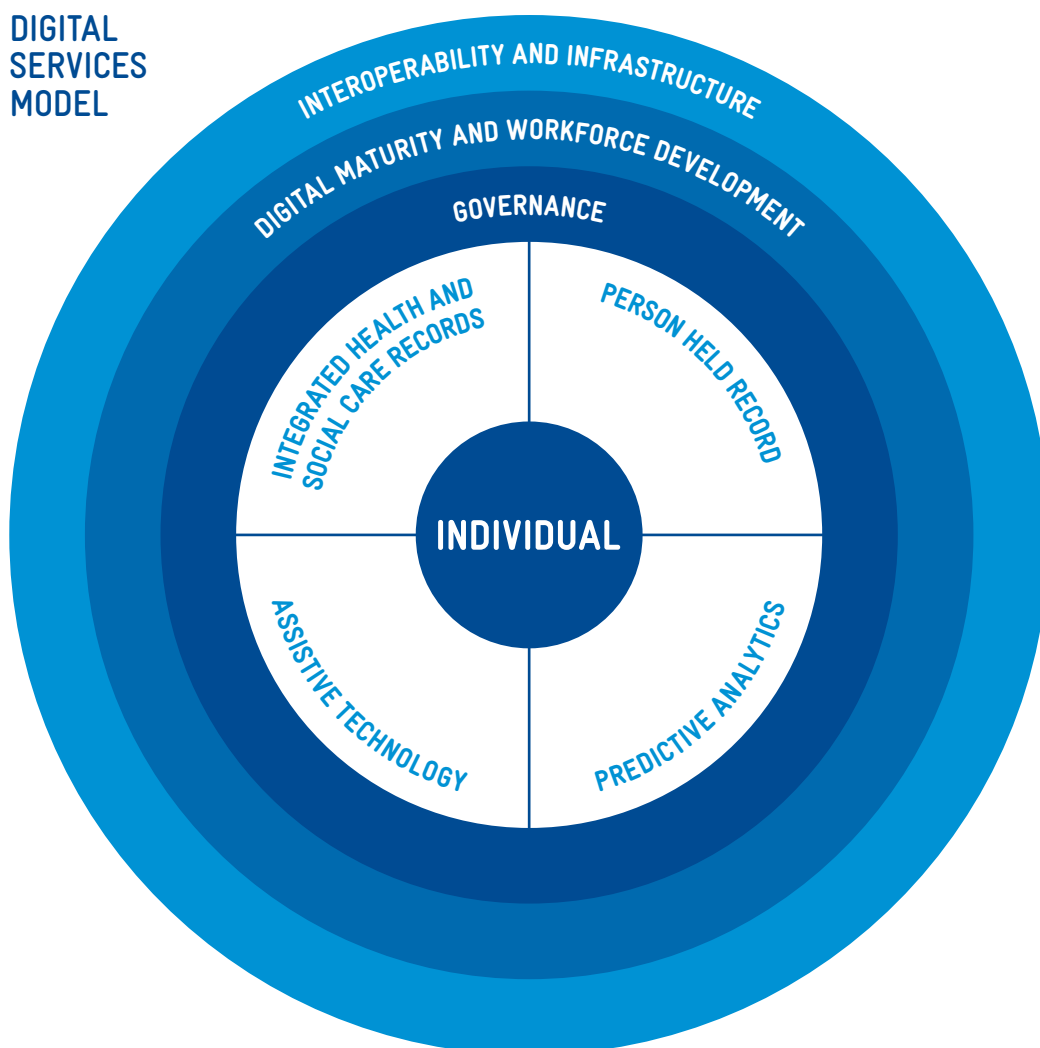
Assistive technology enables people to live more independently in a variety of ways, by deploying technology to support diagnosis, monitoring and self care. The programme

will lead the identification, evaluation and adoption of new technologies in Liverpool with a real focus on innovation.

Predictive Analytics

Predictive analytics is at the forefront of data science, using multiple sources to define health and care issues. Profiling risks at a population and individual level, to predict care trends, will enable us to plan and allocate resources most effectively. For example risk stratification models allow patients most at risk of emergency hospital care to be identified so we can provide proactive care and avoid preventable issues.

DIGITAL SERVICES MODEL



A NUMBER OF DIGITAL OUTCOMES HAVE BEEN IDENTIFIED ACROSS A 1-5, 5 AND 10 YEAR PERIOD:

Practitioners have access to appropriate information 24/7 through class-leading iLinks information exchange and interoperability.

Person Held Record, apps and self care support all available from one place. They can choose the app and support that they want and share their information and plans with whoever they choose. Liverpool citizens can access online records and content using a nationally recognised and secure digital identity.

Apps and digital services are key to the delivery of all services supporting self care.

Assistive technology deployed at scale and integrated with personal technology to maintain self care and prevention activity.

Using a Liverpool based cloud computing centre, data from around the region will be analysed by data scientists to understand and predict when care will be needed, how it will be needed and identify those requiring intervention before the health need arises.

Advanced sensors, designed and manufactured in Liverpool are enabling early detection and management of diseases.

A 'virtual' hospital service across Liverpool providing access to specialist care at any site in the secondary care infrastructure.

A single, integrated care record across the Liverpool health economy.

Digital services are the first contact for all non-emergency health services providing initial advice, triage and appointments at the appropriate care setting.

Transformation of NHS services towards predictive. Changing lifestyles and utilising precision medicine techniques to dramatically reduce unplanned care and long-term condition prevalence.





USING TECHNOLOGY TO SUPPORT INDEPENDENCE

75 year-old grandmother, Win Cumine, suffers from arthritis, limiting her mobility and leaving both her and her family worried about what would happen if she were to have a fall. This all changed with the help of care technology, and she is now able to live more independently and confidently in her own home.

Win uses an intercom system that connects to a helpline. A button is housed on a wristband that she wears in her bungalow, which, when pressed, connects to a friendly voice that's ready to help.

Win says: "It's made a huge difference. My family and I were concerned what might happen

if something went wrong and I ended up stuck at home with no way of calling for help. But now I know that all I need to do is press the button on my wristband and help will be there, 24-hours a day. It's given me tremendous peace of mind. I don't need to feel isolated and worried anymore, because of the helpline.

"Just because you're getting older or have a health problem, you don't have to give up, feel isolated, or trapped in your own home. The technology is there to use. I've recommended it to lots of my friends. It's so easy to use – nothing complicated, just peace of mind."



REDUCING HOSPITAL ADMISSIONS

Dave Haslam's life changed when he was diagnosed with COPD (chronic obstructive pulmonary disease). It left him tired, breathless and constantly coughing. He was also very worried and didn't really understand what was happening to him.

The 67-year old grandad was referred to have health technology installed in his home and he says it has made the world of difference. The gadget works with existing technology to send key health information through to a team of health professionals, who monitor his condition.

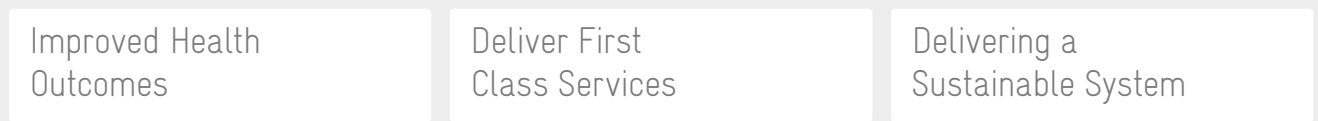
The technology has improved Dave's understanding and helped him come to terms with his condition. He's delighted how effective and easy to use it is. He says: "It really couldn't be simpler to use. It is really easy to understand. It really works – it's brilliant!"

Dave has spent far less time in hospital (he estimates by as much as 60%) and says: "Knowing that someone who really knows what they are doing is keeping an eye on me is great. I've only been in hospital twice this year, which is a huge improvement. It's made a huge difference to our lives, and I would recommend it to anyone."

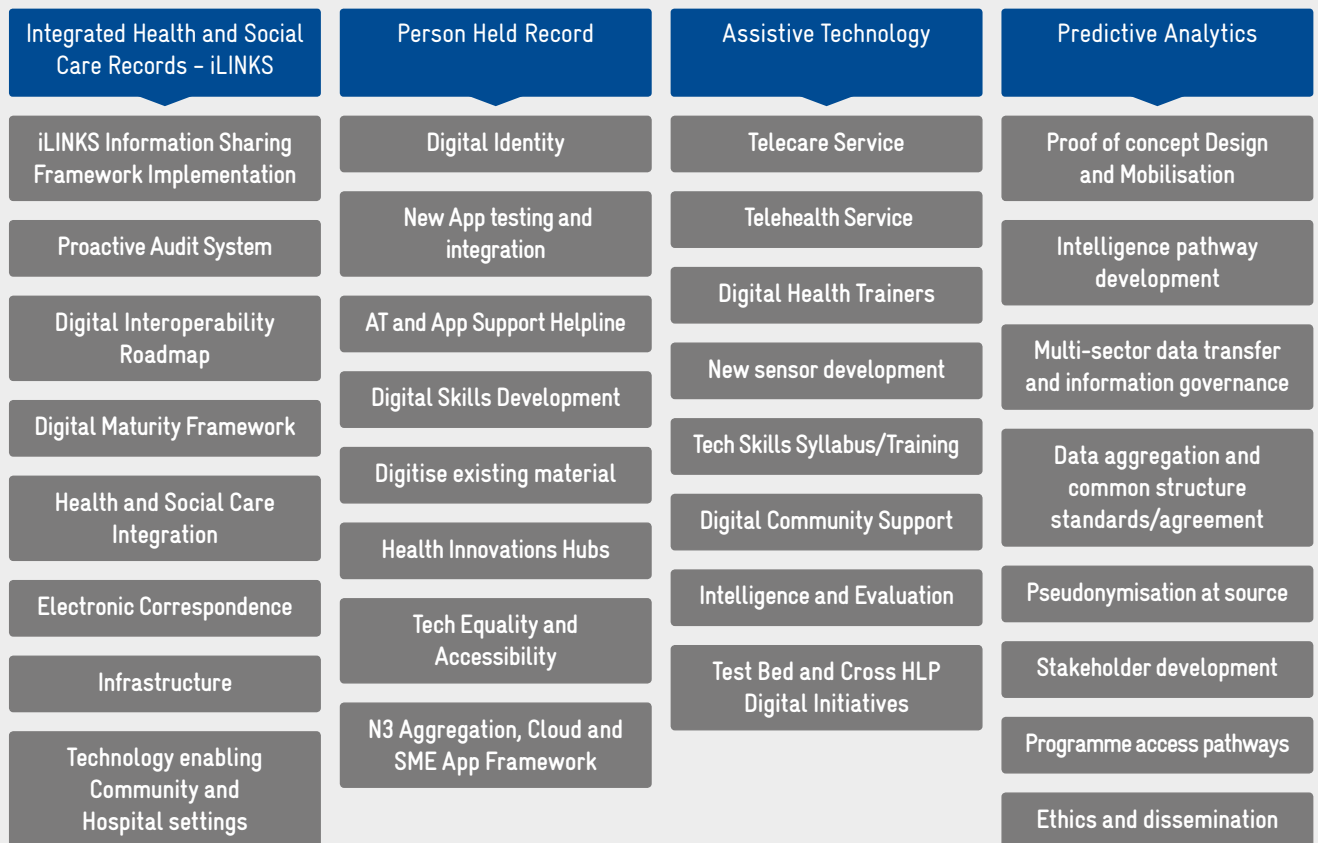
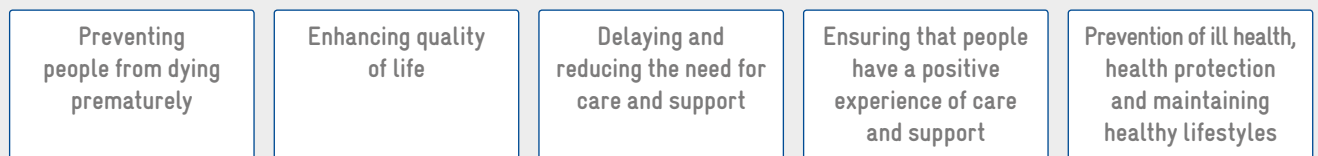
DIGITAL CARE AND INNOVATION PROGRAMME PLAN OVERVIEW

VISION AND OUTCOME AMBITION

‘A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care.’



DIGITAL CARE AND INNOVATION OUTCOME DOMAINS



Principles Utilising Digital to manage own care; Right information, right place, right time; Information exchange across Health & Social care; Technologically enabled workforce; Identification and mobilisation of ‘State of the Art’

Enablers Information Governance, Digital Maturity, Workforce Development, Interoperability and Infrastructure

9

COMMUNITY SERVICES PROGRAMME



Dr Janet Bliss,
Community
Services Clinical
Director

“Liverpool has some fantastic community services, providing crucial care for our population, but a fragmented and illness-focussed approach is holding us back from making the kind of impact we want – and need – for the city’s people.

“Our model for the future brings together the many different pieces of care which happen outside of our hospitals into a single, person-centred system, with integrated planning, commissioning and delivery, which is easier to navigate for both professionals and patients.

“We will take an increasingly proactive role, which recognises the importance of prevention and empowers individuals to manage their own

health and wellbeing. This reflects a growing consensus that we must prioritise efforts to prevent ill-health in the first place, rather than simply managing the end results.

“At the heart of the community model is recognition that although we plan services for the population, we deliver them to individuals; care should be holistic and allow us to address people’s overall needs, rather than just their specific conditions.”



“Transformation of community services is already underway.”

Our vision for community services: “Making the most of our city’s assets to deliver the best in community-based care and support, to improve the health and wellbeing of the people of Liverpool.”

