HEALTHY LIVERPOOL
PROSPECTUS FOR CHANGE

NOVEMBER 2014
My colleagues and I are absolutely committed to putting people first and putting patients first. We are absolutely committed to the Healthy Liverpool Programme’s success and look forward to everyone in Liverpool benefiting from this challenging but essential work.

Joe Anderson
Mayor of Liverpool

The Healthy Liverpool programme is truly a once-in-a-generation opportunity to transform health and social care in Liverpool for the better.

Dr Nadim Fazlani
Chair, NHS Liverpool Clinical Commissioning Group

Joe Anderson
Mayor of Liverpool
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Two years ago I instigated a Commission to determine how best to support and improve the health and well-being of the people of Liverpool. The findings of the Mayoral Health Commission concluded that such is the extent of the poor health outcomes of the people of Liverpool, and the relentless drive on budgets and resources, that only a wholesale comprehensive approach to transformation would be likely to succeed.

The Commission’s vision is for an Integrated Health and Social Care System for Liverpool, with prevention and self-care at its core. To achieve this a 10-point plan was identified to which all partners were asked to sign up to and then to sustain their commitment by collaborating to achieve this vision.

The newly established NHS Liverpool Clinical Commissioning Group, as the body responsible for the vast majority of health commissioning within the city, took up the challenge of delivering the recommendations of the Mayoral Health Commission.

It has set up the Healthy Liverpool Programme as its response to the Commission and is now providing the necessary leadership to achieve this vision of improved health and well-being.

The Healthy Liverpool Programme sets out a clear vision for health improvement for the people of Liverpool, the outcomes we aim to deliver and how we plan to achieve our vision.

The programme is critical to the city’s future. We need healthy communities to engender economic success. Economic success will improve the quality of life for all our families. And we must do everything we can to ensure taxpayer’s money is being spent in the most effective way.

The vision for a New Health Service for Liverpool was subject to a formal public consultation in 2007/08, which provided a clear mandate from the people of Liverpool supporting the principle of care delivered closer to home and approval for significant investment in new neighbourhood health facilities across the city. This vision was successfully achieved, with the development of a network of new or refurbished Neighbourhood Health Centres and an NHS Treatment Centre.

The Healthy Liverpool Programme represents a logical continuation of the journey that commenced with A New Health Service for Liverpool. Our plans represent a further step-change in the development of community care, which aligns with the new hospitals that are now in development and the hospital service re-alignment debate which forms part of the Healthy Liverpool Programme.

A CLEAR VISION...
for health improvement for the people of Liverpool, the outcomes we aim to deliver and how we plan to achieve our vision.

JOE ANDERSON  MAYOR OF LIVERPOOL
More importantly, I believe all people should have access to the right care at the right time and in the right place. I believe it is wrong that the health of people in Liverpool should be so much poorer than in some other places in the UK. And I believe it is wrong that there remain health inequalities within the city itself.

We have much to be proud of in Liverpool when we consider the expertise and dedication of those working in the health and care services, our innovation and some of our globally-leading hospitals and clinicians.

This is the city, after all, that had the country’s very first public health officer in the person of Dr William Duncan, who delivered widespread public health improvements more than 160 years ago. The Healthy Liverpool Programme might be regarded as yet another chapter in a Liverpool story which began with his reforms.

My colleagues and I are absolutely committed to putting people first and putting patients first. We are absolutely committed to the Healthy Liverpool Programme’s success and look forward to everyone in Liverpool benefiting from this challenging but essential work.

THE MAYOR’S HEALTH COMMISSION RECOMMENDED:

1. All the key partners in Liverpool formally sign up to the principle of seeking to create a pioneering, high quality, sustainable Integrated Health and Social Care System, and undertake together to lead, manage, and fund the transformation of the health outcomes of the people of Liverpool.

2. Prevention and self-care become the primary focus in the transformation of the health outcomes, and a focus on young people and older people.

3. The system to be stimulated by a major new initiative to integrate out of hours services across primary, community, secondary, tertiary, mental health and social care.

Achieving the vision will require strong operational over-sight and support. Therefore the Commission further recommended:

4. A single unifying strategic plan, based on the City’s Joint Strategic Needs Assessment, bringing together the local commissioning plans of the CCG, the City Council, the Health and Well-being Strategy of the joint Health and Well-being Board, and NHS England (Merseyside).

5. National bodies to be kept fully informed of the strategic plan, to allow space for the reduction of duplication and unnecessary competition (particularly in secondary care), and for the restructuring of care in all settings to improve the patient pathway and quality of care.

6. Liverpool Health Partners and the North West Coast Academic Health Science Network to play a key part, through research-based input, in helping health and social care to ‘act as one’ and to work together across traditional boundaries.

7. A Neighbourhood Model to be the key way of implementing the proposed integrated Liverpool Health and Social Care System.

8. A workforce strategy to deliver a high quality, integrated 24/7 service, to include the development of new roles; existing staff to work differently, giving young people access to new opportunities and to support the recommendations of the Mayor of Liverpool’s Education Commission.

9. Transformation of the health outcomes of the people of Liverpool through the Integrated Health and Social Care System is research and evidence-based.

10. The City of Liverpool and all its organisations commit to the transformation of the health outcomes by tackling the wider determinants of health and facilitating healthy choices in food, alcohol, smoking, exercise and transport.
Healthcare in Liverpool faces major challenges and needs to reform. Issues such as an ageing population and opportunities such as advances in medical technology means that care services can and should be organised in a more effective way. A different approach will enable people to have the very best health and care and will ensure that we spend taxpayers’ money more efficiently.

We believe we should offer the best care to everyone, irrespective of where they live in Liverpool, to a consistently high standard.

Dr Nadim Fazlani Chair, NHS Liverpool Clinical Commissioning Group

It is wrong, we believe, that people in Liverpool have significantly poorer health than elsewhere in the UK and Europe and that life expectancy within the city is so varied. Our aim is to change that.

Work to reshape some care is already underway – integrated health and social care is an emerging reality and there is work being done on how we better deliver care in neighbourhoods and communities.

However, reform needs to go further, with more improvements in primary care, greater access to GPs, more support for people to manage their own care, better illness prevention and some services moving from hospitals into the community.

Primary and neighbourhood-based care services, GPs in particular, are often the gateway to health and social services and the main source of advice for patients. So reform of primary care is the cornerstone of a changed health and social care system.

Improving primary and neighbourhood care will enable people to stay healthier and independent for longer and also reduce demand on hospitals.
Our hospital services largely continue to operate in the same way as they did in the last century, despite the changing face of the population and technology. We believe some hospital services would benefit from a fresh approach to the way they are organised.

If we reduced emergency admissions to hospitals by just 11% we would be able to afford an extra one and a half GPs in every practice in the city. This is the virtuous circle we are aiming to create.

Quality of care has to be foremost, however. Without quality, we won’t achieve the outcomes we are aiming for. All the proposed reforms under consideration will therefore be underpinned by a rigorous approach to standards and quality.

What must also be at the heart of any change programme is a collaborative approach. Our commitment is to work in partnership to deliver the necessary reforms. Health and social care organisations, including Liverpool City Council, the Third Sector, patients’ groups, GPs and individual health trusts will all be involved in this process.

Most importantly, our approach must put people first. The evidence is overwhelming that taking a person-centred approach to the delivery of care, giving people more say over care plans and better supporting them to look after themselves will improve their health and well-being.

The Healthy Liverpool Programme will undoubtedly be challenging. But we also believe it will be exciting and that it is essential.

I know through my own experience of being a GP in Kensington, Liverpool, where our practice has some 8,500 patients, that some families and communities have become almost accustomed to ill-health and that their expectations are low. I believe we must raise such expectations so that Liverpool people are ambitious for their own health and for that of their families.

Only days before we published our prospectus, NHS England published its Five Year Forward View, which sets out the vision for the future of the NHS, an articulation of why change is needed, what that change might look like and how we can achieve it collectively. This Five Year Forward View aligns closely with the Liverpool vision for the future of our local NHS and reconfirms our belief that the prospective changes we offer in this document will take us where we need to go.

The Healthy Liverpool Programme is truly a once-in-a-generation opportunity to transform health and social care in Liverpool for the better. Some of the improvements we want to see may take a generation. Some are already happening and already improving people’s lives. Please play your part.
Our vision is for a healthcare system in Liverpool that is **person-centred**, supports people to stay well and provides the very best in care.

This vision is underpinned by a number of ambitious outcomes to be achieved by 2020. These include:

- **Health outcomes** for people within Liverpool will have improved relative to the rest of England, and health inequalities within Liverpool will have narrowed.
- **The quality of healthcare** received by Liverpool patients will be consistent and of high quality.
- **There will be a new model of care** which is clinically and financially sustainable for the long-term.
Through the transformation achieved by the Healthy Liverpool Programme, our goals are:

- **24.2%** A 24% reduction in years of life lost.
- **71%** An increase to 71% in the measurement of the quality of life for people with long-term conditions.
- **15%** A 15% reduction in avoidable emergency hospital admissions.
- **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.
THE CASE FOR CHANGE

The case for change is a compelling one. The city’s health economy like many across the NHS in England faces a series of unique challenges and opportunities in future, that if not addressed have the potential to impact the sustainability, delivery and outcomes of local services and therefore adversely affect the health and well-being of Liverpool people.