Improving health outcomes in Liverpool and creating a sustainable healthcare system for the city will require a fundamental shift from the current hospital-centric model to one which is focused on prevention and community-based care.

This will require a major change in the way that people in Liverpool are supported to manage their health, and the way that community services are delivered. At present, while we have some excellent services, they are too often fragmented, lacking integration across health, social and voluntary agencies and focused on specific conditions that an individual may have, rather than holistic care.

Health interventions alone will not deliver the major improvements in health outcomes we need for people in Liverpool. We must make the most of the many community-based assets we have, if we are to be successful in improving outcomes.

9.1 COMMUNITY SERVICES AIMS

We will create a new system of community-based care which meets the needs of people, both clinically and socially, taking into account the wider impact on families and carers. We need to create a new system of community care where:

- **People are empowered to manage their own health and care;**
- **The social model of health will be delivered alongside the medical model;**
- **Care is integrated in commissioning and delivery across health and social care;**
- **Care planning takes into account the impact and dependence on families and carers;**
- **Services enable proactive care, targeted at people most at risk of poor outcomes;**
- **Care is provided closer to people’s homes and is designed to support people to remain independent and in their home environment;**
- **People are supported to return to their home environment, as soon as possible, following admission to hospital.**

The alignment and integration of care for children, young people and adults is a key aspect of this new model of care, recognising the impact that transition to adult support can have on people. The model also recognises that services need to be designed and personalised to meet the specific needs of children, young people and their families, due to the crucial impact that early years have on life chances.

9.2 DELIVERY

Our transformational programme for community care encompasses all care services that are provided outside of a hospital setting, including services provided by health, social care, education, housing and the voluntary, community and independent sector. It includes all age groups, from pre-conception and birth through to end of life.

At the core of the community model is a proactive approach to health, wellbeing and care delivery. It will mean that for the first time there is a clear, overarching direction for community service delivery, focused on the needs of the whole population – children and adults – and sensitive to the particular needs of each neighbourhood community.

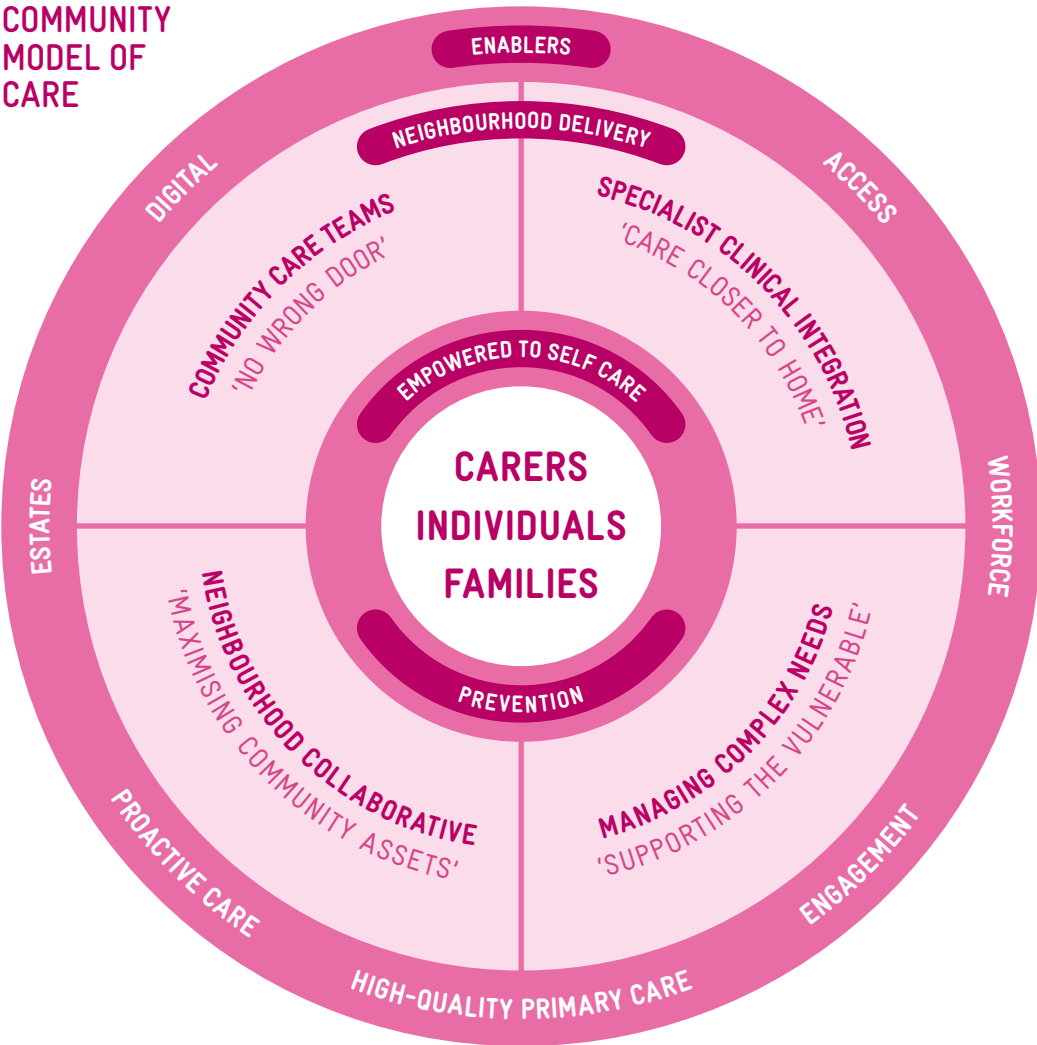
Further improvements will be realised in phases over the next 1-2 years, with others taking 3-5 years and beyond, due to their dependency with planned longer-term changes in hospital services.

9.3 COMMUNITY MODEL OF CARE

The transformation of community services is segmented into four components:

- Community Care Teams
- Specialist Clinical Integration
- Neighbourhood Collaborative
- Managing Complex Needs

COMMUNITY MODEL OF CARE





Integration of community nursing, social care and mental health teams will be fully operational in 2016.



Early help for children integrated across health and social care.



Introducing a new model of extended access to primary care in addition to the services provided by the city's 93 practices.

Community Care Teams

'No wrong door'

Liverpool was one of the early pioneers of integrated care in the North West, bringing together primary care, community, social care, mental health and secondary care clinicians to deliver care across neighbourhood-based teams.³ This has already established robust systems and data flows from all general practices within the city; live operational delivery in neighbourhood teams and multidisciplinary teams working together. However this infrastructure is varied across the city.

We will establish Community Care Teams within each of the city's 18 community neighbourhoods, with 'core' community teams, which include General Practitioners, Practice Nurses, Social Workers, Community Nurses, Community Mental Health Nurses, Health Trainers and Pharmacists, along with other care professionals, voluntary organisations and agencies that may be involved in delivering care, including Health Visitors and School Nurses.

Key services will be co-located, within neighbourhood bases, to support integration and multidisciplinary team working. The integration of community nursing, social care and mental health teams will be fully operational in 2016. These teams will be key to breaking down barriers to co-ordinated care, delivering a 'no wrong door' approach with clear points of access into the care system, ensuring access to the right care professional without being passed around the system.

Addressing poor outcomes for people with mental health issues will be a key priority for our Integrated Care Teams, recognising the connection between mental, emotional, social and physical health. Significant numbers of people with long-term or complex conditions also have an underlying mental health condition and experience high levels of premature mortality and inequality of care.

A common assessment will be the norm for people who need it, with single care plans in place, available to all relevant care professionals, via shared care records, with people holding their own Personal Health Record.

Care Teams will adopt a proactive approach which targets people at increased risk of poor outcomes, alongside taking action in the context of their social circumstances and

needs, providing support such as benefits advice and Healthy Homes assessments.

Risk stratification data will be used systematically to identify people who would benefit from integrated care and more proactive intervention, supporting them to retain independence, be in more control of their health condition and addressing their key risk factors.

We have already established an approach to risk stratification that uses data from general practice and secondary care to predict risk of emergency admission to hospital. This data allows for systematic identification of people and more targeted interventions, including use of specialist resources.

Similarly, for children and young people, the Early Help agenda is being implemented across the city as a multi-agency response to ensure that children and families can benefit quickly from the support that they need. The delivery of Early Help, alongside other services such as the Multi-Agency Safeguarding Hub (MASH) offers a comprehensive and risk-based response to need.

Building on the More Independent (Mi) Liverpool programme, we will work in partnership with the local authority to scale up the use of assistive technologies, including telehealth and telecare services, targeting support for older people and people living with COPD, heart failure and diabetes.

Local evaluation of the impact of telehealth demonstrates that for people with a high risk of hospital admission, the adoption of telehealth support has led to a 23% reduction in hospital admissions.

We will scale up the use of assistive technologies, remote monitoring and clinical support, reviewing the impact of large-scale deployments elsewhere in Europe. This up-scaling will also include increasing the current level of service operating 8am-6pm Monday to Friday, to a seven-day-a-week service.

A cornerstone of community service provision is primary care. We will introduce a new model of extended access to primary care in addition to the existing services provided by the city's 93 GP practices. New locality hubs will be established to deliver 7 day services in primary care, giving greater access to routine and urgent care. General practice remains the bedrock to our

3. Kings Fund (2014). System Leadership. Lessons and learning from AQUA's Integrated Care Discovery Communities.

new model, as this is where the vast majority of people receive care and support. We will continue to build on the major improvements in outcomes delivered over the past five years through the Liverpool General Practice Specification. Eliminating unwarranted variation in provision and standards will be a top priority, contributing to our ambition to reduce health inequalities within the city.

The role of community pharmacy has become more central over the past few years through initiatives such as the Care at the Chemist scheme. We will continue to enhance the critical role pharmacy plays in supporting people to self care, by giving pharmacy a stronger role in the management of long-term conditions, and access to urgent and emergency care.⁴

When people do require a hospital admission, the Community Care Team will work closely with hospital teams to plan for discharge, with people discharged as soon as it is safe to do so. We will build on the successful development of the new frailty unit at the Royal Liverpool Hospital and learn from successful approaches elsewhere.

Effective and cohesive reablement arrangements will be introduced, with timely assessment and deployment of community equipment and a single integrated health and social care community reablement team in place to support people to remain in their home.

A new approach to community-based beds will be adopted, ensuring that there is a cohesive approach for people who need bed-based support, from hospital acute care through to long-term residential care. A new model for people in care homes will be put in place, with greater provision of 'step-up' beds for people who need support but do not require specialist hospital beds.

The vital role that domiciliary care services play in supporting people to retain their independence will be strengthened through increased integration with Neighbourhood Care Teams; the introduction of a new jointly commissioned contract in 2015; and working collaboratively with services such as Ambulance and GP Out of Hours, to reduce the need for hospital admission.

Specialist Clinical Integration

'Care delivered closer to home'

Care will be provided in a community setting, closer to people's homes, unless hospital care is necessary.

A key focus will be on supporting people with long-term conditions, where there is considerable opportunity to reduce the need for hospital-based care.

Significant progress has already been made on diabetes care management and plans are in place to do the same for COPD, heart failure and cancer. Other opportunities include gynaecology and musculoskeletal conditions.

There is an opportunity to realise a significant reduction in outpatient appointments delivered currently within hospital settings. In addition to providing more specialist clinics in community-based settings, we will also utilise digital technologies such as virtual clinics, using tools such as clinical video consultation.

We will maximise the use of the community-based estate available within Liverpool, taking full advantage of the significant investment made within the city in neighbourhood health centres.

Managing Complexity

'Supporting the vulnerable'

One of Healthy Liverpool's key priorities is to narrow the inequality gap within the city. We will target support towards key groups who currently experience high levels of inequality in health.

The Healthy Child Programme (HCP) is an early intervention and prevention programme that lies at the heart of universal services for children and families. Failure to meet the needs of children and young people stores up problems for the future of the child; the community model can play a key role in preventing escalation of need into hospital-based or specialist services.

A key initial focus will be to design better services to support the homeless population, people with severe mental illness and people with complex alcohol problems. Data clearly demonstrates that these groups experience significantly poorer outcomes than the general population and high levels of premature mortality; high use of emergency care; and poor access to services, including screening.

4. NHS England (2013).
Improving Health and Patient
Care through Community
Pharmacy – A Call to Action.

The Healthy Lung Project will improve detection of lung cancers and identify COPD at an earlier stage.

Neighbourhood Collaborative 'Maximising community assets'

We are clear that in order to improve health and wellbeing in Liverpool we will need to deliver a 'social model of health' that addresses the broader influences on health, social, cultural, environmental and economic factors.

We have much to be proud of already within the city with a strong legacy of innovative approaches such as More Independent (Mi) Liverpool, Healthy Homes and Social Inclusion Teams. The CCG has continued this legacy and has commissioned a range of non-medical support including Benefits Advice on Prescription, the Community Grants programme and Liverpool Active City.

Building on the strong relationships established with housing associations in Liverpool we will seek to maximise opportunities for joint working, delivering the key objectives of the 'Healthy New Towns' programme.

A number of enablers will support the delivery of the Healthy Liverpool community model of care:

Prevention and Wellbeing

To achieve improvements in health and wellbeing we need to raise awareness of the opportunities and risks of lifestyle behaviours, including physical activity, smoking, alcohol and social isolation.

Support services available in communities, such as smoking cessation, benefits and housing advice, mental health, reducing social isolation and improving emotional wellbeing will be fully utilised and clear information promoted to the public and care professionals through the 'Live Well Liverpool' directory and information portal.

We will establish new Centres for Wellbeing, providing locality-based hubs designed to provide people, carers and families with access to resources and support. A key focus will be support for children and families, with early years development and family resilience a major priority area.

We will build on developments such as the Liverpool Community Grants programme, designed to support community groups in providing wellbeing initiatives. Joint work with the local authority and the voluntary sector will also focus on sustainability of this sector in light of austerity measures.

Self Care and Empowerment

There is considerable evidence that empowering people to take more control over their health and conditions will lead to reduced mortality, lower emergency admissions and better quality of life.⁵

Focusing initially on long-term conditions we will equip people and professionals with the tools, techniques, resources and confidence to deliver this approach to self care and management of conditions. The Healthy Liverpool self care model has already been rolled out to support people with diabetes and COPD.

Peer support models have proved successful in Liverpool, including health trainers and community champions. We will scale-up their use as part of a social model of support. A new service specification for health trainers, including a review of capacity and function, will be introduced in 2016.

Early Identification and Intervention

Screening, diagnosis and vaccination rates in Liverpool often lag behind other areas of the country, impacting on outcomes including mortality and quality of life. There is high variation in take-up across the city, impacted by factors such as deprivation, disability and ethnicity.

Liverpool has some of the highest levels of mortality in the country, so tackling cancer is a major priority for Healthy Liverpool. We are introducing programmes to improve early diagnosis of cancer, which will include the national 'Be Clear on Cancer' programme; Cancer Research UK bowel screening intervention; primary care based audit of pathways and significant event analysis of emergency presentations, along with increased support for screening programmes to reduce the variation in screening rates across GP practices.

Priority is being given to lung cancer, for which mortality in Liverpool is almost double that of England. The 'Healthy Lung' project will focus on early detection of lung cancer and COPD, aiming to raise awareness of respiratory health within communities, targeting neighbourhoods with high mortality rates and high-risk groups. Through this approach we aim to detect between 140-153 lung cancers and identify COPD at an earlier stage – an estimated 6,000 people in Liverpool have undiagnosed COPD.

5. NHS National Institute for Health Research (2015). A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions.

We will improve access to diagnostic services, with clear pathways and availability of tests in community settings. Liverpool will be at the forefront of new developments in community-based diagnostics and will establish pilot initiatives to implement Multidisciplinary Diagnostic Centres (MDC) for detection of cancers.⁶

Six priority clinical workstreams have been identified to support transformation of services and improvement of outcomes. These areas will drive the transformation of community care and provide a key focus for the development of multi-professional teams and outcome improvement plans.

Children and Maternity

We will establish clear integrated pathways for children's services for priority areas including asthma, occupational therapy, neurodevelopmental pathways, mental health and maternity.

We will improve children's community services to ensure targeted and specialist services are accessible for those with the highest levels of need.

Neurodevelopmental services will be redesigned and additional investment made to support children with autistic spectrum disorder, attention deficit hyperactivity disorder and sensory processing difficulties. The new model of delivery will focus on expansion of community-based services in neighbourhoods.

The Child and Adolescent Mental Health Services (CAMHS) pathway will be improved, including: increased mental health promotion across education and community-based services; the establishment of three community-based mental health hubs offering early help; dedicated mental health professionals attached to schools and colleges; an acute care team working out of hours for young people aged 0-25 years, including street triage; and robust transition to adult services, and to and from inpatient care.

Occupational therapy services will be re-designed and enhanced for children and young people, including integration of the existing teams across education, social care and health.

New arrangements will be established, with joint commissioning and pooled budgets for community equipment for children, designed to improve productivity and reduce duplication.

Cancer

Our overarching strategic aim is to reduce the impact of cancer in Liverpool. Key planned developments over the next two years include:

- Raising awareness and understanding of cancer to encourage early detection, through a range of interventions;
- Focus on diagnostic services, and on improving diagnostic pathways;
- Focus on cancer survivorship, supporting people to live well;
- Transforming hospital cancer services, ensuring integration with community provision.

Long-term Conditions

Our aim is to provide world class support to people living with long-term conditions, helping them to lead healthy and fulfilling lives for as long as possible.

Key planned developments over the next two years include:

- **Diabetes:** We have already established a redesigned diabetes service with a new model of care, focused on outcomes and delivered collaboratively by three providers; Aintree University Hospital Trust, the Royal Liverpool & Broadgreen University Hospitals Trust and Liverpool Community Health Trust.
- **Stroke redesign:** In 2015/16 we will address gaps and inequity in the early supported discharge rehabilitation pathway. There are plans also for wider system redesign in collaboration with neighbouring CCGs. We will also improve identification and support for people with Atrial Fibrillation (AF).
- **Cardiology:** Provision across the city is in the early stages of clinical consultation and review. This programme will be accelerated to deliver a new integrated community model of care, beginning in 2016.
- **Respiratory:** A new model of care is in development to kick-start system transformation; for example asthma clinics in the community and greater access to spirometry.
- **Kidney health:** A pilot is underway to improve identification and management of acute kidney injury. We plan to roll out the community pilot across the city.

6. Report of the Independent Cancer Taskforce (2015). Achieving World-Class Cancer Outcomes. A Strategy for England 2015-2020.

Healthy Ageing

The Healthy Ageing workstream aims to keep people living safely in their homes or place of residence for longer, by maximising independence. When people do need care, this will be responsive, high-quality, based on personal needs and delivered seamlessly across health and social care.

Key planned developments over the next two years include:

- Introducing simple screening tools to identify people at risk of frailty and to redesign services to provide a proactive response for those people.
- Establishing clear pathways to respond to the frailty syndromes of dementia, delirium, end of life, falls, immobility, incontinence and poly-pharmacy.
- A new clinical model will be implemented in 2016 to support the care of people in residential and nursing home beds in the community.
- Developing hospital-based frailty units to enable the rapid step-up from the community and discharge of patients following acute medical intervention.

Mental Health

The vision is for mental health services to operate seamlessly across the spectrum of severity, offering timely, equitable care and shifting the balance towards community-based prevention and recovery. Key planned developments over the next two years include:

- Neighbourhood Mental Health Teams will form a central part of the new model, with Primary Care Mental Health Liaison Officers already providing proactive patient care and peer support across the city. Additional capacity will be added soon with more mental health support workers, integrating psychological support into long-term condition care pathways and ensuring people with serious mental illness have access to other health services.
- Specialist Community Mental Health Services, providing care to some of the most complex patients, will support Neighbourhood Mental Health Teams. Clearer pathways and thresholds for referral will enable both patients and professionals to more easily navigate the system.
- Further development of Specialist Community Mental Health Services and Social Inclusion and Recovery services, establishing a fully integrated mental health and wellbeing community model in 2016.

Youth Mental Health Transitions:

A number of developments have taken place during the past three years to support young people facing the transition from child to adult mental health services. We are committed to doing more, including:

- Developing tier 3 and 4 pathways for children and young people in partnership with NHS England
- Review the ASD (Autistic Spectrum Disorder) pathway
- Explore opportunities to develop CAMHS out of hours provision (0-18 years)

Learning Disabilities

People with learning disabilities experience worse health outcomes and die at a younger age than the general population. This is partly as a result of a failure to identify people with learning disabilities and provide tailored, proactive care.

The establishment of a Learning Disability Transformation Board and the development of an Integrated Learning Disability Strategy in 2016/17 will define the approach to commissioning better community-based services for those with learning disability in Liverpool.

Liverpool Primary Care Learning Disability Liaison service has already demonstrated the benefits of providing specialist support direct to general practice and community services. The plan for 2016/17 is to double current capacity.

Further development of learning disability services in our hospitals in 2016/17 will include a network of learning disability nurses to support people and their families/carers.



IMPROVING DIABETES OUTCOMES

The Liverpool Diabetes Partnership is one of our first examples of an integrated model of care – an approach which is central to how Healthy Liverpool will transform health services in the city.

Aintree University Hospital NHS Foundation Trust, The Royal Liverpool and Broadgreen University Hospitals NHS Trust and Liverpool Community Health NHS Trust have joined together to deliver the service, with a shared vision: to improve outcomes for people living with diabetes in Liverpool.

Launched in December 2014, the service

represents a considerable shift in focus from hospital to community-based delivery of care. It focusses on promoting good self-management, integrated delivery with GPs and education in the community.

Patients see consultants, nurses, GPs, dieticians and podiatrists, closer to home in community-based clinics. The programme also has a focus on education for clinicians. Expert consultants and nurses also go into local practices and hold educational sessions to better support primary care colleagues in the management of patients living with diabetes.



SUPPORTING PEOPLE LIVING WITH DEMENTIA

Joanne, a retired administrator, was diagnosed with young onset dementia aged 57, after a number of years struggling and suspecting something was wrong. The diagnosis, although upsetting, was also somewhat of a relief, and helped Joanne and her family to start to understand what was happening and to plan for the future.

Through Healthy Liverpool, new working practices have been put in place so that consultants at Mersey Care, the Royal Liverpool Hospital and the Walton Centre, who have a responsibility for diagnosing dementia, are collaborating and working to commonly agreed standards and protocols.

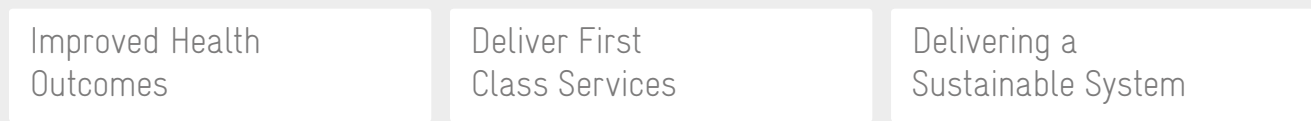
A new service is being established which will ensure that all people in Liverpool who receive a diagnosis, will be offered the support of a care navigator and timely access to a range of high quality psychological and practical support.

This new service is providing Joanne and her family with the information, tools and strategies to help accept and adjust their lives, and providing access to a range of local support networks and peer groups to show that people can and do live well with dementia. Joanne and her family will be able to contact a Care Navigator if they have any concerns in the future, or require signposting to other services or support.

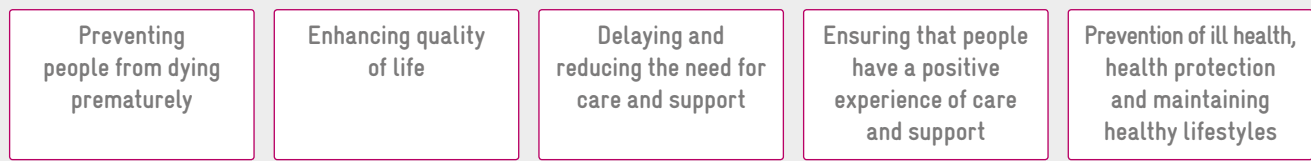
COMMUNITY SERVICES PROGRAMME PLAN OVERVIEW

VISION AND OUTCOME AMBITION

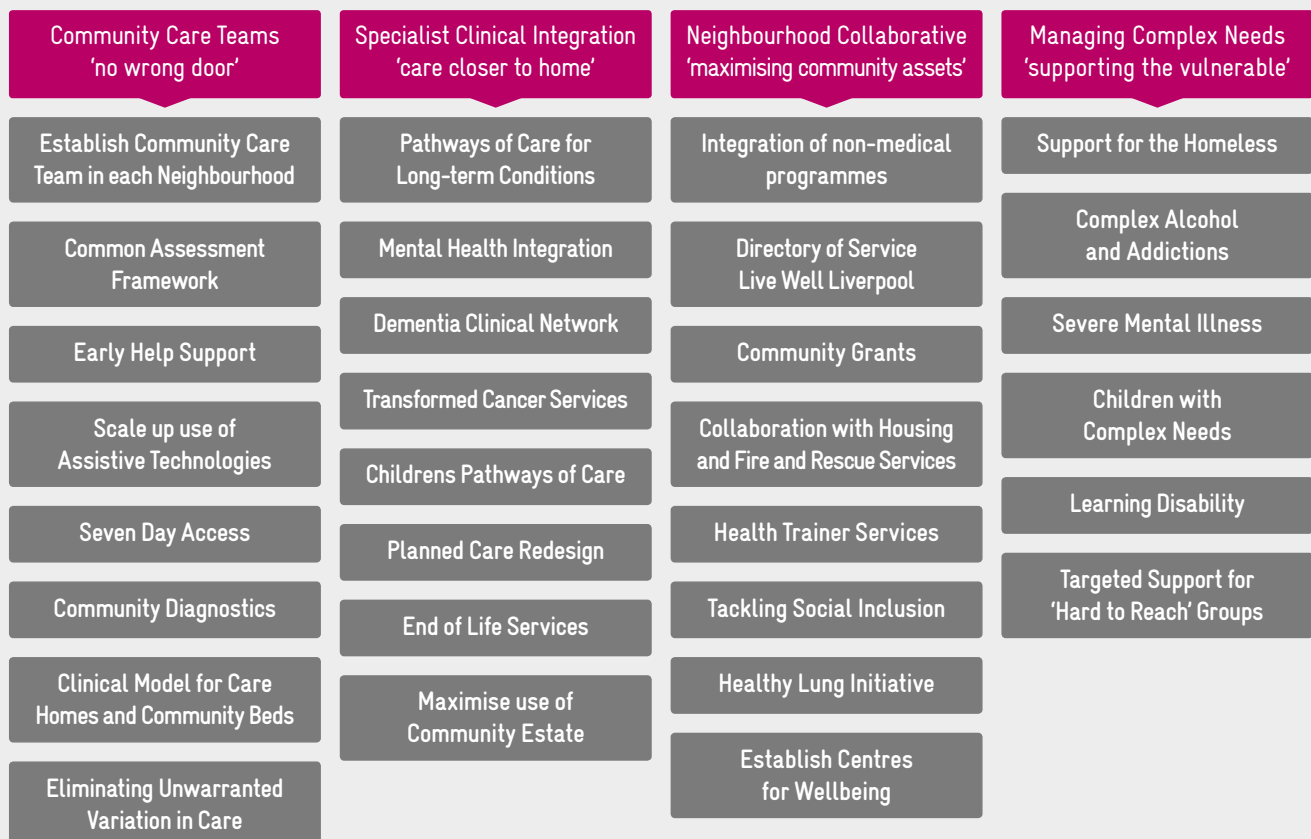
‘A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care.’