These drivers for change are not necessarily unique to Liverpool but like every health economy, local needs, structures and circumstances can mean that their impact can be potentially significant if left unaddressed. If we are to achieve our vision for a Healthy Liverpool we must first understand these drivers and then seek to design a system that is able to rise to the challenges faced and the opportunities available. For Liverpool there are a significant range of challenges to be addressed:

### Poor Health Outcomes and City-Wide Health Inequalities
Residents in the City experience a range of worse health outcomes in comparison with similar cities, with significant levels of inequality within parts of the city and with other parts of the country. Inevitably with such variation, positive progress and outcomes are harder to achieve. What we need is an approach to change that is strongly clinically led, sustainable and appropriately resourced. In essence, the ‘prescription’ is the Healthy Liverpool Programme with its whole-system emphasis.

Inequalities within the city are shocking:
- the gap in life expectancy between the ward with the highest (Woolton) and the ward with the lowest (Kirkdale) life expectancy is 10.5 years;
- people in Woolton on average live 10.5 years longer than people in Kirkdale;
- for cancer, people in Kirkdale are 3 times more likely to die of cancer than in Woolton;
- for cardio-vascular disease (CVD), people living in Picton ward are 2.5 times more likely to die of CVD than Mossley Hill;
- for respiratory disease, people living in Princes Park are 6.5 times more likely to die of this disease than Mossley Hill.

### Population Change
Despite poor health outcomes, Liverpool’s population is living longer, with an expected 9% growth in the numbers of people aged 65+ years by 2021 and significant growth in those aged 70-75 and 85+. Although the total population is not expected to significantly change, changes in the age profile within the population will impact upon health and health service delivery. As the population ages there will be more people living with health conditions and often multiple needs, placing greater demands upon our health system, both in community and in hospital care settings.
Liverpool is fortunate to have a robust infrastructure of neighbourhood health facilities delivering primary and community services, as well as a unique range of hospitals; with eight NHS trusts serving the city’s population. Like all health systems Liverpool is subject to a variety of challenges, including financial, operational, quality, workforce and regulatory issues. If we are to realise the vision for Healthy Liverpool, we will have to ensure that all our health services across all settings of care are able to meet the future needs of the city and that we are able to develop and sustain the best health system in the country, which will be necessary in order to achieve our ambitions for significant improvement in health outcomes.

Outcomes across the city for local people are unacceptably variable; this is being experienced in primary care, community care and in our hospitals. This can manifest itself in a variety of ways, including differing referral rates for cancer, high admission or conversion rates in hospitals, variances in hospital length of stay and clinical outcomes. Similarly patient experience and quality of service delivery across the city can vary significantly. Such variations have to be tackled; we will work to a future where services are delivered consistently to the highest standards in a fair, sustainable and equitable manner.

True transformation of health in Liverpool will be dependent upon people taking more responsibility for their own health. Obesity, alcohol misuse and smoking-related ill-health are all significant factors affecting the health of Liverpool people. The Healthy Liverpool Programme will incorporate evidence-based approaches, working with our partners, to support people to take control of their own well-being, and live healthier lifestyles. The challenges impacting on our local NHS services now and into the future can be tackled most effectively by helping people to remain healthy for longer.

Against the backdrop of significant health and care challenges, we are improving our understanding of the best approaches to maintain health and provide better treatment for people who need care. There is strong evidence that for some conditions, developing more specialised hospital care can result in better outcomes for patients through the concentration of highly-effective technology along with the most highly trained and specialist staff.

It is clear that significant opportunities exist to improve health outcomes through empowering patients to get involved in decision-making about their and their loved ones’ care. In this way we can improve outcomes by addressing the whole person, rather than focusing on single facets of their health. Too many people report negative or unsatisfactory experiences and for too many people there are barriers to accessing care in a straightforward fashion. Putting people first will therefore underpin our approach to achieving a healthy Liverpool.
We have a legacy in Liverpool of taking bold decisions to improve health.

KATHERINE SHEERIN CHIEF OFFICER, NHS LIVERPOOL CCG

Liverpool has a strong legacy of strategic and proactive investment in physical health infrastructure and ambitious re-design of health and health services.

Between 2008-2013 the former commissioners of health services, Liverpool Primary Care Trust, invested many millions into new and improved community health facilities and an expansion of community-based healthcare to enable more services to be delivered closer to people’s home. This programme complemented and was a necessary precursor for the new Royal Liverpool and Alder Hey hospitals which are now being developed.

The vision for a New Health Service for Liverpool was subject to a formal public consultation in 2007/08, which provided a clear mandate from the people of Liverpool for the principle of care delivered closer to home.

This vision was successfully achieved, with the development of a network of new or refurbished Neighbourhood Health Centres and an NHS Treatment Centre across the city.

The Healthy Liverpool Programme represents a logical continuation of the journey that commenced with A New Health Service for Liverpool. Our plans represent a further step-change in the development of community care, which aligns with the new hospitals that are now in development and the hospital service re-alignment debate which forms part of the Healthy Liverpool Programme.
OUR AMBITION – A NEW MODEL OF CARE

In order to achieve the Healthy Liverpool vision we need to identify new ways of working and to design services that support our ambitions. Healthy Liverpool will deliver a new model of care – person-centred care. So the health and care system must take into account the needs of the entire person, rather than addressing just one particular element of what may be a complex range of health and social needs.

In reality, this means being prepared to set aside traditional approaches which may suit the health and care system’s traditional organisational needs but do not best serve the needs of the individual.

This new model of care means that the different tiers of the health and care system must connect better. In practical terms, specialists and other staff will break traditional organisational boundaries and work in different locations and different settings, centred on the needs of people and communities.

4.1 HEALTHY LIVERPOOL SETTINGS OF CARE
The Healthy Liverpool Model is built around three ‘settings’ of care:

**DELIVERING** care in communities across the city, including GP practices, schools, health and community centres, pharmacies, people’s homes and residential care facilities. Our intention is to bring as much care as possible closer to people’s homes.

**SUPPORTING** people to self-care and equipping them with the knowledge and resources to take healthy lifestyle decisions.

**ENSURING** that, in future, our hospitals will be used for only those services which absolutely must be delivered in this setting, because of the complexity of the service or the seriousness of a person’s illness.
We have to manage competing priorities and make decisions that will give us the best chance to achieve the ambitious improvements in health outcomes of Liverpool people.

4.2 PRIORITISING TO ACHIEVE THE BEST OUTCOMES

The multiple demands on our NHS mean that in planning for the future we have to manage competing priorities and make decisions that will give us the best chance to achieve the ambitious improvements in health outcomes of Liverpool people.

We have examined a wide evidence-base, including the findings of the Mayor’s Health Commission and the Liverpool Joint Strategic Needs Assessment, to identify six priority areas which, through effective re-design and focused investment, will drive improved health outcomes.

This does not mean that other areas will be neglected; we will continue to improve all health services, but we are prioritising these key areas, as evidence indicates that we can achieve the biggest improvement in health outcomes by transforming the way that these areas are designed and delivered.

THE SIX PRIORITY AREAS:

MENTAL HEALTH

HEALTHY AGEING

LONG-TERM CONDITIONS

CHILDREN

LEARNING DISABILITIES

CANCER
National research tells us what people want from their health and care services. We took that research and asked people in Liverpool about their needs. What they told us is represented in the following statement:

“We want to live the most independent lives possible. We want services that are easier to navigate and access, services that are organised around, and responsive to, our human needs. We want the care system to recognise that one size does not fit all; we each have our own definitions of independence and services should be able to flex to this.”

“We want our families and carers to be identified and involved in our care. We want to plan our care with people who work together to understand us and our carers, allow us control, and bring together services to achieve the outcomes important to us. The care system can feel like a maze so we want primary and community healthcare, social care, hospital care, voluntary, charity and housing organisations to work together to help us succeed in maintaining our independence for as long as possible.”

The vast majority of contacts in healthcare and social care take place in community settings rather than in hospitals – in GP practices, with health visitors, midwives, district nurses, community matrons, social workers, mental health workers, therapists and pharmacists. Achieving person-centred, joined-up care could transform the way these services are offered and make an enormous contribution to improved experience of care for Liverpool people.

The Liverpool way to joined-up care will not be led by a focus on structures and organisations. Our focus will be on people and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes. This will be the guiding light in everything we do. So for us, success will be judged by whether a Liverpool patient is able to say:

“I can plan my care with people who work together to understand me and my carers, allow me control of that care, and bring together services to achieve the outcomes important to me.”
Fundamentally, joined-up care will deliver better outcomes for patients, meaning:
- fewer people require hospital and long-term care;
- more people are supported to live independently at home for longer;
- reduced health inequalities, as a result of delivering the right services in response to the specific needs of communities and neighbourhoods;
- more people living well for longer, through better self-care and self-management of their conditions.

This model of care also provides a more financially sustainable future for health and social care services in our city. By enabling partners to collaborate and be guided by the needs of people rather than systems and organisations, we will avoid duplication, intervene more quickly to prevent ill-health or manage conditions better and we will benefit from shared expertise and resources.

Making this vision a reality will require all local NHS organisations and partners to unite around shared core values that are led first by what is best for people – person-centred care. This journey has challenges. However, the recent reforms to the health and care system have created the right conditions for change, by empowering doctors and other health professionals to lead this process.