COMMUNITY CARE OUTCOME DOMAINS



NEIGHBOURHOOD DELIVERY



Principles Self-Care, Shared Decision Making, Prevention at Scale, Early Detection and Diagnosis

Enablers Digital Care, Estates, Proactive Care, High Quality Primary Care, Community Engagement, Workforce, Access

10

URGENT AND EMERGENCY CARE PROGRAMME



Dr Fiona Lemmens,
Urgent and
Emergency Care
Clinical Director

“ We are dealing with a complex, multi-layered urgent and emergency care system, which both patients and professionals find confusing. At a patient level, we know that this often prevents people from identifying the right care for their needs, which in turn places additional pressure on services already experiencing rising demand.

“We want Healthy Liverpool to be a catalyst for transforming how we support people to access the right advice in the right place, first time.

“This is an issue which spans many different areas of the health service, including NHS 111, general practice, acute hospitals, and the ambulance service. We need a whole-system, city-wide approach, which sees different providers working collaboratively towards a shared goal.

“In addition, we need a more comprehensive approach to self care so that, where appropriate, individuals have the knowledge and confidence to manage their own health. This is particularly true of people with long-term conditions, where effective self-management skills can reduce the likelihood of an escalation in illness and a subsequent emergency hospital admission.”



“Driving a transformational shift towards self care and more urgent care in communities.”

Our vision is: “To deliver an urgent and emergency care pathway that is recognisable and clear to patients, the public and health care professionals, that delivers the right care, in the right place, first time”.

The urgent and emergency care system is complex and includes all patient contact points, from first telephone contact or face to face encounter through to specialist trauma care.

10.1 URGENT CARE AIMS

The NHS England Urgent and Emergency Care Review identified five key strategic aims, which Healthy Liverpool has adopted:

- Providing better support for people to self care
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in Accident and Emergency (A&E)
- Ensuring that people with more serious or life-threatening emergency needs receive treatment in centres with the right facilities and expertise, in order to maximise chances of survival and a good recovery
- Connecting urgent and emergency care services to the overall system becomes more than just a sum of the parts

Locally a number of further objectives have been identified. We will:

- Improve and simplify city wide urgent and emergency care
- Implement a sustainable model for urgent and emergency care across the city; addressing matters such as clinical staffing, future training and education
- Optimise technologies including telehealth and electronic access to health care records
- Convert more urgent care activity to planned care
- Improve assessment and discharge processes
- Improve timely access to services
- Use risk stratification to proactively manage high urgent care service users

10.2 WHY CHANGE?

Currently we have an urgent care system that is fragmented and offers a bewildering array of access points and service options. In a complicated and confused system patients, and at times health care professionals, struggle to identify and then access the right care at the right time all of the time.

Each year the NHS in Liverpool deals with:

- 5 million visits to pharmacy in Liverpool for health-related reasons;
- 2.1 million GP consultations;
- 45,000 calls to NHS urgent and emergency care telephone services;
- 277,594 attendances at A&E Departments and walk-in centres
- 53,828 emergency admissions to Liverpool’s hospitals

And demand for services continues to increase.

To address the problems created by increasing demand, we need a strategic approach to reduce complexity, reshape primary care and chronic disease management and support for patients in their own homes and in nursing and residential care.

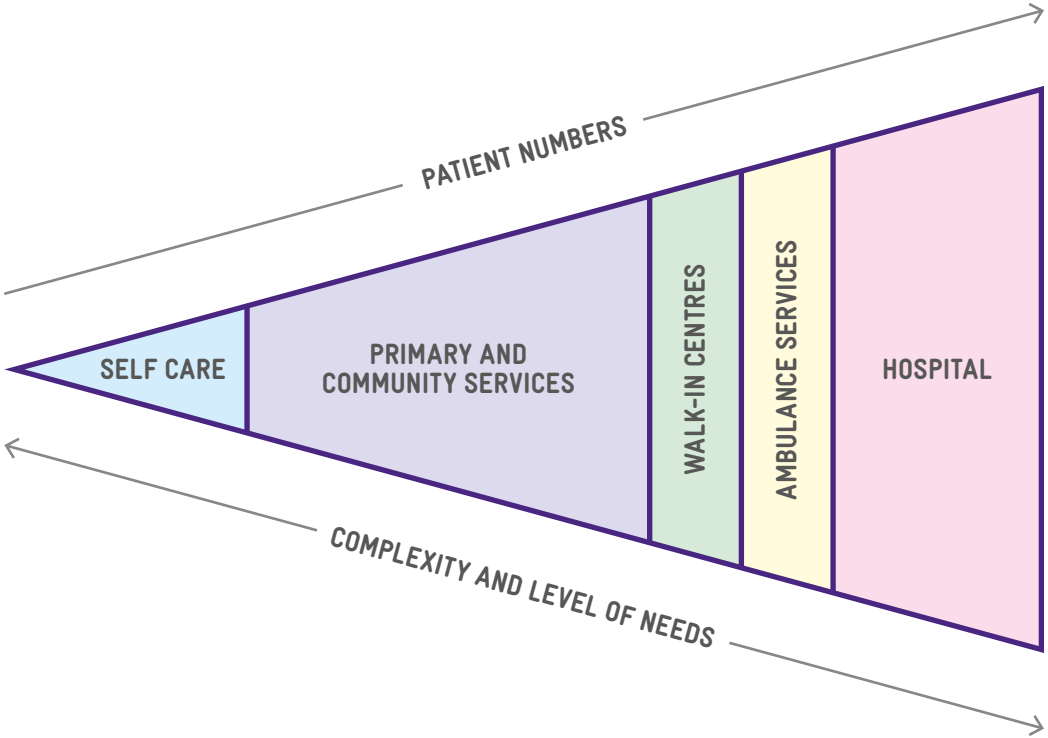
10.3 DELIVERY

The scope of the Urgent and Emergency Care Programme runs through all Healthy Liverpool programmes and involved multiple providers and partners.

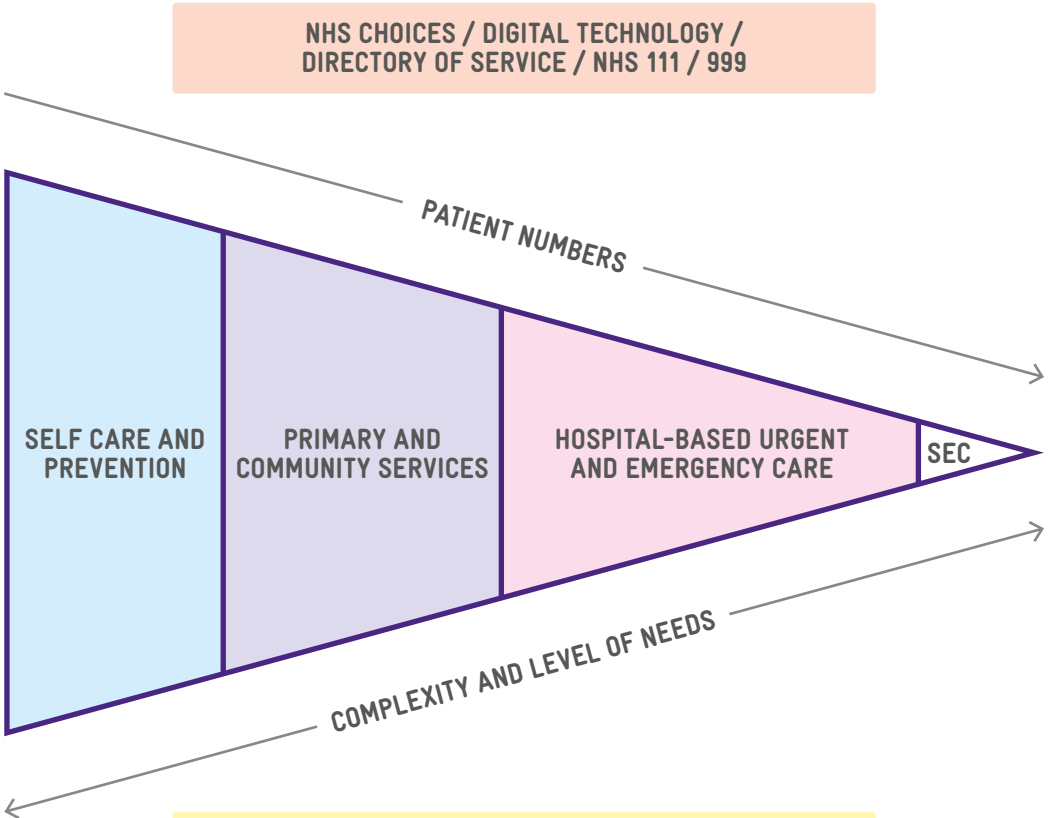
The geographical catchment for the local urgent and emergency care system is wider than the city of Liverpool, so we are working closely with colleagues in South Sefton and Knowsley CCGs and specialist commissioners in NHS England.

The following diagram illustrates what the future model of urgent and emergency care will look like across the city, representing a transformational shift towards self care and community-based services, enabling hospital services to concentrate on people with acute urgent care needs.

URGENT CARE: HERE AND NOW



URGENT CARE: FUTURE MODEL



Note: SEC = Specialist Emergency Centre(s) e.g. Major Trauma Centre, HASU.

AMBULANCE SERVICE: 'HEAR AND TREAT - SEE AND TREAT - TREAT AND CONVEY'

A single access point for advice and sign-posting; enabling right care, right place, right time.

Our aim is to direct patients into a simplified system that can meet their needs. To achieve this we recognise the essential role played by NHS Choices, NHS 111 and 999, providing advice and entry into the urgent and emergency care system.

NHS Choices/Digital Technology/ Directory of Service/NHS 111/999

We will make much better use of technology, through trusted websites and increasingly apps that provide people with better online advice to help them decide both the urgency of their need and the service options available, including self care.

An expansion of telehealth, including remote monitoring, promises a revolution in the way in which people can be supported in the community, with action triggered at a point of crisis or a worsening of their condition.

Sharing real time access to health records will allow urgent and emergency staff at all levels of intervention to be better informed about patients' medical history, current care and treatment plans.

The move to more fully integrate NHS 111 and the ambulance service 999, is a significant opportunity to improve access to urgent and emergency care and signpost patients to the right care, at the right time first time. This integration will remove the need for people to make that initial decision as to the severity of their need and service response.

Self Care and Self-Management

Self care plays a crucial role in influencing the level of demand for urgent and emergency care; up to 80 per cent of health issues can be treated at home without the need to involve other NHS services.

We need to promote and support self care and enable people to be more confident in taking responsibility for their own health.

While much use has been made of social media and the 'Examine your Options' campaign over several years, there is further opportunity to enhance the current levels of self care.

A key 'partner' in delivering this approach will be the NHS 111 service, providing a free telephone call into information, self care advice and reassurance.



Community pharmacies have a crucial role in supporting self care.

Key actions include:

- Developing a self care strategy across all Healthy Liverpool programmes to make an impact at scale that supports and directs people into making informed self care decisions.
- A social marketing approach to help people access tools and information to help them make informed choices, particularly promoting the role of NHS 111 as the one-stop portal.
- Maximising opportunities for local community pharmacies to be a key resource in supporting self care.

Primary and Community Services

Primary care encompasses general medical practice, GP Out of Hours, dental services, pharmacies, optometrists and Walk-in Centres.

Despite significant local investment there is evidence that access into primary care for some people does not meet their expectations or lifestyles, and too many of us present at emergency departments with illnesses or injuries that could be better managed elsewhere.

Urgent care in general practice matters; our aim is that nobody should have to attend an emergency department as a walk in or self-presenting patient because they have been unable to get an urgent appointment with a GP.

Key actions include:

- Delivery of an extended 7 day primary care service in 2016, led by GPs, delivering enhanced capacity and access to routine and urgent primary care.
- Maximising the use of telephone triage, in GP practice and by NHS 111, to assess and direct patients to services outside of hospital.
- A pilot scheme for rapid response home visits, delivering a more proactive approach to avoid hospital attendance or admission.
- Through the delivery of the 'new' community model, we will transform the way in which the discharge of frail and vulnerable people is managed.

Community Pharmacies

Community pharmacies across the city already play a major role in the treatment of minor ailments. Services include: medicine reviews; repeat prescription management; supporting patients to optimise medicines use; supporting self care; providing urgent access to medicines; flu vaccinations; and promoting health and wellbeing. Community pharmacies offer effective care and have the potential to

reduce pressure on other parts of the health system, particularly general practice.

Our aim is to promote positive perceptions about the role of the community pharmacist in supporting and delivering elements of urgent and emergency care.

Key actions include:

- New protocols and care pathways that facilitate NHS 111, general practice, the ambulance service and urgent care centres to direct patients to community pharmacies.
- An expansion of the role of community pharmacists working in general practices as part of the practice team, supporting patients to self care and optimising medicines.
- Delivery of a social marketing campaign to build confidence and satisfaction in the enhanced role of community pharmacy.

Urgent Care Centres

The high level of hospital-based urgent care activity demonstrates the imbalance in the way current services are designed and delivered, with too many people accessing services at Liverpool's two emergency centres.

The Healthy Liverpool model of care will address this imbalance by transforming community services, offering effective proactive care and greater self care.

The urgent care centre model, which could see centres co-located with a hospital emergency centre, represents an acceptance of the behaviour of a significant number of people who prefer an 'always open' emergency centre even if they have to wait longer than for other available options.

Urgent Care Centres would treat minor injuries and illness; ambulatory emergency care; urgent primary care; urgent diagnostics, mental health liaison and intervention; social care support; alcohol misuse; pharmacy and dentistry.

Patients with serious or life threatening conditions arriving by emergency ambulance would bypass the Urgent Care Centre and go directly into the Emergency Centre.

If urgent care centres were to be established in Liverpool this would represent a move away from our current Walk-in Centre model. We will explore, including through public engagement, whether urgent care centres are right for Liverpool.

Hospitals

The current emergency care service is from two adult emergency centres (Royal Liverpool and Aintree University Hospitals), of which Aintree is intended to be designated as the single site for the Cheshire & Merseyside Adult Regional Trauma Centre, in association with The Walton Centre. There is also a paediatric emergency department and major trauma centre at Alder Hey Hospital.

The two adult emergency centres will move towards a single clinical service in line with the hospital vision of "Single-Service, City-Wide Delivery". This would include common clinical standards, a shared clinical staffing rota, training, education and development.

Whilst both emergency centres offer 24/7 access, each will have an element of specialisation which means that patients would be streamed to the site best able to meet their needs.

In the longer-term whole system transformation is expected to deliver a reduction in the demand for urgent and emergency care, as the benefits of living well, prevention and community services come together. We will be evaluating this impact and may, in the longer-term, revisit the two centre emergency model when the impact of transformation is better understood.

Key actions include:

- Transfer of all adult major trauma to Aintree Hospital, working with The Walton Centre as the single Major Trauma Centre receiving site for Cheshire and Merseyside in line with NHS England commissioning intentions.
- Establish a shared Emergency Department Consultant clinical rota/workforce.

Ambulance Service

Historically the Paramedic Emergency Service (PES) has been seen by many as a 'transport provider' taking people to hospital. In the future the service will become a pivotal 'care provider', offering a range of interventions from 'hear & treat', 'see & treat' to 'treat & convey'.

The majority of calls, aside from 'red' calls, will be subject to clinically-led triage, which would see a significant number of less urgent 'green' calls receiving a 'hear & treat' telephone-based service.

Where an ambulance is dispatched to red calls and the more serious green calls the emphasis

will shift where possible to a 'see & treat' response. Here crews will increasingly look after the patient at the scene, providing treatment or stabilising and handing over their care to another service.

For people who require transport to hospital, 'treat & convey' will ensure that such patients are transported to the hospital most able to meet their core presenting needs, which may not be the local or closest emergency department. For example patients who are assessed as likely to be experiencing a stroke will be taken to the nearest Hyper-acute Stroke Unit; trauma patients will be taken to the Regional Major Trauma Centre.

Key actions include:

- Maximise the potential for 'hear & treat' and 'see & treat' responses as an alternative to hospital conveyance.
- Ensure that patients are transported to the most appropriate care setting that is able to meet their needs first time.
- Development of an integrated clinical advice hub between NHS 111 and the PES emergency controls which receive 999 calls to provide access to 24/7 clinical advice and support.
- Provide digital access to patients' records to support prioritisation and clinical decision making.

- Provide access to the electronic Directory of Service and clinical support desk to support non-conveyance and referral to alternative services.
- Introduce 'less urgent' transport options for patients who require transport, but do not require the 'blue light' response of a paramedic ambulance.

Payment Reform

In Liverpool we are committed to exploring a new funding mechanism with NHS England and Monitor as a crucial part of re-designing and modernising the urgent and emergency care pathway. We are exploring ways to reflect the 'always on' nature of urgent and emergency care, which requires having a pre-planned level of capacity continuously available to respond to patient needs, and needs to be staffed and resourced at a 'core' level irrespective of demand.

In conclusion, the urgent care operating model is for a whole-system city-wide model, delivered collaboratively by multiple providers – "Single-Service, City-Wide Delivery".

People will not need to 'think' about the badge or logo on an individual or service, instead they will access a city-wide urgent and emergency care system that delivers the right care in the right place, first time.





IMPROVING PATIENT EXPERIENCE

NHS Liverpool CCG and North West Ambulance Service (NWAS) have worked together to provide Liverpool with a 'frequent caller' paramedic.

The dedicated specialist paramedic works in collaboration with other health and social care providers, to identify and support 'frequent callers' within the CCG's footprint. Since November 2014 when the frequent caller specialist paramedic came into post, annual 'frequent' calls to NWAS have reduced by 80%.

Derek, a 77 year old man who is diagnosed with asbestosis, lives alone and is bed-bound after suffering a severe stroke several years ago. Derek was identified as a frequent caller after requesting an ambulance on five occasions in a 28 day period. The specialist

paramedic spoke with Derek and found that he was very hard of hearing and extremely short of breath.

Derek's calls continued to be monitored over the next couple of months and although they reduced slightly, Derek's condition was deteriorating rapidly. He was extremely weak and was prone to chest infections. The specialist paramedic contacted the community matron and asked her to visit Derek. The matron is now visiting Derek on a weekly basis and he is eating and drinking well. She is in the process of implementing a care plan with rescue medication for acute episodes.

Derek has not dialled 999 since the day of the community matron's initial visit and his condition is continuing to improve.

REDUCING HOSPITAL ADMISSIONS

When a patient dials 999, typically a single crewed paramedic rapid response vehicle attends the scene to assess the patient. A pathfinder assessment tool has been put in place for North West Ambulance Service (NWAS) clinicians, aimed at providing treatment alternatives for patients, such as GP services or Walk-in Centres, reducing the need for people to go to hospital.

After assessment, the paramedic might determine that the patient doesn't require immediate transport to hospital, but does need to speak to or see a GP. The Acute Visiting Scheme allows the paramedic to refer the patient to Urgent Care 24, who provide the GP Out of Hours

service in Liverpool. A GP will then speak to the patient and provide advice, or if required, they will see the patient for a face to face appointment within a two hour target timeframe.

The scheme allows patients to remain at home, where possible, and frees up both ambulance and hospital resources for those in greater and more immediate need.

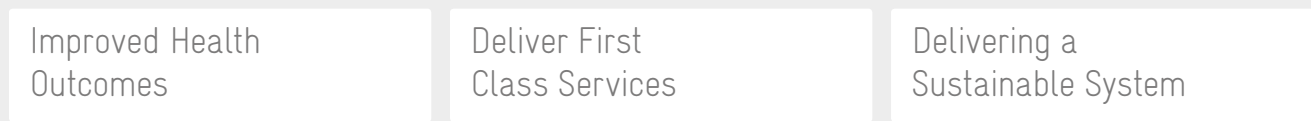
In total, 85% of patients who have used the Acute Visiting Scheme have been dealt with by the Out of Hours GP in their home, avoiding a trip to hospital. This avoided an estimated 723 admissions and potentially saved nearly £2 million.



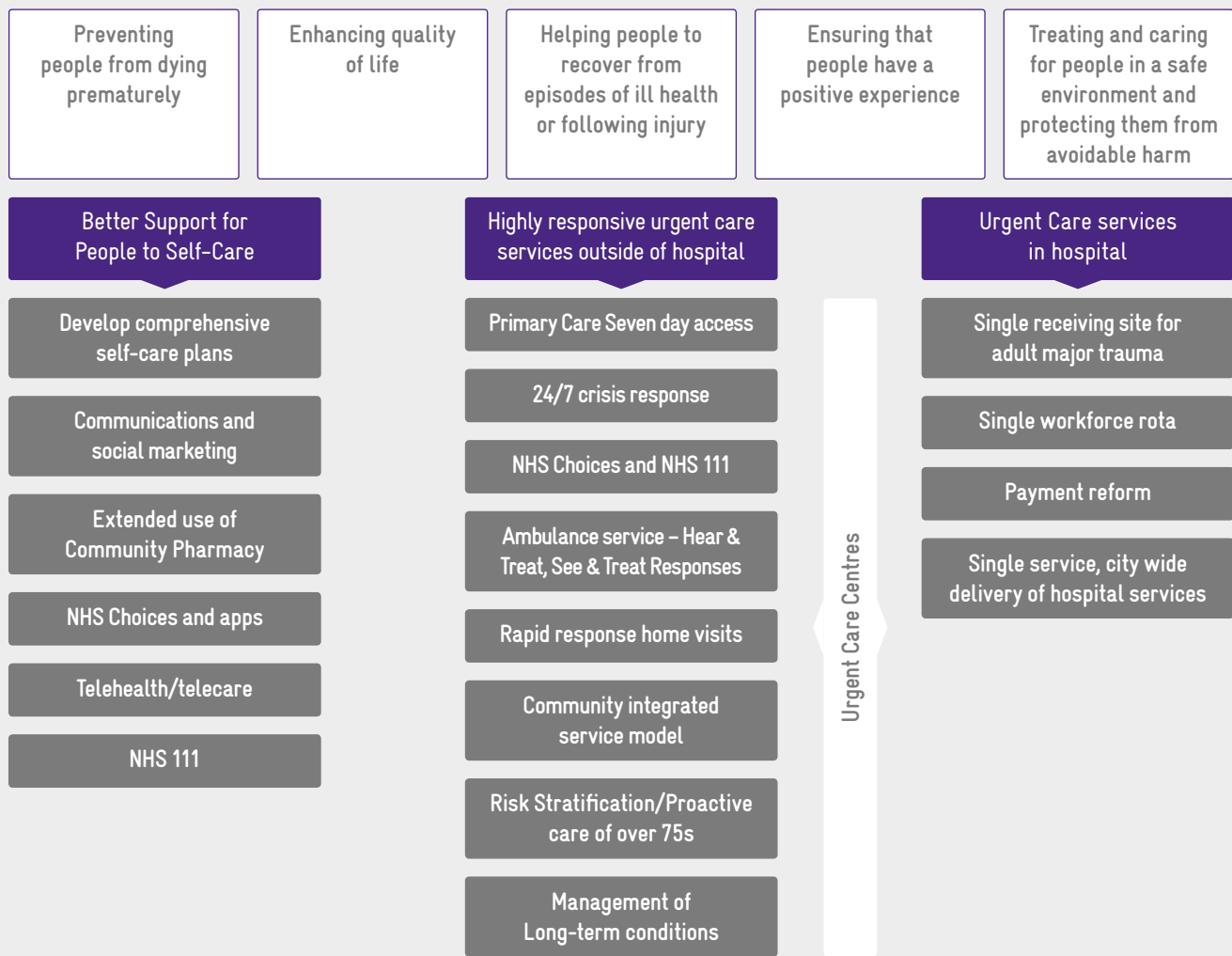
URGENT AND CARE EMERGENCY PROGRAMME PLAN OVERVIEW

VISION AND OUTCOME AMBITION

‘A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care.’



URGENT AND EMERGENCY CARE OUTCOME DOMAINS



Principles → Right Care, Right Place, First Time.

Enablers → Digital Care, Estates, Proactive Care, High Quality Primary Care, Community Engagement, Workforce, Access

11

HOSPITALS PROGRAMME



Professor Donal O'Donoghue,
Liverpool CCG
Secondary Care
Doctor

“We want the people of Liverpool to have access to excellent hospital services, where they can receive the very best care, in a system which is sustainable for the future.”

“The city has a relatively large number of hospitals, offering both general and specialist services. The current situation has bred duplication and inefficiency; the focus on organisational rather than population goals hampers our ability to collaborate and improve.”

“We are developing plans for hospital care to be delivered as a single service, by single teams, across the city. This approach will reduce variation and improve patient care,

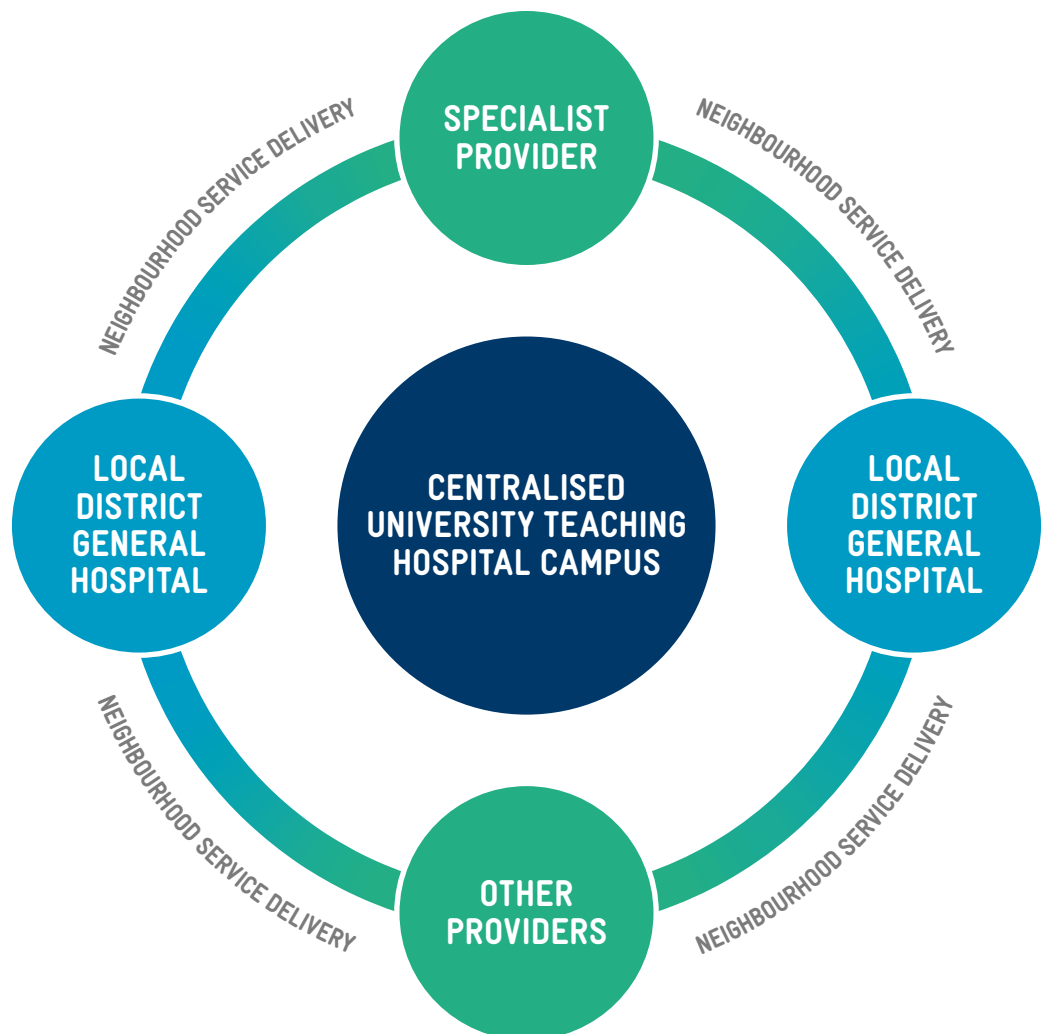
while allowing us to find long-term solutions to some of the shared challenges we face, particularly around workforce and finance.”