**ADVICE ON PRESCRIPTION**

‘Sue’, a mum of 3, was referred to the Advice on Prescription programme with a long-standing diagnosis of anxiety and depression. She was referred by her GP for counselling because she was worried about her increasing debt, particularly rent arrears. The counsellor was able to refer her to the Liverpool Advice on Prescription Programme for practical assistance.

In 2013, Sue had been assessed as being fit for work; she was taken off Incapacity Benefit onto Job Seeker’s Allowance (JSA). However, due to her health problems, she was unable to meet the conditions of JSA, which resulted in her benefits being stopped. Her rent and council tax arrears increased considerably and she became very worried about losing her home. The Advice on Prescription service assisted Sue by securing an award of Employment Support Allowance and a backdate of suspended payments. All court action relating to rent and council tax arrears was also stopped. Sue’s weekly income has increased by over £200 and she has returned to counselling to support her recovery, without the added worries about debt.
Just 30 minutes activity each day will save hundreds of lives.
HOW WE WILL SUPPORT PEOPLE IN LIVING WELL

Our ambition is for Liverpool to become the most physically active city in the country.

DR MAURICE SMITH GP, NHS LIVERPOOL CCG

Liverpool has a strong legacy of strategic and proactive investment in physical health infrastructure and ambitious re-design of health and health services.

Living Well is built upon two work-streams – one focusing on activity which will help to prevent ill-health in the population and another focusing on how we ensure people with long-term health conditions are able to look after and care for themselves.

Liverpool has a long tradition of partnership working across a wide range of health improvement and lifestyles agendas, resulting in better outcomes in key areas such as smoking and alcohol-related admissions to hospital.

Liverpool City Council and Liverpool CCG believe that partnership approaches to prevention are essential to success.

We have prioritised three areas of prevention where we will focus our attention: physical activity, smoking and alcohol. These areas have been identified as key health issues in Liverpool, particularly influencing high mortality for cancer, cardio-vascular disease and respiratory disease.

6.1 IMPROVING PHYSICAL ACTIVITY

We have a bold ambition to transform the health of Liverpool people. Our goal:

Liverpool will be the most physically active city in the country by 2021.

There is clear evidence of the health benefits of undertaking at least 30 minutes physical activity a day. When we say physical activity this does not need to be overly strenuous, it can be simple activities such as walking and gentle cycling.

Currently in Liverpool about half of the adult population does not participate in any form of physical activity. Around 86% of adults in Liverpool are not active enough to maintain good health, compared to 70% nationally.
If we were able to get every adult in the city to undertake 30 minutes of activity per day for at least 5 days per week we estimate that would prevent:
- 424 deaths per year;
- 146 CHD emergency admissions per year;
- 2,452 new Diabetes cases;
- 55 cases of Breast Cancer;
- 43 Colorectal Cancer cases.

For people with long-term health conditions there are significant benefits from being active:
- an active patient with diabetes (who walks 3 hours a week) is 2½ times less likely to die of heart disease than an inactive person without diabetes;
- patients with COPD who walk gently for half an hour per day halve their risk of an emergency admission;
- 10% of all deaths from heart disease and 18% of all breast cancer deaths are due to inactivity;
- physical activity reduces blood pressure in patients with hypertension, far greater than prescribed medication;
- the National Institute of Clinical Evidence (NICE) recommends physical activity as an effective treatment for depression, particularly when undertaken in groups.

We will work with Liverpool City Council and other key organisations with expertise, including our professional sports clubs and Sport England, to focus significant investment to achieve our ambition, through the jointly agreed Liverpool Physical Activity and Sport Strategy.

The city has a wealth of assets, including some of the best green spaces in the country, which we will harness to make physical activity opportunities available to all, regardless of where people live or how fit they are. We will be developing large scale programmes which will be informed by insight into the particular needs of our city, reaching the whole population; from pre-school to older people, people living with, or at risk of developing, long-term health conditions, and people with a disability.

Our intention is to create a social movement, mobilising people of all ages, backgrounds and abilities to improve their health through activity. We will recruit champions who will promote the benefits of activity and offer support to people who want to get started. Alongside this, we will invest in weight management and healthy eating programmes.

### 50%

50% How much a daily gentle walk will reduce the risk of an emergency admission for a COPD patient.

### 10%

10% The percentage of all deaths that are due to heart disease.

### 18%

18% The percentage of breast cancer deaths that are due to inactivity.

### REDUCING ALCOHOL MISUSE

An estimated 11,300 people in Liverpool drink at high risk levels and approximately 10% of all admissions in the city are estimated to be alcohol-related – the 4th highest in the country. Alcohol-related mortality is amongst the highest in the country.

Our aim is to create effective partnership working to prevent and reduce alcohol-related problems to improve the quality of life for people who live in, work in and visit our city.

Using the best evidence available we will put in place programmes that target specific groups that are often difficult to influence in terms of behaviour change, including young people and middle-aged women. We will use insight data and social marketing approaches to reach and influence these groups.

We will also continue to lead the drive for minimum pricing for alcohol at national level and use local powers and influence with local businesses.

We aim, over the next five years to significantly reduce the under-75 death rate for liver disease and reduce the impact on our health services of alcohol-related problems.

### REDUCING SMOKING LEVELS

Smoking is the single biggest behavioural risk factor for premature death and has a significant impact on Lung Cancer, COPD and CVD, which are the major killers in Liverpool.

If we were able to increase numbers of people on smoking cessation setting quit dates to a level of 15%, we estimate we would avoid 114 deaths per year.

Our vision is for the city to be a place where children are not exposed to tobacco smoke; smoking levels are decreasing and smoking is not seen as the norm.

Providing a comprehensive tobacco control programme including a specialist stop smoking service has already helped to reduce Liverpool’s smoking prevalence from 35% in 2005 to 25% in 2013. However we need to reduce this even further; our plan is to deliver a further 5% reduction by 2020.

Working with partners we will put in place a number of specialist programmes aimed at supporting individuals to stop smoking, including targeted interventions for key groups such as young people and pregnant women; increasing the range of brief interventions advice and specialist stop smoking services.
**6.4 BETTER SELF-CARE FOR PEOPLE WITH LONG-TERM CONDITIONS**

The self-care model for people with long-term conditions in Liverpool encompasses a range of activities, actions and ideas that individuals, families and communities can undertake to better manage their own condition.

The model is also designed to empower people to take care of their own health and to have a high degree of self-reliance and, therefore, less reliance on health and care services.

The priority areas identified for self-care for long-term conditions are:
- people with diabetes,
- people with respiratory problems, including chronic obstructive pulmonary disease (COPD) and asthma,
- those with coronary heart disease,
- frail elderly people.

Some 24,000 people registered with a GP in Liverpool have diabetes, 14,000 with COPD, 28,000 with asthma and 18,500 with coronary heart disease.

Our approach to self-care is to offer a range of support for people to live well and have a high degree of self-reliance. Our focus will be on:
- involving people in decision-making, encouraging problem-solving and goal-setting,
- developing care plans in partnership with professionals,
- promoting healthy lifestyles and offering practical tools to achieve this,
- providing the tools for people to monitor their symptoms and to know when to take action,
- supporting people to understand and manage the emotional, social and physical impact of their conditions,
- harnessing the power of digital tools and assistive technology to support the adoption of self-care at scale.

We intend to develop a menu of services with patients who suffer from one or more of these conditions and to create a toolkit for healthcare professionals that can help them initiate and support the self-care journey, in partnership with patients.

There will also be a unified self-care portal accessible via all GP practices in Liverpool so that healthcare professionals can access information on all services in a simple fashion.

Through this approach, we aim to create an education and cultural shift towards a collaborative partnership between health professionals and patients.

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**SUPPORTING SELF CARE**

**TONY COULTER**

61-year old former painter and decorator, Tony Coulter's life changed completely when he was diagnosed with a brain tumour at just 48. A series of operations then left Tony totally blind and epileptic.

Care technology has allowed him to regain his independence and live by himself, whereas previously he was heavily reliant on his sister.

Tony now lives in a Riverside Independent Living Housing community, where he is supported by care technology made available through Mi – More Independent, a NHS Liverpool CCG programme which deploys technology to support self-care.

Tony uses technology to improve his quality of life. This includes a talking microwave, a talking computer and a talking watch that tells him the time. He also has a special device that detects if he suffers a fall, a Lifeline pendant around his neck that he can press for help, and sensors in his bed that raise an alarm if he suffers a fit.

Tony says: “I can’t say that life isn’t a challenge, but the technology has helped a lot – it gives you reassurance and peace of mind that someone is always looking out for you.

“The last straw would be losing my independence. I have a supportive family, but don’t want to rely on them all the time. The technology has allowed me to stay in my own home, living alone, and being as independent as I can possibly be.”
We want to be able to answer yes to; are we putting people first? Is the experience of care good? Are services centred around people’s needs? This is person-centred care.

DR PAULA FINNERTY GP, NHS LIVERPOOL CCG
TRANSFORMING COMMUNITY SERVICES

We will provide excellent 7-day services in all our communities.

DR JUDE MAHADANAARACHCHI   GP, NHS LIVERPOOL CCG

The Mayor’s Health Commission recommended that the City of Liverpool and all its organisations commit to the transformation of health outcomes by tackling the wider determinants of health. This reflects the fact that health is not just the physical well-being of an individual, but includes the social, emotional and cultural well-being of the whole community.

Working together, all local organisations should enable each individual to achieve their full potential as a person, which will contribute to the total well-being of their community.