“The new model is centred on the principle of a central city centre teaching campus which will bring health and academia together in one location, so that we can take maximum advantage of the city's research and development capabilities.”

Our vision for hospitals is “A centralised university teaching hospital campus with single-service, city-wide delivery, delivered through centres of academic, clinical and service excellence.”

This vision is underpinned by the principle of a centralised university hospital teaching campus on the site of the new Royal Liverpool University

Hospital and Clatterbridge Cancer Centre, providing an axis against which specialised and general adult services can be built around.



Single-service, city-wide delivery will support long-term clinical and financial sustainability.

This model for hospital services will see delivery of specialised and general adult services delivered from a network of centres, including the Royal Liverpool centralised campus site and neighbouring District General Hospitals (DGHs), alongside the shift to more services being provided by our hospital clinicians in neighbourhoods across the city.

This transformational model will bring significant additional benefits, including improved recruitment and retention of the best clinicians; integration with teaching, research and development, and service efficiencies from a critical mass of services working collaboratively at a scale and concentration not seen before.

We are not prescribing the future organisational form for service delivery. We do, however, specify a framework which we want providers to work within. This also provides a platform for developing system improvements to meet the clinical and financial challenges ahead.

Our commitment to “Single-Service, City-Wide Delivery” directs that hospital services will be re-designed as single service pathways, delivered against high quality clinical standards, under single clinical leadership across organisations and sites.

11.1 HOSPITAL AIMS

By transforming hospital services we aim to:

- **Have the best hospital care system in the country**
- **For all patients to receive the right care in the right place first time**
- **Have a safe health care system that is sustainable clinically and financially into the future**
- **Maximise patient outcomes and experience**

This transformation is based on the following principles:

- **Services will be delivered by single teams**
- **Services will be of high quality, delivered to consistent best practice standards and unwarranted variation will be eliminated**
- **Services will be local whenever practicable, central where necessary**
- **Services will be delivered by a workforce that is sustainable, motivated and champions improved patient care, experience and outcomes.**

11.2 WHY CHANGE?

The case for change for hospitals in the city is compelling. The challenges we face are significant and if left unaddressed will

undermine service delivery, sustainability and health outcomes. The economic climate in which the NHS operates means that we must find new and innovative ways to deliver better services at a lower cost if we are to meet the future needs of our population.

Whilst the required scale of challenge is daunting, we have a great opportunity to deliver this change due to a high level of clinical collaboration, alignment about the solutions and a shared commitment to transform the way we deliver hospital services in the city.

There are a number of other reasons why change is necessary.

Provider Sustainability

The large number of Trusts in Liverpool presents challenges for our health economy. Historically, Trusts have competed with each other, with some key services duplicated, leading to inefficiencies and a shortage of clinical expertise, impacting on workforce sustainability, training and education. Our priority is to secure long-term clinical and financial sustainability of services in the city, rather than protect the status quo. Collaboration and a whole-system strategy for service delivery is crucial to achieving our aim to have the best hospital care system in the country.

Clinical Variation

Variation in the quality of services means that patients do not always get the best possible care, first time and every time. This is unacceptable and a key driver for change, as reduced variation will directly improve patient outcomes.

NHS Estate

We have a wide variation in the quality and functionality of the NHS estate in the city, despite a significant investment of £100m in primary care premises and the new Alder Hey Children’s Hospital (£240m) and Royal Liverpool University Hospital (£430m), alongside investment of in Mersey Care mental health facilities (£25m) and the planned relocation of the Clatterbridge Cancer Centre from the Wirral onto the Royal Liverpool Hospital campus.

The current configuration of NHS sites has developed in a piecemeal way rather than by design, informed by individual organisational needs rather than a whole-system approach. The two new hospitals and the relocation of the Clatterbridge Cancer Centre onto the Royal campus will direct the core shape of key elements

of the hospital estate infrastructure for the next twenty years or more across the city. Healthy Liverpool aims to fully utilise those significant assets to roll out single-service, city-wide services.

Specialised Commissioning

NHS England (NHSE) has responsibility for commissioning specialist services.

Liverpool has a number of hospital providers that collectively deliver a wide range of specialist services to the value of circa £300 million per year to Liverpool, the city region, the North West, Isle of Man and a large part of North Wales. Many of these services have a national and international reputation.

Working in partnership with our NHSE specialist commissioning colleagues Healthy Liverpool aims to harness opportunities for specialist services to support their development and potential for expansion.

Workforce

The current configuration of services set alongside the challenge of delivering 7 day services presents significant challenges for the recruitment, retention and training of hospital clinicians and staff. The duplication of many services means that Trusts are often competing against each other for scarce staffing resources.

Competition for medical training places is also problematic in a number of key specialties and there are falling numbers of hospital training places, which in some cases is having a significant impact upon medical staffing. Healthy Liverpool has to address these fundamental issues.

11.3 DELIVERY

Our focus for transformation is primarily on the major trusts that provide adult services in the city: Royal Liverpool and Broadgreen University Hospitals; Aintree University Hospital; Liverpool Women's Hospital; Clatterbridge Cancer Centre; Liverpool Heart and Chest Hospital; The Walton Centre, Liverpool Community Health; and North West Ambulance Service.

Although the hospitals programme is predominantly focused around adult care, Healthy Liverpool includes Alder Hey Children's Hospital; recognising the importance of transitional care, specialist care, the delivery of neonatal support in partnership with Liverpool Women's Hospital and the wider contribution the Trust makes to the health

and wellbeing of the city's next generation. Alder Hey in the Park, which opened in October 2015, will be one of the city's centres of academic and clinical excellence.

The important role of Mersey Care NHS Trust as the principle provider of mental health services is recognised, with the delivery of community and hospital-based mental health care making a significant contribution to the wellbeing of the city.

Clinicians from across our health and care system have been leading the strategic clinical direction of this component of Healthy Liverpool; developing clinical standards that set quality and operational delivery requirements based upon best practice and guidance. In 2016, we will engage with the public on the first phase of service change proposals.

Whilst Liverpool CCG is the major commissioner of services for the Liverpool population, the city's hospital services are delivered to a wider population, particularly the two neighbouring populations of South Sefton and Knowsley and to a regional and in part national footprint through NHSE specialist commissioning. From the outset Liverpool CCG has recognised this complexity and has put in place governance arrangements to ensure that the programme is inclusive, with involvement from all these commissioners and taking into account the needs and interests of the wider population.

To provide a framework and direction for the programme, a series of clinical priority areas have been identified that form the core work of the programme in the shorter term, aligned with our vision for "Single-Service, City-Wide Delivery". For us, hospitals are not just about services that are provided under their roof but increasingly they will be the providers of specialist care and treatment out in the community, working in partnership with primary and community services, with an emphasis on sharing and transferring skills between health care professionals.

Our immediate priorities for transformation are:

- **Delivering 7 day hospital services**
- **Improving cancer services**
- **Women's health, including maternity services, gynaecology and neonatal critical care**
- **Urgent and emergency care**
- **Cardiology**
- **Stroke**

Delivering 7 day hospital services

The delivery of safe, effective and appropriate 7 days hospital services is a development which we are committed to achieve in a sustainable and affordable manner. Delivery of the national clinical standards across all of our hospitals is essential if we are to reduce variations in quality and improve patient experience and outcomes.

Our approach is not just about addressing issues surrounding weekend working but rather improving access to high quality services every day of the week in all our hospitals. In the future, staff will increasingly work across and between sites to deliver services to patients every day of the week: single-service, city-wide delivery.

Improving Cancer Services

Liverpool has some of the highest death rates from cancer in the UK, so it is important that any review considers how outcomes could be improved in the context of cancer services provided by our hospitals.

Cancer services are currently provided by multiple providers across multiple sites, including the specialist services at the Clatterbridge Cancer Centre (CCC) currently located on the Wirral, with satellite clinics across Merseyside.

The new Clatterbridge Cancer Centre on the Royal Liverpool Campus, opening in 2019, will provide all inpatient oncology beds for Merseyside and Cheshire, together with outpatient oncology and radiotherapy services. It will operate as the hub supporting a network of cancer services, including the satellite radiotherapy centre on the Aintree Hospital campus, and the existing cancer centre at Clatterbridge.

Whilst the new centre will provide a concentration of the majority of cancer services, cancer surgery is also provided at the Royal Liverpool, Aintree, Liverpool Women's, Liverpool Heart and Chest, The Walton Centre and Alder Hey Hospitals. The city's ambition is to truly become a world class centre of excellence for cancer care, treatment and research and it is appropriate to consider the case for the relocation of the majority of surgical cancer services onto the new central campus at the Royal Liverpool Hospital site, delivered through an integrated model.

There is a strong clinical case to retain certain cancer surgery on other specialist sites where

this delivers the best possible outcomes for patients. Examples include cancer surgery carried out at The Walton Centre and at Alder Hey Hospital.

The case for the integration of cancer surgery on the Royal Liverpool campus is compelling:

- Better pathways of care for cancer patients by bringing together specialist services on a single health campus which will host the majority of Specialist Cancer Multi-Disciplinary Teams
- Improved access to specialists from other clinical disciplines and to specialist clinical facilities
- Closer integration between the NHS and research teams within the University of Liverpool and other key research partners
- Maintenance of other cancer services which are best delivered in more local settings, including other local hospitals and the community

The clinical cancer leadership in the city has a shared vision to improve cancer outcomes and to work collaboratively to truly integrate pathways and services. Our approach to developing this comprehensive 'Liverpool Cancer Centre' would for the first time see diagnostics and cancer surgery working alongside palliative care, a phase 1 trials unit and the Northwest Cancer Research Centre.

The roll out of "Single-Service, City-Wide Delivery" for cancer services is a long-term programme. However, there are a number of early priorities for transformation of cancer services which we aim to address in 2016/17.

Pelvic Cancer (including complex gynaecology, colorectal and urology): Women with complex gynaecology needs and cancer are currently cared for by the gynaecology teams on the Crown Street site of Liverpool Women's Hospital. In complex cases patients often need to access treatment from colorectal and urology surgical teams, along with diagnostic CT scanning, which are based at the Royal Liverpool Hospital. This lack of onsite wider surgical and cancer expertise means that for these complex patients, their experience and outcomes are not necessarily of the best standards possible.

Haemo-Oncology: Clatterbridge Cancer Centre (CCC) plans to relocate from their current Wirral site onto the Royal Liverpool campus in 2018/19, in a world class, purpose built cancer centre. Haemo-Oncology (blood cancers) clinicians put forward a case to maximise this opportunity

by developing a centre of excellence, bringing together the services currently provided by CCC, Royal Liverpool and Aintree Hospitals into a 'single service' led by CCC in the new centre.

HPB and Upper GI: Oesophageal (Upper GI) surgery is currently non-compliant against national standards, as it is delivered across two sites rather than the recommended single site. Currently, liver surgery is performed at University Hospital Aintree and pancreatic surgery at the Royal Liverpool University Hospital. By consolidating these services together we will improve patient outcomes and ensure sustainability of the clinical workforce.

Women's Health and Maternity

Currently, the majority of births in the city, around 8,000 per year, take place in the Liverpool Women's Hospital, which the people of Liverpool view rightly with great pride.

However, if we aim to have the best hospital based care for women we need to consider ways in which care can meet, and in some cases exceed, national clinical quality and patient safety standards. We have worked with the clinicians at Liverpool Women's Hospital to explore how we can improve services for women.

The delivery of maternity, gynaecology and neonatal care on a separate isolated site presents a variety of challenges. We want to determine how we can deliver care in a sustainable, safe and effective manner, including hospital-based care and midwifery-led support including home delivery/community-based models of care.

Liverpool Women's Hospital does not have on-site access to general adult and paediatric services. There is an increasing trend in women with complex needs who need to be transferred by ambulance for treatment at a local acute hospital, usually at the Royal Liverpool Hospital, to receive a specialist opinion, diagnostics and/or treatment, including respiratory or cardiac, a non-obstetric surgical intervention or critical care support. Such transfers, although relatively short in distance, are not best practice.