Liverpool aims to have fantastic community services to serve its population.

Liverpool has a history of working together and our intention is for the City to come together as a whole and make better use of all its assets, services, staff and patient experiences to ensure that we transform community services to improve the health and well-being of the people of the City.

For the population as a whole, we recognise that the vast majority of citizens in Liverpool maintain and manage their own health and well-being close to home. People do this through their own motivation, through their families, friends, carers and faith groups, through local amenities such as parks and gyms, libraries, schools, community organisations and transport systems, or through their dentists, pharmacists or employers, amongst many others.
The next largest group of people to access health and social care services will be those who require routine care from their GP or who require specific support to enable them to remain as healthy as possible and to live as independent a life as possible. In the scheme of things it is a small minority of people who go on to require specialist care or have more complex conditions. It is an even smaller group of people who go on to require hospital based care.

At present Liverpool has many excellent services and staff but as we know services can be disjointed and fragmented. For people this can mean that access to health, social care and other community services is not joined-up which can lead to delays and multiple assessments. We recognise that Liverpool has a fantastic opportunity now to bring together all our resources which includes health and social care, patient expertise and the Voluntary Sector.

We aim to work in a joined-up way so that people get excellent care and support in a timely manner in the right place from the right professional. This needs to involve all those who provide care and support so that the care an individual receives is person-centred and has a greater emphasis on supporting them to care for themselves. We want to place a real focus on people living well and having healthier lives but also to ensure that when required services are accessible, responsive and work together to meet individual need. People tell us that this is what they want and this is what we aim to deliver.

Our intention is that everyone in Liverpool can expect to receive joined-up care from services located close to the community where they live. This will provide people for example with improved access to GPs, community nurses, social workers, health visitors, simple diagnostic tests, pharmacies and voluntary services. At the heart of this will be the way these services work together to provide care.

The Mayor’s Health Commission recommended that a neighbourhood model should be the key way of implementing the proposed integrated Liverpool Health and Social Care System.

**7.1 Better Links Between Health, Social Care and Voluntary Services**

Liverpool has a wealth of voluntary, community and social enterprise (VCSE) partners. We recognise that our ambitions for health and well-being are more likely to succeed if our models of health, care and support services reflect all aspects of health and well-being and operate as a strong and integrated part of our health and care system.

Many voluntary organisations have a detailed understanding of specific local needs, high levels of trust and engagement with local communities and the ability to work across multiple services to provide care for individuals. For example, within the context of an ageing population, the Voluntary Sector has a crucial role to play in addressing social isolation as well as harnessing the power of the local community.

Evidence demonstrates that social determinants of health have a defining impact on health outcomes. More preventive and less intensive interventions for health will be needed to make the system sustainable. Consequently we need to understand the challenges and opportunities in this area and to plan how to build such approaches into the Healthy Liverpool Programme.

Health, Social Care and Voluntary Care services will be provided in a variety of settings, for example:

- **for the person at the centre** – this may mean adopting a healthier lifestyle, and being a proactive partner in treatment;
- **at the GP Practice** – this may mean proactive prevention and partnering with Voluntary Care Services throughout pathways;
- **in the neighbourhood** – this may mean voluntary care services supporting healthy communities, health promoting neighbourhoods, and training and development.

We will ensure we know which voluntary care services are in our communities to enable us to signpost people appropriately to get the support they need when they need it.

**7.2 Neighbourhoods**

The Mayor’s Health Commission recommended that a neighbourhood model should be the key way of implementing the proposed integrated Liverpool Health and Social Care System.

7.2% The increase in 60-75 year olds receiving bowel cancer screening in the last two years.
THE LIVERPOOL MODEL OF CARE
Primary and neighbourhood based care services, GPs in particular, are often the gateway to health and social services and the main source of advice for people, so improvements in primary care will be the cornerstone of a transformed health and social care system. It’s clear therefore that Liverpool needs a General Practice Service that’s fit for the future. This means we will look at ways in which we can deliver 7-day services, which will improve access and the experience of care.

Liverpool people must have access to consistent GP services which are delivered to an agreed level of quality and to ensure that people are treated outside of hospital whenever appropriate. This is what every person registered with a Liverpool General Practice will expect. To drive this endeavour in 2011, Liverpool established the “GP Specification” to improve the quality and consistency of General Practice across the city, improve the health of people, reduce variation and health inequalities and ensure most cost effective use of resources. Target areas for this “GP Specification” include:

- improving access to General Practice;
- increasing screening;
- increasing vaccinations and immunisations;
- increasing Health Checks;
- Chronic Disease Management.

Examples of improvements achieved so far, and expected to continue, include:

- 7.2% more patients aged 60-75 years old have had bowel cancer screening in the last 24 months;
- 5% improvement in people with coronary heart disease having lower cholesterol;
- 3.9% improvement in people who have had a stroke or TIA having lower cholesterol;
- 7.6% improvement in people with diabetes who have had all nine key care processes that are known to improve their conditions;
- 38.1% improvement in the number of newly diagnosed diabetics aged 17+ who have been offered structured education in the last 12 months;
- 11% improvement in the number of people with COPD and breathlessness who have been offered a pulmonary rehab programme;
- 5.4% improvement in the number of people with severe mental illness who have a record of five key physical health checks in the previous 12 months.

NHS England has invited CCGs to come forward to take on an increased role in the commissioning of primary care services. This could lead to co-commissioning arrangements between the CCG and NHS England from 2015. We welcome this change, which would accelerate our ability to improve quality and access to a broader range of services in primary care and empower us to improve primary care services in line with the vision for Healthy Liverpool.

The Mayor’s Health Commission recommended that a neighbourhood model is the best way of achieving an integrated Liverpool Health and Social Care system, and that transformation of health outcomes should be research and evidence based.

In the same way as the neighbourhood model has supported GP practices to work together it is also crucial to enable the coming together of these GP practice groups with other health and social care professionals voluntary, community and social enterprise partners. All of these organisations need to work together to shape and deliver joined-up local services in order to ensure real person-centred care.

To enable this more joined-up working, a number of modern models for integration will be considered and tested in the local health and social care economy. We have already begun to establish integrated health and social care services and teams, organised around GP practices in neighbourhoods. In addition to this, we are exploring innovative models of integration between some organisations in our system. One approach is the use of joint agreements, to purchase health and social care services. Similar arrangements have been developed to deliver a range of services for adults.

For people with the most complex health and social care needs, communities need a proactive approach to delivery of services which at their core are about providing the right local services in the right place for all. This means working together across health and social care to systemically identify vulnerable people at risk of a crisis or hospitalisation and working with them earlier to help them self-care and prevent this happening where possible.
The improvement in the number of newly diagnosed diabetics, aged 17+, who have been offered structured education in the last 12 months.
7.6% DELIVERING MORE SPECIALISED CARE IN COMMUNITY SETTINGS
We will also move more specialist health services that are currently offered from local hospitals. We want to do this because some specialist services that are traditionally provided in hospital can be safely and effectively provided in our communities. In future we will see more hospital consultants leading integrated teams in community locations and they will work more closely with General Practice and neighbourhood teams to show them how to provide more specialist support to those with highly complex conditions, without the person at the centre having to go into hospital. We are planning for specialist diabetes care, heart failure and COPD to be provided in this way.

Liverpool has prioritised six areas to improve health outcomes for the city – Mental Health, Healthy Ageing, Long-Term Conditions, Children, learning disabilities and Cancer. Each of these areas will have a community focus to ensure we achieve our goals for improvement. For example:
- a Community Reablement Team will provide a city-wide falls service as an alternative to hospital admissions;
- a new model of diabetes care will provide a one-stop shop for newly diagnosed people;
- children and family health hubs will provide joined-up care for children with complex needs;
- hospital doctors will work from community settings to provide more convenient clinics for people.

WHAT SHOULD PEOPLE EXPECT FROM THEIR COMMUNITY SERVICES?
We have identified a clear set of standards and anticipated benefits that demonstrate how this new model for community services will transform the experience of care for people and contribute to our outcome ambitions:

ACCESS
Between 8am and 6.30pm, Monday to Friday, everyone will have access to telephone triage with a GP within one hour in case of an urgent health need and an appointment on the same day.

Everyone with an urgent social care need will have access to social care within 2 hours, those with a less urgent need will be contacted within two days;

All health and social care partners will provide the same high standard of service in the day, night or at the weekend.

QUALITY AND SAFETY
Reduction in variation and health inequalities across the City.

People working in the service are recruited, organised, developed and supported so that they have the skills, competencies and knowledge to enable the delivery of high quality, safe and reliable care.

Identification of patients who are at risk of developing illnesses, and offering proactive prevention/management of conditions.

Identification of patients who are already ill and at risk of being admitted to hospital as an emergency, and offering proactive treatment to avoid unnecessary admissions.

All people who would benefit from a care plan will have one.

Delivering care to people so that they can die in their own homes with respect.

IMPLEMENTATION OF THE CARE ACT 2014
Social Care Services will have a duty to promote a person’s well-being.

People’s access to personal budgets will be formalised.

Counselling and advocacy will become Social Care services; funding will be available to provide these services for those who do not have anyone else to do this for them.

The whole family will be entitled to an assessment when assessing an adult’s needs.

Carers will have the same rights to assessment and support as those they care for.

Young carers aged 16-18 years old who are transitioning to adulthood will have a new right to have their specific needs assessed in light of how their role might change.
People newly diagnosed with Type II Diabetes have the opportunity to participate in a six-week ‘X-Pert’ Diabetes Programme, which enables people to develop a good understanding of their condition, supports them to self-care and encourages them to share their experiences. As it is a group session, it facilitates individuals to learn and support one another.

People often attend the sessions with misconceptions, myths and little understanding of what diabetes is and what the possible complications may be if it is not well controlled. One such patient sent a letter to Sarah-Jane Daley, Community Diabetes Specialist Nurse, telling her that the X-Pert Programme provided them with the “confidence to discuss their treatment with healthcare professionals, family and friends in an open and informed manner”.

Following on from attending the course the patient had lost weight and as a result achieved a healthy BMI and improved their overall glycaemic control.

“Having just completed a six-week X-Pert programme, I had to write and say what a wonderful job you are doing. I have to give particular praise to the educator who delivered the course with great professionalism but also humour, understanding and patience, which not only helped the group to relax and gel together, but to participate, share experiences and build trust in each other. I hope the work of the Diabetes Team is extended into schools, the workplace and GPs where your X-Pert knowledge could help so many people appreciate the value of a healthier lifestyle and avoid the pitfalls of diabetes.”
Our hospitals are already good. We will ensure they are excellent 7 days a week.

DR FIONA LEMMENS GP, NHS LIVERPOOL CCG
RE-ALIGNING HOSPITAL SERVICES

Doctors, nurses and other professionals are leading on the proposals for change.

PROFESSOR DONAL O’DONOGHUE  SECONDARY CARE DOCTOR, NHS LIVERPOOL CCG GOVERNING BODY

A key element of the Healthy Liverpool vision is for the city to have the best hospital services in the country. In determining the shape and content of hospital services we will be guided by the following principles:

- all patients will receive the right care in the right place first time;
- services must be of high quality and delivered to best practice quality standards;
- continuity and co-ordination of care will be maximised and any necessary transfer of care across hospitals optimised to reduce risks and improve the experience of patients;
- a safe healthcare system that provides a quality service and is sustainable financially and operationally into the future;
- equality for all, delivering safe care seven days a week.

The ambition of this vision must be set against the backdrop of a Liverpool health economy which, like many across the NHS in England, faces both challenges and opportunities. If we are to achieve our vision and design the best hospital-based care system in the country, we must first understand these drivers and then seek to design a system that is able to rise to the challenges faced and the opportunities available.

SUSTAINABILITY OF OUR HOSPITAL SERVICES

Liverpool’s health economy has a unique mix of hospitals, with eight NHS or NHS Foundation Trusts serving the city’s population. Like all hospitals they are subject to a variety of challenges including financial, operational, quality, workforce and regulatory.

The Liverpool hospital service landscape has largely evolved over time, rather than to a plan, which has resulted in duplication of services and a focus upon individual organisational performance and delivery rather than a co-ordinated and integrated whole system approach. Without change we believe our current hospital system is not best placed to respond to the future needs of local people or the wider health and social care system.

Achieving a sustainable, financially stable hospital provider landscape going forward is a key objective of the Healthy Liverpool Programme, as without such a foundation it is difficult to see how services can change and develop for the long-term benefit of patients.
8.2 LIVERPOOL’S SPECIALIST HOSPITAL SERVICES

Liverpool, unlike many cities, benefits significantly from having a high concentration of specialist trusts – Alder Hey, The Walton Centre, Liverpool Heart & Chest and the Clatterbridge Cancer Centre, with specialist services also provided in our two main acute providers the Royal Liverpool & Broadgreen University Hospital and Aintree University Hospital, and at Liverpool Women’s Hospital.

In planning for the future it is essential that we safeguard, nurture and develop the city’s role as a ‘centre of excellence’ for specialist services, which are not just for the people of Liverpool but also for residents of Merseyside and the region.

Liverpool CCG plays an active role in supporting current co-working arrangements to support the commissioning of specialised services, which is the responsibility of NHS England. The majority of specialist hospitals located in Liverpool provide services for people across the whole of Merseyside and further. As such, any options proposed by the Healthy Liverpool Programme for redesign of specialised commissioned services will be developed in partnership with neighbouring CCGs, NHS England and people from both within and outside the city who depend upon these services. Future option development will also be informed by nationally determined specifications for specialised services.

NHS England is exploring options for CCGs to take on an increased role in the commissioning of specialised services. We welcome the opportunity to co-commission higher volume specialised services in the city, as local decision-making will facilitate the process for improving hospital services in Liverpool. For example, to improve outcomes for cancer, our biggest killer, it makes sense to align the commissioning of high volume cancer treatments, such as chemotherapy, with other ‘non-specialised’ cancer services and priorities, to deliver improved cancer outcomes.

8.3 DELIVERING 7-DAY HOSPITAL SERVICES

The delivery of safe, effective and appropriate 7-day 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. The national agenda makes it clear, to quote NHS England Medical Director Sir Bruce Keogh:

“We have got to stop talking about ‘seven day working’, where the emphasis is on the people delivering the service. We have to talk about ‘seven day services’ and focus on the people receiving the services. This is about how and not about why.

SIR BRUCE KEOGH
MEDICAL DIRECTOR, NHS ENGLAND

Our approach is not just about addressing issues surrounding weekend working, but rather improving access to high quality services on every day of the week, in all our hospitals. This implies change in provider behaviours and organisation, informed by engaging with and listening to patients and the public. Our hospitals have begun the journey to improve collaboration and innovation to better sustain services across the city, with staff potentially in the future working across and between sites to deliver services to patients in an effective and efficient manner every day of the week.

8.4 CLINICIANS LEADING CHANGE

The development of the vision for a sustainable and deliverable system of hospital care has been led by local clinicians – doctors, consultants, nurses and other healthcare practitioners. As Liverpool’s hospitals frequently care for people who live outside the city boundaries, we have also engaged from the outset with colleagues from elsewhere in the Liverpool City region and beyond.
In achieving the best hospital care in the country we would expect to see the following benefits:
- enhanced patient experience and outcomes;
- first class general and specialist hospital services;
- reduced variation in service delivery quality, performance and outcomes;
- a safe healthcare system that provides a quality centred service for patients;
- a sustainable provider landscape for the future;
- a service delivery model that promotes a workforce that is sustainable, motivated and champions service quality and improved patient outcomes;
- a hospital care system that is complementary and supportive of the wider Healthy Liverpool Programme and other settings of care;
- a system that enables Liverpool to keep specialist hospital-based services in the city.

It has become apparent in discussion with clinicians that when considering the future of hospital services we will also need to examine the future shape of cardiology and stroke services. Both services are closely linked to the delivery of urgent and emergency care, the future landscape for community and acute services, prevention and rehabilitation. Therefore work will soon begin to consider the future direction for cardiology and stroke services, as well as the future delivery of elective care.

The future delivery of urgent and emergency care is being considered as part of a national review of major trauma services and also because of the challenges being experienced due to current service pressures across the city.

Our approach to determining the future shape of urgent and emergency care in the city has been informed by a number of individuals and organisations. A series of workshops with leading clinicians involved in the delivery of urgent and emergency care have been held to explore the current delivery and configuration of services; explore and develop the clinical standards for the future delivery of care, and to shape what the provider landscape in the city could look like.

We have not at this stage sought to identify individual options for future provider sites in detail, but instead have focused on the clinical standards we expect patients in the city should expect to receive to deliver the best urgent and emergency care.

The outcome of this clinically-led work is to develop a series of profiles or descriptions as to how services might be configured and delivered in the future. In developing the work we have initially prioritised a review of the following areas:
- urgent and emergency care;
- cancer;
- women’s health and maternity services.
We believe urgent and emergency care will be best served in future by a delivery model that sees patients benefit from services delivered from two adult emergency centres, one of which would provide Major Trauma services.

In essence, an emergency centre comprises hospital-based facilities that are able to receive the full range of emergency patients and which provide for resuscitation, diagnosis and onward referral where appropriate. Importantly, this service is under the continuous supervision of one or more consultants in emergency medicine, who have clinical accountability for this care.

Liverpool currently has two emergency centres and the proposed continuation of access to our two emergency centres in the city reflects the current and anticipated future demand for such care. It also takes into account the geography and needs of people from neighbouring areas, particularly South Sefton and the Kirkby area of Knowsley.

The proposal for a single major trauma service would offer specialist facilities that receive patients who have suffered trauma from other emergency centres or directly from an emergency ambulance, which in this case would include adult major trauma cases for Cheshire & Merseyside. There are other elements of specialist emergency care, such as hyper-acute stroke, which could be delivered from either or both emergency centres. Designations for other specialist emergency services will be the subject of further exploration by clinicians over the coming months.

In determining the shape of urgent and emergency care for the city we have taken into consideration issues such as patient activity, access, workforce, deliverability, service sustainability, clinical interdependencies and estate. Clinicians have also developed a schedule of minimum standards which outline the quality of care and service delivery that patients in the city expect.

Our aim is that services across the two emergency centres would be delivered on a collaborative staffing model basis, with staff working and interchanging across the two sites to deliver the best care 7 days a week, 24 hours a day, with maximum staff resilience, enhanced training, and improved recruitment and retention.

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**IMPROVING CANCER SERVICES**

Liverpool has the highest rate of deaths 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 local hospitals.

Cancer services across the city are currently provided by multiple providers across multiple sites, including the specialist medical oncology, diagnostic and radiotherapy resources of the Clatterbridge Cancer Centre (CCC) located on the Wirral.