Whilst the Liverpool Women's Hospital has a specialist (level 3) neonatal critical care unit on site, the separation of paediatric services some 4.5 miles away on the Alder Hey Children's Hospital site provides similar challenges when

a newborn child requires an acute intervention. Currently the child is transferred by emergency ambulance with a transport team to Alder Hey for surgery or access to other co-located paediatric support or expertise, with a subsequent return back to Liverpool Women's Hospital to benefit from their Neonatal Intensive Care Unit (NICU). Determining a solution here is of equal importance.

Options being considered include performing some neonatal surgery where Liverpool Women's services are delivered and for those requiring the very specialist skills and infrastructure that can only be found on the Alder Hey site enhancing the existing NICU cots at Alder Hey thereby removing the need for post-surgical transfer back to the Liverpool Women's hospital. This is an area where further guidance and direction from NHS England is awaited regarding their future requirements and standards for neonatal/paediatric surgery.

Gynaecology services, including those relating to cancer, are concentrated on the Liverpool Women's Hospital site. They too are not co-located with other key specialties such as urology, general surgery, colorectal and other cancer services including specialist diagnostics. This means that patients, in many cases, have to be transferred for specialist support, most often to the Royal Liverpool Hospital. The planned relocation of the Clatterbridge Cancer Centre onto the Royal Liverpool site and the opportunity to develop a centre of excellence for cancer care presents a compelling case to support the transfer of gynaecology cancer services to the Royal Liverpool site.

The clinically-led Liverpool Women's Future Generations programme is considering how we might move forward to deliver a safe, effective and sustainable service for patients in the future. Operating under the umbrella of Healthy Liverpool, this work is exploring the options for future service delivery informed by the inter-dependencies of women's and maternity services with emergency medical care and the care of very young children who require specialist hospital services.

Urgent and Emergency Care including Major Trauma

The current emergency care service configuration is from two adult emergency centres (Royal Liverpool and Aintree University Hospitals), of which Aintree is intended to be designated as the single site for the Cheshire & Merseyside Adult Regional Trauma Centre, in association with The Walton Centre. A paediatric emergency department and major trauma centre would remain at Alder Hey Hospital.

The two Liverpool emergency centres will move towards operating as a single clinical service in line with the hospital vision of "Single-Service, City-Wide Delivery". This would include common clinical standards, a shared clinical staffing rota, training, education and development. Whilst it is envisaged that both emergency centres would offer 24/7 access each will have some element of specialisation which means that patients either arriving by ambulance or directed by a health care professional would be streamed to the site best able to meet their needs first time.

In the longer-term the whole-system elements of the programme are expected to deliver a reduction in the demand for urgent and emergency care, as the benefits of living well, prevention, community and neighbourhood services all come together, the impact of which will need to be evaluated to inform future plans.

Cardiology

Cardiology services are currently delivered by three Trusts across the city: University Hospital Aintree, Liverpool Heart and Chest and Royal Liverpool Hospital, with services that are not delivered collaboratively and with elements of duplication. Our aim is to deliver world class cardiology, including the delivery of specialist services for the wider city region.

Cardiac clinicians have come together to develop a new clinical model for cardiology services to provide an even safer, equitable service in the future, aligned with our single-service, city-wide vision.

Our plan is for a 24/7 cardiology service with:

- Access to specialist cardiology care at emergency centres and seamless transfer to definitive treatment without delay or duplication of tests;

- High risk NSTEMI patients guaranteed treatment within 24 hours;
- Patients with acute coronary syndromes able to access immediate coronary angiography (<2 hours) for patients with cardiogenic shock or post resuscitation or within 24 hours for other high risk patients;
- Equality of access, with a single common pathway for all patients;
- Network and NICE standards to be delivered;
- Cardiologists working with primary and community care to support the management of long-term conditions such as heart failure, delivered in community settings;
- Shift to community services for diagnostics where possible;
- Effective access to cardiovascular screening for high risk groups.

Stroke

Our aim is to deliver hyper acute stroke services across the city that best meet the population needs, which are unfortunately significant.

Currently this service is offered from two hyper acute stroke units (HASU) for Liverpool, at Aintree and the Royal Liverpool hospitals.

Evidence suggests that there is a minimum threshold for delivering effective care for hyper acute stroke units (HASU), including timeliness of response and having 24/7 consultants on call, as well as access to rapid scanning and thrombolysis services. It is recommended that HASUs treat a minimum of 600 confirmed stroke patients per year for clinical quality, by enabling clinicians to manage enough patients to maintain their skills. National and regional evidence also indicates that if patients have access to larger units they have a reduced risk of death or long-term disability.

Our plans for stroke services are to:

- Develop a single-service, city-wide acute model for stroke services
- Commission a set of ambitious outcomes specific to stroke
- Ensure there is equity in stroke care
- Ensure there is consistency in services 24/7
- Maximise technology to improve clinical collaboration and patient care
- Support the long-term sustainability of stroke services in Liverpool and neighbouring areas

Implementation of the Healthy Liverpool Hospitals programme is likely to be taken forward in a phased manner and will be subject to further public engagement and, if required, formal public consultation.

Our hospitals system is complex and for this reason transformation of hospital services will be influenced by a number of factors, including clinical standards, medical innovation, workforce, estates, financial, the political environment and public support. We will communicate the clear case for change, led by clinicians.

Healthy Liverpool aims to deliver significant changes to our hospital services, but whole system hospital transformation is a continuous process. We will need to take account of long-term planning considerations, to ensure that what is delivered within the next five years complements and supports a longer-term direction of travel for the Liverpool health and care system.

CASE STUDY



SINGLE-SERVICE, CITY-WIDE HOSPITAL SERVICES

A new centre of excellence for Haematological-Oncology (H-O; blood cancers) services is an example of the Healthy Liverpool “Single-Service, City-Wide Delivery” model.

Currently, Liverpool patients access H-O at both the Royal Liverpool Hospital and Aintree Hospital. It has been agreed that in the future, these services will move to the Clatterbridge Cancer Centre (CCC)’s £109m cancer facility on the site of the new Royal Liverpool University Hospital campus.

Bringing services together in this way will create a concentration of skills and expertise that will

bring benefits for both safety and quality of care. The move means that people in Liverpool who require H-O services will also be able to access a wide range of cancer services and holistic support in the new Cancer Centre.

By achieving a ‘critical mass’, the new centre has the potential to create improved opportunities for education and training, research, and clinical trials.

Haematological malignancies collectively make up the fifth most common group of cancers in the UK. In Liverpool there are 321 new diagnoses of haematological cancers each year.

HOSPITALS PROGRAMME PLAN OVERVIEW

VISION AND OUTCOME AMBITION

'A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care.'

Improved Health
Outcomes

Deliver First
Class Services

Delivering a
Sustainable System

HOSPITALS OUTCOME DOMAINS

Preventing
people from dying
prematurely

Enhancing quality of
life for people with
long-term conditions

Helping people to
recover from episodes
of ill health or
following injury

Ensuring that people
have a positive
experience of care

Treating and caring
for people in a safe
environment and
protecting them from
avoidable harm

HOSPITAL PRINCIPLES OF CARE

Single service,
city wide delivery

Standardisation: Services will
be of high quality, delivered
to best practice standards
and unwarranted variation
will be eliminated

Services will be local
whenever practicable,
central where necessary

Services will be delivered by a
workforce that is sustainable,
motivated and champions
improved patient care,
experience and outcomes

Pelvic Cancer Surgery (including complex gynaecology, colorectal and urology)

Haemo-oncology

Women's and Children's Services (including maternity, neonates and gynaecology services)

Single Major Trauma receiving site

HPB and Upper GI surgery (including liver and pancreas)

Cardiology

The delivery of safe, effective and appropriate 7 day hospital services

Urgent Care

Stroke

Added value factors

World class academic research and development, Commercial application and opportunity, Economic and social benefits, Long-term workforce and training solutions

Enablers

Digital Care, Estates, High Quality Primary Care and Community Services, Engagement, Workforce, Access, Research & Development, Education and Training

12

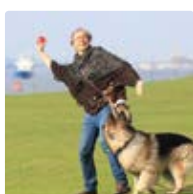
SUPPORTING TRANSFORMATION



The Healthy Liverpool Model of Care: more care in community settings.



The Hospitals Model of Care: Delivered through a Centralised University Teaching Hospital Campus.



Prevention and self care at the core.

There are a number of cross-cutting enablers which support the effective delivery of Healthy Liverpool.

12.1 PATIENT AND PUBLIC ENGAGEMENT

We are committed to meaningful, sustained engagement with both stakeholders and the public, to inform and co-produce our plans across all components of Healthy Liverpool. Some of our proposals for transformation and service change may require formal public consultation, in line with statutory requirements.

During summer 2015 we carried out public engagement around the Healthy Liverpool 'case for change', and the results of this process will inform the next stage of the programme.

The next phase of engagement process is due to commence in January 2016, where we will generate conversations with Liverpool people about the key principles and concepts driving transformation, including:

The Healthy Liverpool Model of Care: The shift of more care into community settings – "Local Where Practicable, Central When Necessary"

The Hospitals Model of Care: Single-Service, City-Wide Delivery; delivered through a Centralised University Teaching Hospital Campus Delivered Through Centres of Clinical and Service Excellence

Urgent Care: Designing services responding to people's requirements and expectations

7 Day Services: Ensuring the same access and quality to primary care, community and hospital services 7 days a week

Digital Enablers: Opportunities arising from data sharing and the electronic person held record

12.2 WORKFORCE

The workforce agenda is challenging and will require close collaboration between

stakeholders across health and social care to support the development of a whole system workforce strategy and delivery plan, informed by new models of care and opportunities to re-shape the workforce to ensure long-term sustainability.

Along with interpreting workforce requirements there is a role in influencing the commissioning of the education and training provision to meet those requirements. We will also support the design of new roles arising from new models of care.

One of the key success factors will be effective engagement with a large range of stakeholders, including service providers and commissioners, patients, staff and their representatives.

12.3 ESTATES

In line with the Healthy Liverpool vision, NHS estate will need to be redesigned to enable more services to move into the community and provide opportunities for greater integration. Our vision needs to take account of suitability and long-term sustainability, including hospitals, community assets and the wider public estate in the city.

The Healthy Liverpool Estates Strategy will set out short, medium and long-term plans to support the new model of care. All health and care partners, along with other public sector partners, will work together to best configure our estate to support our transformation and service change plans.

We will soon publish the first version of our estates strategy, which will set out our strategic intentions for primary and community care estate.

12.4 FINANCE

The health and social care financial landscape in and around Liverpool is significant, complex and can be viewed from many

Liverpool CCG has committed to ensuring £73m (10%) of its annual financial allocation will be used to fund new ways of working by 2017/18.

perspectives. To deliver the Healthy Liverpool programme, a financial strategy will be developed which provides stability and assurance to future planning whilst at the same time enabling agility to support developing models and initiatives.

Although the future demographic impacts will not be as pronounced in Liverpool as elsewhere, our outcomes and health inequalities challenges are stark and will require significant resources to effect change.

Health commissioners can expect growth in resources to be in the region of zero (flat cash) to minimal (1.5% per annum) although it is possible growth may be outside these parameters. Within social care the position is firmer and resources can be expected to reduce significantly over the period.

Healthy Liverpool has undertaken preliminary modelling of the financial position, which indicates a potential shortfall of circa £90m by 2023/24, as growth in demand for services is not mirrored by a corresponding growth in resources.

Liverpool CCG has committed to ensuring £73m (10%) of its annual financial allocation will be used to fund new ways of working by 2017/18. This will partly be delivered through the use of new resources from growth and efficiencies, and partly through redesign and reconfiguration of services and pathways.

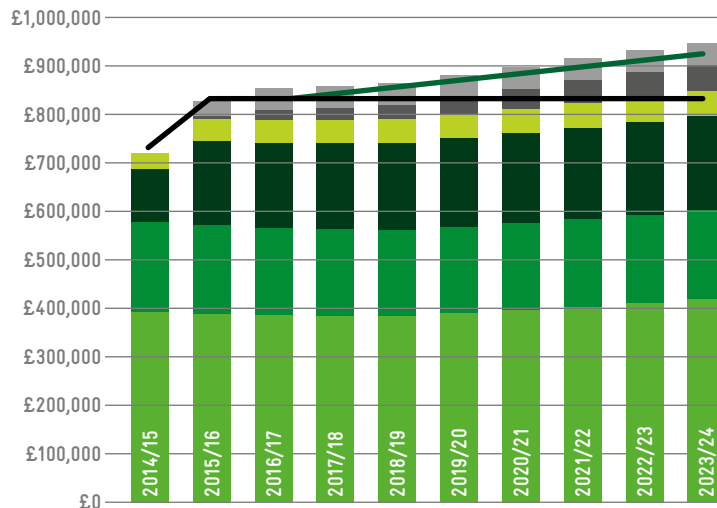
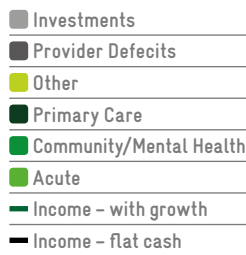
A key element of the financial strategy will be to drive value in the wider sense, improved decision making and the development of innovative financial levers and incentives to transform.