A public consultation has been conducted by the CCC to seek to develop a new Cancer Centre on the Royal Liverpool Hospital campus site to serve the Merseyside and Cheshire Cancer Network (MCCN). This new cancer centre would provide all inpatient oncology beds for the Merseyside and Cheshire network, together with outpatient oncology services for those patients for whom the Liverpool site is the most accessible.

The proposed new cancer centre would operate as the hub, supporting a network of cancer services which would include a satellite centre at Aintree Hospital offering radiotherapy and other services, the existing cancer centre at Clatterbridge - which would continue to deliver outpatient cancer care to its local population on the Wirral and in West Cheshire - and the distributed network of outpatient and chemotherapy clinics operated in partner hospitals throughout the area. We strongly support the proposed development.

The specific service changes include:
- the creation of a new cancer centre on the Royal Liverpool campus, bringing together inpatient cancer services with critical care, other support facilities and a wide range of medical and surgical experts;
- the establishment of a new radiotherapy service in Liverpool and an overall increase in radiotherapy capacity;
- the relocation of complex outpatient radiotherapy from Wirral to Liverpool, representing about 6% of treatments given;
- an increase in the capacity of chemotherapy and outpatient services in Liverpool.
Whilst the new centre would provide a concentration of the majority of cancer services, cancer surgery is currently provided across the city in the Royal Liverpool, Aintree University Hospital, Liverpool Women's, Liverpool Heart & Chest, The Walton Centre and Alder Hey Hospitals. If the city’s ambition is to truly become a world class centre of excellence for cancer care, treatment and research it is appropriate to consider the case for the relocation of surgical cancer services onto the new central campus at the Royal Liverpool Hospital site, bringing together cancer services through a collaborative and integrated delivery model for the benefit of patients and their families.

It is however recognised that 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 development of the new Clatterbridge Cancer Centre, articulated below, mirrors the case for concentrating the delivery of the majority of cancer surgery on the Royal Liverpool Hospital site:

- better co-ordination of pathways of care for cancer patients by bringing together key 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;
- location of specialist services in one place, more easily accessible to the majority of patients;
- best use of NHS resources by enabling clinical teams to work more effectively and efficiently together;
- maintenance of other cancer services which are best delivered in more local settings, including other local hospitals and the community.

As with any proposed major service change, it is essential that a thorough and comprehensive analysis of the case for change is carried out involving all stakeholders and partners.

This would involve the clinicians who deliver services across all local providers, the multiple commissioners involved including local Clinical Commissioning Groups, NHS England in its role as a commissioner of specialised services; the Merseyside & Cheshire Cancer Network; patients, voluntary and community groups associated with cancer care and the wider population of Liverpool and Merseyside.

Our intention is to facilitate a detailed examination of the case for change in the way in which surgical cancer interventions are delivered, in light of the proposed development of the new Clatterbridge Cancer Centre on the Royal Liverpool Hospital site that is scheduled to open in 2018. The work to develop a detailed case for change will take place over the latter half of 2014/15.
8.9 WOMEN’S AND MATERNITY SERVICES

The city is unique in having a specialist women’s hospital, which the people of Liverpool view with great affection and pride. Currently the majority of births in the city, around 8,000 per year, take place in Liverpool Women’s hospital.

Women’s health services in Liverpool are good. However, if we aspire to have the best hospital based care in the system we need to consider how we can address the challenges of effectively delivering national clinical standards for 7-day services; meeting revised national service specifications for specialist services; dealing with changes in the training of doctors, all of which is putting pressure on acute hospital services.

Clinicians at the Liverpool Women’s Hospital are leading a review to explore how services for women could be improved to deliver even better outcomes.

One of the challenges to be addressed in this review is about access to general adult and paediatric services. There are a growing number of pregnant women with more complex health needs who need to be safely transferred by ambulance for treatment at a local acute hospital, often to the Royal Liverpool Hospital. This multi-disciplinary support by clinicians from other organisations includes haematology, cardiology, neurology, endocrinology and renal medicine. Support is also required from other trusts for complex diagnostic services, interventional and diagnostic radiology.

The Liverpool Women’s Hospital has a specialist (level 3) neonatal critical care unit which cares for 1,100 babies per year, some of whom are transferred from other units across Cheshire, Merseyside and beyond. Access to specialist paediatric services presents similar challenges to adult services. A review by clinicians from both the Women’s and Alder Hey Hospitals is developing proposals to address this challenge and to recommend a new approach to improve care for these patients. Despite some of the clinical challenges at Liverpool Women’s the Neonatal Unit continues to deliver high quality care for a high risk population.

Gynaecology services, including for cancer, are concentrated on the Liverpool Women’s Hospital site. As with maternity services, they are not co-located with other key specialties such as urology, general surgery, colorectal and specialist diagnostic services and level 3 critical care beds, which means that women have to be safely transported between different hospital sites, most often to the Royal Liverpool Hospital, although in some cases consultant staff from other hospitals will travel to support patient care. 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 consider a different model of care, which would improve outcomes for cancer patients.

The clinically-led work done to date has sought to describe the clinical challenges to the current delivery model for maternity and gynaecology services at Liverpool Women’s Hospital and how we might move forward to deliver the best care in a sustainable way for patients in the future. Work is ongoing to explore options for any proposed changes, informed by the inter-dependencies of women’s and maternity services with emergency medical care and the care of babies who require specialist hospital services.

Despite these challenges, evidence shows that patient outcomes are better than the national average in most indicators. Our aim is to achieve the best outcomes in the country.
Liverpool Community Health, which provides community services in Liverpool, are now able to access and share patient information with GPs using a platform called EMIS Web.

This has enabled Community Matrons to have full access to the GP’s Patient record. Previously, Matrons would have spent a lot of time either phoning GP surgeries or driving to the surgery to access information in patient notes.

This more efficient way of sharing information has benefited patients in a number of ways, including quicker diagnosis, which has helped reduce hospital admissions and improved patient safety, as clinical decisions on treatment are better informed due to access to the same information across Primary, Community, Secondary and Out of Hours settings. Karen Brogan Liverpool Community Health (LCH) Matron in Aintree has experienced how much of a difference this has made.

“I value EMIS Web sharing as it enables me to see everything relevant in the GP patient record in addition to other community services involved with the patient. I can see any recent changes to the patient’s medication, recent problems and known allergies. This helps me to make a more informed decision regarding the patient’s care. It is enabling us to spend more time with patients as I have the information I need at my fingertips!”

Karen Brogan  Liverpool Community Health Matron, based in Walton.
TECHNOLOGICAL INNOVATION

Liverpool will be the first place in the country to give our professionals, and the people they care for, access to the information they need, when they need it.

DR SIMON BOWERS  GP, NHS LIVERPOOL CCG

Our vision for joined-up, people-centred care will only be achieved by having access to high quality information, available in the right place, at the right time. One of the key enablers for this will be through the use of technology to share information and work collaboratively across settings of care and organisations.

Liverpool CCG will be investing to:

- create and deliver an information exchange across health and social care;
- ensure system-wide strategic leadership and alignment in informatics across the whole system;
- fully exploit the benefits and investment in existing technologies and processes.

Working with partners, including Informatics Merseyside and neighbouring CCGs, we will jointly deliver a Merseyside iLinks strategy to achieve a number of outcomes that will enable this transformation:

- electronic information will be available 24/7;
- information is relevant and available at the point of care in real-time;
- individuals can access and contribute to their own electronic record;
- working towards a ‘paper-light’ local health system.

WHY CAN’T WE?

There is a shared ambition and enthusiasm amongst health professionals to achieve an effective information exchange, to support improved, person-centred care and to support a culture where we share, moving to a focus on how do we? rather than why can’t we? Sharing information in this way will take us closer to the goal of a person only having to tell their story once.
HOW WE WILL DELIVER TRANSFORMATION

We have set out six programmes which, through effective re-design and focused investment, will drive the ambitious improvements in health outcomes that are so needed for the city.

10.1 TRANSFORMING MENTAL HEALTH SERVICES

THE CHALLENGES

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

50,900 adults (16–74) living in the city will experience anxiety or depressive disorders in any given year.

5,923 patients registered with Liverpool GPs in Aug 2014 had been diagnosed with schizophrenia, bipolar affective disorder or other psychoses.
Liverpool has amongst the highest levels of mental health need in the country. The prevalence of Severe Mental Illness (SMI) such as schizophrenia and bipolar disorder is the highest of the major cities outside London and significantly above national and regional levels. Estimates suggest Liverpool experiences the second highest prevalence of common mental illness in England.

Most mental health problems relate to depression and anxiety and can be predominantly managed in primary care. Smaller numbers of people experience more severe forms of mental illness which may require specialist input from mental health professionals and sometimes hospital based care.

The impact of mental illness on our healthcare system is significant. Liverpool has the highest rate of hospital admissions for mental health problems amongst the core cities of England and 1 in 3 consultations in general practice is related to mental health.

Service users and carers report that the system can often feel disjointed, lacking clear pathways and a lack of focus on supporting recovery – it can be hard to access services and then hard to exit services once in the mental health system.

We have established a clear vision for what we wish to achieve for people in Liverpool who experience a mental health problem:

Mental health services will operate as a seamless system of health and social care across the spectrum of severity, offering care which is holistic, timely and equitable, shifting the balance towards community based prevention and recovery.