INVESTING IN TRANSFORMATION £'000

2013/14	2014/15	2015/16	2016/17	TOTAL
£25,182	£25,840	£29,343	£44,569	£124,934

LCCG FINANCIAL FORECAST WITH INVESTMENTS

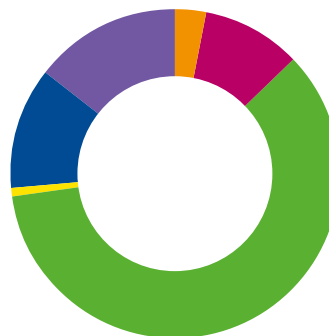
£'000, financial years



HEALTHY LIVERPOOL FINANCIAL STRATEGY

Planned spend for the population of Liverpool in 2015/16

Public Health:	£41,436,000
Primary Care:	£120,174,000
Secondary Care:	£749,604,000
CCG Running Costs:	£10,429,000
Specialist Commissioning:	£147,835,000
Social Care:	£180,384,000
	£1,249,862,000



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CONCLUSION

Healthy Liverpool has evolved from an aspirational vision and a set of bold ambitions into a clear series of plans for transforming our health and health services, as represented in this document.

After more than two years of intensive discussion and planning, the whole of Liverpool's health and care system is mobilised to work together in partnership and with a shared commitment to make this happen. We have a level of clinical consensus never seen before, and provider organisations are now exploring new ways of working together which enable us to put the needs of the city's patients first.

The next stage, implementation, has already begun. In recent months we have announced significant funding for a number of key areas, including £15 million for digital innovation,

nearly £3 million for physical activity, and around £12 million for blood cancer services. This level of financial investment will continue as the programme gathers pace, but significantly the focus of these resources will increasingly be on community delivery, including prevention. This shift to care closer to home reflects a long-term vision for Liverpool which is finally being realised.

This transformation is needed. Healthy Liverpool provides a once in a generation opportunity to ensure we create a clinically and financially sustainable health and care system for the future.



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OUTCOMES

In setting levels of ambition for the potential years of life lost and emergency admissions indicators, detailed evidence review and modelling has been undertaken to identify the most effective interventions and the level of impact each intervention can have.

The following tables describe the expected impact of these community interventions:

YEARS OF LIFE LOST: DELIVER A 24.2% REDUCTION IN AVOIDABLE MORTALITY

In 2011-2013 there were 3,210 deaths under 75 that were considered avoidable against the national definition e.g. chronic diseases such as CVD and COPD. The table right details the expected lives saved by 18/19 if targets were achieved.

Community Intervention	Expected lives saved if targets achieved
Smoking cessation	44-114
Physical activity	27-159
Stroke prevention	17
Secondary prevention of CVD	28-42
Hypertension	10-15
Pulmonary rehabilitation	48-84

A 15% REDUCTION IN AVOIDABLE EMERGENCY HOSPITAL ADMISSIONS

In 2013 (baseline) there were 56,618 non-elective admissions, of these 12,055 (21.3%) were deemed avoidable against the national definition. Right is a list of the schemes within the community strategy and their potential impact on avoidable admissions. The target is a 15.3% reduction in avoidable admission by 18/19. Please note that the individual schemes right will double count patients. The net impact is a reduction of 1,659 by 18/19.

Community Intervention	Expected reduction in emergency admissions by 18/19
Proactive care	489
Pulmonary rehabilitation	463
Care homes	228
Cardiac rehab	244
End of life	88
Community physio for children's asthma	64
Heart failure prescribing beta blockers	27
CHD prescribing of statins	8
Stop smoking in CHD	11
AF and stroke prescribing	35
Brief interventions for alcohol	560
Physical exercise in CHD	18

A set of lower level outcomes by programme have been derived in order to monitor improvement towards the higher level aims of the community strategy. These are listed for each programme below. Those with * are

performance managed by NHS England as part of Liverpool 5 year strategic plan; the Better Care Fund plan; and/or attract an incentive payment as part of our local quality premium.

HEALTH IMPROVEMENT

Overarching

*A reduction in potential years of life lost by 24.2% by 18/19

Alcohol

A reduction in the under 75 mortality rate for liver disease

A reduction in alcohol-related admissions to hospital by 223 admissions in 14/15 and 15/16

Drug dependency

Increase % of people receiving successful drug treatment

Tobacco control

Reduction in under 75 mortality rate from lung cancer

Reduction in smoking prevalence in adults from 25.2% to 20.2% by 2020

Increase in the % of patients quitting smoking

Reduction in CHD admissions by 10 by 18/19

Healthy Weight (including food and physical activity)

Reduction in excess weight in adults

Reduction in % of adults classed as inactive

Increase in % of adults classed as active by 2% per year

Reduction in CHD admissions by 18 by 18/19

Accident prevention

Reduction in hospital admissions for accidents

Health Checks

Increase in the % of patients receiving a health check to 20% of eligible population invited and, of these, an increase to 65% receiving a health check

LONG-TERM CONDITIONS

Overarching

*A 15.3% reduction in avoidable emergency hospital admissions. Equivalent to a reduction of 1,659 emergency admissions by 18/19

Self care

Increase in the % of patients feeling in control to manage their condition

*Increase in the % of patients reporting an improvement in health-related quality of life from 65.3 to 71.0 by 18/19

An increase in the number of patients accepted onto the pulmonary rehabilitation programme from 238 to 700 by year 18/19

A decrease in CVD admissions (due to increased cardiac rehab) by 448 by 18/19

An increase in the number of people being offered cardiac rehabilitation from 881 to 1,800 by 18/19

A decrease in COPD admissions (due to increased pulmonary rehab) by 463 by 18/19

Cardio vascular disease and heart failure

An increase in the number of people with CHD who are on a statin from 85.1% to 88.8%

An increase in the number of people with heart failure who are on a beta blocker from 66.2% to 83.1%

A reduction in the number of people with CHD who smoke by 62

Stroke/TIA

Increase in the % of >65 (excluding AF) who have received a pulse check from 67% to 82.3% and finding an extra 65 AF patients

Increase the % of patients with AF with CHADS score >1 being prescribed anti-coagulant from 81.7% to 90.9%

An reduction in the number of patients exception reported for AF prescribed anti-coagulant of 168 (from 671 to 504 - 25%)

An increase in the number of patients with stroke who are prescribed an anti-coagulant or antiplatelet from 94.4% to 97.2%

Healthy weight (including food and physical activity)

*Increase in the number of people receiving all 8 diabetes care processes

Reduction in the proportion of people at risk of impaired vision from diabetes

Reduction in the proportion of people with diabetes becoming blind

Reduction in the proportion of people with diabetes with circulation problems (peripheral vascular disease)

Reduction in the proportion of people with diabetes undergoing amputations

Reduction in the proportion of people with diabetes experiencing numbness, tingling or pain (neuropathy)

Reduction in the proportion of people with diabetes with kidney disease

Reduction in the proportion of people with diabetes with kidney failure

Reduction in the proportion of people with diabetes with heart disease

Reduction in the proportion of people with diabetes having a heart attack

Reduction in the proportion of people with diabetes having a Transient Ischaemic Attack (TIA)

Reduction in the proportion of people with diabetes having a stroke

Reduction in serious episodes of hypoglycaemia

Reduction in serious episodes of ketoacidosis

Reduction in the rate of mortality for diabetes patients under 75

HEALTHY AGEING

Dementia

*Increase in recorded prevalence of dementia towards expected from 54.4% to 64.9% by 15/16
 Decrease in the % of people with dementia being prescribed anti-psychotic medication

Reablement

Increase in the % of adults, older people and carers receiving self-directed support

*Increase the % of patients still at home 91 days after discharge to reablement services from 78.9% to 83% by 15/16

*Reduce the number of delayed transfers of care from 2,664.5 per 100,000 population to 2,602.7 per 100,000 population by the end of 15/16

Increase in the % of people who were offered rehabilitation following discharge from acute or community setting

Proportion of patients recovering to their previous levels of mobility/walking ability at i) 30 and ii) 120 days

Reduction in emergency re-admissions to hospital within 30 days of discharge

Reduction in hip fractures for people aged 65 and over

Reduction in injuries due to falls in people aged 65 and over

Reduction in emergency admissions for hip and vertebral fractures by 25.6% (167) by 18/19

Maintenance of the number of people receiving an MDT within intermediate care to avoid further permanent residential admissions

*To provide a community-based care experience that puts us in the top 5 of CCG's nationally

End of life

Increase in the % of people dying in preferred place of death

Reduction in emergency admissions due to less people dying in hospital of 29.3% (738) by 18/19

Neighbourhood working (Integrated MDTs)

Increase in the number of people receiving an MDT review from 400 to 1,500 per year from 14/15

Reduction in the number of emergency admissions for people receiving integrated care by 30% (1,944 admissions) by 18/19

Transformation of nursing and care home commissioning

*Reduction in the number of permanent admissions to residential and nursing care homes from 767.3 to 612.9 per 100,000 people

A reduction in emergency admissions to hospital for people from care homes by 40% (985 admissions) by 18/19

Geriatric assessment in care homes for 100% of patients within 1 month of admission

Advanced care plans for 100% of patients within the last 12 months of life

A reduction in the prescription of anti-psychotic medications

A reduction in medication errors in care homes by 10% by 2016

Carers

Increase in the % of adults, older people and carers receiving self-directed support

Bereaved carers views on the quality of care in the last 3 months of life

*Carer-reported quality of life

Increase in the proportion of carers who reported that they had as much social contact they would like

Overall satisfaction of carers with social services

Increase in the proportion of carers who report that they have been included or consulted in discussions about the person they care for

Increase in the proportion of carers who find it easy to find information about services

CANCER

Health improvement (cancer screening)

Reducing the all age all cancer mortality rate from 225.1 deaths per 100,000 in 2009-11 to 160.9 in 2019-21

Reducing the under 75 mortality rate for cancer from 148.5 deaths per 100,000 in 2009-11 to 110.6 in 2019-21

Increase in % of people receiving bowel cancer screening to 60%

Increase in % of people receiving breast cancer screening 70%

Increase in % of patient receiving cervical cancer screening to 80%

*Seeing less than 90% of patients waiting 62 days from referral from screening service to first definitive treatment

*Seeing less than 85% of people waiting 62 days from urgent referral to first definitive treatment

*Seeing less than 93% of people waiting 2 weeks from urgent GP referral to first outpatient appointment

Increasing the 1 and 5 year survival rates for breast bowel and lung cancer

Reducing smoking prevalence from 25.2% to 20.2% by 2020

Increasing the number of people who stop smoking



MENTAL HEALTH

Psychological therapies

*Proportion of adults with relevant disorders who have entered psychological therapy treatment will increase from 8.6% to 15% by Q4 15/16

*Increase recovery following talking therapies from 32% to 50% by the end of 15/16

*The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period

Improvement in the quality of life and wellbeing using standardised tools

To improve total health gain by patients receiving psychology therapies

Street Cars

Increase in the % of mental health assessment under taken

Decrease in % of patients receiving section 136 assessments and detained under mental health act

Primary Care

*The % of patients aged 40 and over who have schizophrenia bipolar affective disorder and other psychoses who have a record of alcohol consumption, BMI, blood pressure, total cholesterol and blood glucose in the previous 15 months

Patient experience/outcomes

Improve the average score for people finding talking therapies helpful from 6/10 (2013: National Community and Mental Health Survey)

General

Increase in the proportion of adults in contact with mental health services living independently, with or without support

Improvement in % of people receiving mental health care programme approach to 95%

*Reduction in the number of patients with AED 4 hour breaches who have attended with a mental health need and a defined improvement in coding of patients attending AED

*Improvement in health-related quality of life for people with a long-term mental health condition

*Reduction in the number of people with severe mental illness who are smokers

*Increase the number of people with secondary mental health conditions in paid employment

Patient experience/outcomes

Improve the average score for people finding talking therapies helpful from 6/10 (2013: National Community and Mental Health Survey)

CHILDREN'S AND MATERNITY

Children's and maternity

A reduction in children's admissions for asthma by 28.8% by 16/17
A reduction in unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
A reduction in unplanned hospitalisation for lower respiratory tract infection in under 19s
A reduction in waiting times for children's community equipment
A reduction in waiting times for neurological development services from 14 months to 18 weeks
90% service satisfaction maintained for child and adolescent mental health services
A reduction in excess weight in children aged 4-5 and a reduction in excess weight in children's ages 10-11
An increase in the number of women breastfeeding at 6-8 weeks
A reduction in the number of women smoking at time of delivery
An increase in Antenatal Assessment < 13 weeks
Increase the % of children receiving vaccinations to 95%

Where possible these outcomes have been built into contracts for providers.

An example of this is the GP specification. A list of 50+ indicators is published on a portal for general practice to review and make improvement. The indicators relate directly to the achievement of the CCG's overarching health outcomes.

Those listed below attract an incentive payment if thresholds are achieved.

GP Specification

The rate per 1,000 in hours, self-referred, minor attendances at AED where advice or prescription was given
% of registered patients for CHD, HF, stroke, AF, hypertension, COPD, diabetes registers
Average Exception Reporting Percentage against register size on the registers of CHD, HF, stroke, AF, hypertension, COPD and diabetes
The percentage of patients aged 18 years and over who have had the alcohol consumption recorded
The percentage of patients aged 18 years and over who are drinking more than recommended units per week, have their alcohol intake recorded using the AUDIT-C or AUDIT Tool and received a brief intervention
Full participation and adherence in the gold standards framework for End of Life
The practice to establish a register of Mild Cognitive Impairment and to develop an annual recall and review system for people identified with MCI; to review patients with MCI once only at 12 months post-diagnosis
Rate per 1,000 hospital weighted population for admissions for a selection of ACS conditions
Rate per 1,000 hospital weighted population for GP referred first Outpatient attendances to certain specialties
% of choose and book GP referrals to consultant-led clinics out of total GP referrals to consultant-led clinics
Medication indicators relating to safe prescribing for the following conditions/drugs; lithium, warfarin, dementia, asthma, Addison's, type 2 diabetes
Antibiotic use