We have embarked upon a transformation of support and service provision, working collaboratively with major stakeholders in the city, including Liverpool City Council; Mersey Care NHS Trust; the Voluntary Sector and the Police Commissioners Office. The key characteristics of a transformed mental health and well-being system will include:

- access to essential advice, assessment and treatment in a straightforward and timely way. There will be ‘no wrong door’ for mental health services for those in need. People with multiple needs, and their carers, will receive a ‘joined-up’ response from services;
- mental health will be integrated into long-term condition management and there will be greater mental health input alongside physical health support;
- effective and seamless collaboration between the NHS, social care and criminal justice system at the ‘front door’ of the crisis system;
- high quality mental health inpatient and specialist mental healthcare, available with capacity to meet the needs of the local population. There will be planned, adequate bed spaces delivered in modern, fit for purpose facilities, supported by multidisciplinary teams.
- Care will extend to integrated community based mental health support providing rapid diagnosis and treatment;
- there will be a focus on supporting families and social networks, building upon family and community support;
- improved supported accommodation and living services, enabling people experiencing mental distress to remain within their community and close to family and friends networks;
- greater focus on supporting people to move on from specialist residential and nursing environments into supported living environments (step down services) where it is safe and appropriate to do so.

We want to see person-centred, mental healthcare, with an emphasis on prevention, more community services and a focus on recovery.

Dr Nadim Fazlani  CHAIR, NHS Liverpool CCG
Significant progress is already being made with key developments across the system including:

- Benefits on Advice Service covering the whole of the city, focused on supporting the management of debt and income for people with mental health issues;
- delivery of a new model for psychological therapies;
- the opening of a new inpatient facility ‘Clock View’ providing a new assessment suite, expanded psychiatric intensive care unit and recovery wards;
- improved communication through better liaison across services;
- launch of Recovery College at Mersey Care NHS Trust, with over 400 students enrolled providing education and training as a route to recovery, and further plans for increasing provision across community based services.

MENTAL HEALTH SERVICES – WHAT WOULD SUCCESS LOOK LIKE?

- Reducing excess under 75 mortality rate in adults with serious mental illness.
- Increasing the number of people with severe mental illness who have received a list of physical checks.
- Increasing the proportion of people Mental Health Care programme approach to 95%.
- Decrease the number of delayed discharges from hospital because of mental health.
- Increase employment for people with mental health conditions.
- Decrease admissions to hospital for self-harm.
- Increase the proportion of people who have entered psychological therapy treatment against expected from 11.8% to 15% by the end of 14/15.
- Increase the proportion of people moving to recovery from 32% to 50% by the end of 14/15.

- Increase the proportion of adults in contact with mental health services living independently, with or without support.
- Increase employment for people with mental health conditions.
SUPPORTING HEALTHY AGEING

THE CHALLENGES

Liverpool’s population is living longer with an expected 9% growth in the number of people aged 65+ years by 2021, and particular growth in those aged 70-75 and 85+.

The estimated number of people living with dementia in Liverpool is predicted to rise by 10.7% by 2021. Nationally, it is estimated that each dementia patient costs the economy £27,647 per year; 55% of which is met by unpaid carers, 40% by social care and 5% by healthcare.

Liverpool has the second highest mortality rate for falls aged 65+.

Liverpool has the greatest level of unpaid carers among the core cities.

Older people are more likely to stay a long time in hospital, to experience delayed discharge, and to be readmitted within a month as an emergency.

Liverpool has a higher proportion of people dying in hospital compared to the national average.

Our aim is for people to be able to retain independence and live at home for longer, with the right support.

DR JIM CUTHBERT  GP, NHS LIVERPOOL CCG

Liverpool’s population, like that of every city in the UK, is living longer. As the population ages there will be more people living with health conditions that place increasing demands on health and social care.

Whilst the number of older people is expected to increase, the number of people of working age is expected to decline so there will be fewer people to provide informal care and economic support to the ageing population.

It is expected that more people will be living with one or more long-term condition, ill-health or disability; there will be increased demand for health provision and long-term care and a rise in the number of people entering a caring role.

Our vision for our older citizens in Liverpool is to keep them living at home for longer by helping them retain their independence with the support of care professionals and families. When people do need care, this will be of high quality, based on personal needs and delivered seamlessly across health and social care.
Jointly, Liverpool CCG and Liverpool City Council spend about £232m each year on health and social care for older people. Analysis shows that two-thirds of this expenditure is for care provided by ‘specialist’ providers such as hospitals and nursing or residential long-term care.

The health and care system is therefore skewed towards hospital and long-term care, so providing care reactively when people are in crisis and experiencing high levels of need with limited opportunities to increase independence.

We need to shift focus so that we identify issues and intervene earlier, before people enter crisis. That way, greater impact on health and care outcomes can be achieved.

Focussing on interventions which promote prevention, early identification, proactive care and self-management will be less costly and more effective. It will also, most crucially, improve the quality of life for older people.

Our reform of health and care for the elderly will focus on the following areas: improving care home provision and the clinical support which care homes receive; ensuring services are in place to support those with dementia; helping older people get better quickly, for instance after a fall, supporting carers of the older people, and providing end-of-life care in the best possible way, for instance in people’s homes.

We will ensure a successful and stable care home sector by creating clearly defined and specific service specifications including a quality and capability framework for care homes to ensure delivery of expected outcomes for residents.

There will also be a new clinical model to support care homes with dedicated care home community matrons and redesigned working arrangements so that homes are working closely with allied health professionals.

The proposed reforms of intermediate care and reablement services are designed to reduce the number of people being admitted unnecessarily to hospitals, reduce length of stay and delayed discharges in acute care, enable independent living in the community and prevent long-term placements in nursing care homes.

To do this, we are establishing frailty units at the Royal Liverpool University and Aintree Hospitals. These units will be staffed by a geriatrician-led multi-disciplinary team. Dedicated staff will work across the unit and the community to manage the discharge of patients from hospital and their onward care needs, providing continuity of care for patients leaving hospital.

There will also be a redesigned community reablement service to create a modern, integrated service that reduces the current over-reliance on hospital beds, providing care to more people in their own homes.

The Community Reablement Team will be commissioned to deliver a city-wide falls service within the community as a step up for general practice and an alternative to hospital for ambulance services.

To tackle dementia, we will create joined-up, high quality specialist services with the introduction of new working practices between secondary care specialist providers and GPs to create a clinical network for dementia. This will assure high quality care, seamless provision across organisational boundaries and standardised practice which will reduce variation in services.

We will also implement a comprehensive range of post-diagnostic support tailored to the needs of the person with dementia and their carers. For those requiring hospital stay or long-term residential needs, there will be increased assisted housing provision, excellent hospital care and high quality nursing care in care homes.

Good quality supportive and end-of-life care is important in ensuring that those people, and their families, approaching the end of their life are treated to optimise their quality of life with dignity and respect. One of the aims is to enable people to be supported and die in a location of their own choosing; research suggests many people would prefer to die in their home rather than in hospital.

Our reforms will ensure everyone has equal access to services that provide care at the end of life, supported by the provision of specialist palliative care consultants in the community.
### Healthy Ageing – What Would Success Look Like?

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
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<tbody>
<tr>
<td>Increasing the proportion of people who are still at home after 91 days after hospital discharge, from 79.7% to 82% in 2014/15.</td>
<td>This would be the equivalent to keeping 580 people at home.</td>
</tr>
<tr>
<td>Reduction in permanent admissions for over 65s to residential and nursing homes, from 737.3 (13/14) to 612.9 (15/16).</td>
<td>This would be the equivalent of keeping 87 people at home for longer.</td>
</tr>
<tr>
<td>Reduction in emergency admissions for vertebral and hip fractures of 25.6% (167) by 2018/19 amongst those aged 65-79/80-plus.</td>
<td>Reduction in permanent admissions for over 65s to residential and nursing homes, from 737.3 (13/14) to 612.9 (15/16). This would be the equivalent of keeping 87 people at home for longer.</td>
</tr>
<tr>
<td>Measurable improvements in patients’ experience of primary care/hospital care/integrated care.</td>
<td>A reduction in emergency admissions to hospital for people from care homes by 40% (985 admissions) by 2018/19.</td>
</tr>
<tr>
<td>An increase in the estimated diagnosis rate for people with dementia from 58% to 64% by March 2015 and 70% by March 2016.</td>
<td>A reduction in emergency admissions for people at the end of life of 29.3% (738) by 2018/19.</td>
</tr>
<tr>
<td>Reduction in people dying in hospital from 56.5% to 40% by 2018/19 and increase in those dying at home from 22.9%.</td>
<td>Reduction in emergency admissions for people at the end of life of 29.3% (738) by 2018/19.</td>
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</table>

There will be a new clinical model to support care homes with dedicated care home community matrons and redesigned working arrangements.
Cancer mortality rates have fallen by 10% in Liverpool since 1993 but nationally they have fallen by 20%. Liverpool has one of the highest cancer mortality rates in the country.

In 2010 there were 2,584 new cases of cancer in Liverpool – an 8% increase on the number recorded in 2001. The main causes were lung, colon, prostate and breast cancer.

Lung cancer accounts for 12% of the gap in life expectancy for both males and females.

New cases of malignant melanoma of skin have more than doubled over the last decade from 48 to 99 in Liverpool, whilst nationally there has been just a 65% increase.

In 2010, 78% of female patients in Liverpool who were diagnosed with breast cancer had survived the disease after 5 years but nationally that figure was 84%.

Research suggests that up to half of all cancers could be prevented by changes to lifestyle behaviours.

Early diagnosis and people living well are how we will reduce deaths from cancer.

**Dr Ed Gaynor, GP, NHS Liverpool CCG**

Over our lifetimes it is estimated that one in three of us will develop some form of cancer. As the population lives longer, this figure is expected to increase further. It is a major contributor to the gap in life expectancy between Liverpool and England. Latest analysis suggests that lung cancer alone accounts for over 12% of the gap in life expectancy for both males and females.

Cancer has now replaced cardiovascular disease as the biggest killer in Liverpool, with more than three out of 10 deaths in 2011 being attributed to the disease, equating to 1,297 residents. Against many measures, the city does not compare well with the rest of the UK when it comes to the incidence of cancer and the survival rates.
Our approach to addressing Liverpool’s biggest killer is built upon two fundamental principles. One is that early diagnosis of cancer is the best way of improving patient outcomes – the quicker the disease can be treated, the better the chances of survival. The other is that up to half of all cancers could be prevented by changes to lifestyle behaviour.

So we must put in place the measures which encourage and assist people to live healthier lifestyles and ensure people are educated about the signs and symptoms of cancer.

This public education and information drive will be supported by systematic and expanded screening for cancer and the right services and support for patients as they undergo diagnosis, treatment and recovery. This includes bringing cancer treatments closer to home.

So our vision is that Liverpool residents will understand and appreciate the risk factors associated with cancer and know the signs and symptoms of the disease. They will feel confident to approach their GP early and we will have the right systems in place so that they are seen quickly by high quality staff. Patients will also have support around lifestyle and recovery issues no matter what kind of cancer they have or where they live in the city.

Screening is key in Liverpool for diagnosing cancer, although uptake remains low. Through increased uptake for screening programmes and availability of screening, the aim is to reach national targets for breast, cervical and bowel cancer screening. We will also ensure flexible sigmoidoscopy is available to detect upper gastro-intestinal cancers in patients most at risk.

We also intend to launch a major lung cancer campaign – ‘Liverpool Fights Lung Cancer’.

CT scans to screen for lung cancer will be proactively offered to those at highest risk in deprived areas, therefore targeting inequalities. Currently about 2,700 people have been identified who will be invited to take part in the lung cancer screening programme. Populations at high risk of lung cancer will be targeted for stop smoking campaigns and raising awareness of signs and symptoms of lung cancer.

These initiatives will lead to an increase in people being diagnosed at an earlier stage of disease; increased one and five year cancer survival rates; a decrease in under 75 mortality and a reduction in inequalities and gap in life expectancy across the city.

A range of campaigns for the public and primary care health professionals will raise awareness of the lifestyle risks which can cause cancer and the signs and symptoms of different types of the disease. We will improve the tools available to primary care professionals so that they are supported to help diagnose cancer earlier.

A key element of future cancer care in the city will be ensuring patients are able to access the best cancer care and most advanced treatment, facilities and equipment as close to home as possible. The Clatterbridge Cancer Centre has proposed developing a new site alongside the Royal Liverpool University Hospital to deliver more services close to Liverpool patients. This co-location will mean patients being treated closer to home, better integration with the Royal’s services and access to world class specialist and expertise.

Work is also underway to ensure improved pathways and access to diagnostic tests for lung, colorectal, upper gastro-intestinal and ovarian cancers which will ensure that patients receive the correct test first time and that they are seen more quickly, diagnosed faster, and treated quicker.

Systematic cancer screening will be expanded to support a public education and information drive.

The number of deaths in Liverpool attributed to cancer in 2011.
## Tackling Cancer – What Would Success Look Like?

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target</th>
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<tr>
<td>Seeing less than 90% of patients waiting 62 days from referral from screening service to first definitive treatment.</td>
<td>Reduction in waiting times from referral to treatment</td>
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<tr>
<td>Seeing less than 85% of people waiting 62 days from urgent GP referral to first definitive treatment.</td>
<td>Improvement in access to definitive treatments</td>
</tr>
<tr>
<td>Seeing less than 93% of people waiting 2 weeks from urgent GP referral to first outpatient appointment.</td>
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<tr>
<td>Reducing the under-75 mortality rate for cancer.</td>
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<tr>
<td>Increasing bowel cancer screening rate to 60%.</td>
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<tr>
<td>Increasing breast cancer screening rate to 70%.</td>
<td></td>
</tr>
<tr>
<td>Increasing cervical cancer screening rate to 80%.</td>
<td></td>
</tr>
<tr>
<td>Increasing 1 and 5 year survival rates for breast, bowel and lung cancer.</td>
<td></td>
</tr>
<tr>
<td>Reducing smoking prevalence from 25.2 to 20.2 by 2020.</td>
<td></td>
</tr>
<tr>
<td>Increasing the number of people who stop smoking.</td>
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</table>

A key element of future cancer care in the city will be ensuring patients are able to access the best cancer care and most advanced treatment facilities and equipment as close to home as possible.
A family-centred approach is the only way to address Liverpool children’s needs. We will enable families to access help early and on their terms.

**DR SIMON BOWERS** GP, NHS LIVERPOOL CCG

Managing the health and well-being of children is complex and challenging, requiring a patient-centred approach and close working between multiple parties, including education, health and social services professionals. Child health and well-being is closely related to poverty and to societal issues. Outcomes for children and young people in Liverpool are poor, with the health and well-being of children in the city generally worse than the England average and the level of child poverty, though improving, also worse than the England average.

There are also particular challenges which must be addressed. For instance, Liverpool has one of the highest emergency admission rates for asthma and epilepsy (patients 0-17yrs) and also one of the highest rates of A&E attendances in children under five years.

Currently there are inconsistencies in the way care is planned, commissioned and delivered across the many partners involved. Patients and their families tell us that they experience fragmentation, duplication, lack of clarity and uncertainty.
With growing demand and rising expectations, the current system is unsustainable and unfit for purpose. We need to develop a co-ordinated and integrated approach to maternity and children’s health and social care services, which will result in improved experiences and better outcomes. This approach will encompass a cohesive, holistic, family-based model so that, where necessary, we address an entire family’s needs rather than just an individual child’s needs.

We also need to ensure systems are in place so that young people requiring ongoing care are supported during the transition to adulthood and beyond and do not ‘fall off’ the health and care system radar.

Access to uptake of universal services needs to be optimised. Our objectives are to intervene as early as possible where a child has needs and to take a multi-agency co-ordinated approach to preventative and early intervention services. Designated teams with identified lead professionals will manage a child’s care and we will deliver care in neighbourhood and community settings when that is most appropriate.

One of the key initiatives that will enable the identification of children with health and care needs is through the establishment of a common assessment framework so that all public service professionals in the city – including health, social services, police, fire and education professionals – are using the same criteria and tool to assess a child’s potential needs. The ‘early help assessment tool’ was launched across the city in October 2014. This initiative, alongside the development of the early help locality hubs in January 2015, will support earlier intervention.

We also plan to establish three children’s and family neighbourhood health and care hubs in Liverpool, from which child healthcare needs will be co-ordinated across different agencies, delivering services close to home. A “virtual” team will be created within each hub and this will reflect the specialties and services that are able to support and manage care delivery closer to home, where appropriate and safe. The team will incorporate services such as those provided by health visitors, social workers, school nurses, therapy services, community midwives, community paediatrics and others.

Where a child has serious health and social care needs, a dedicated lead professional will be responsible for ensuring they receive joined-up care from the various bodies and professionals concerned in that child’s well-being.

Another initiative which is being developed is the establishment of a comprehensive database of every child in the city who is likely to require care into adulthood. That database will be used to ensure those individuals continue to receive the right care after they reach the age of 16.

We are also conducting a pilot around paediatric asthma in the community which would bring care and education professionals together to help families manage the illness and, ultimately, reduce the number of emergency admissions to hospital of children experiencing asthma attacks.

Another priority is to ensure children with complex neurodevelopmental needs and mental health problems are properly cared for. Addressing such needs at the earliest possible opportunity can prevent them worsening as the child grows older.

An integrated and comprehensive pathway for young patients with mental health issues is already being commissioned in partnership with schools, Alder Hey NHS Foundation Trust and the Voluntary Sector. This focuses on self-care and early intervention. This new approach is delivering much improved outcomes and will be expanded so that it has more capacity in the future.

Using the Royal College of Paediatrics and Child Health Invited Reviews Programme, plans are being developed to define a model of integrated care delivery. The model will focus on optimising safeguarding functions whilst improving the interface with other clinical services, so that the journey between primary and secondary care is seamless.
CARING FOR CHILDREN AND YOUNG PEOPLE – WHAT WOULD SUCCESS LOOK LIKE?

- A reduction in children’s admissions for Asthma by 28.8% by 16/17.
- A reduction in emergency attendances in secondary care.
- A reduction in waiting times for children’s community equipment services from 6 months to days.
- 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 ages 10-11.
- An increase in the number of women breast feeding at 6-8 weeks.
- A reduction in the number of women smoking at time of delivery.

TRANSFORMING CARE FOR CHILDREN AND YOUNG PEOPLE

ADVICE AND GUIDANCE (IAG) SERVICE

“I am a 16 year old male. I first came to YPAS when I was 15, I have attended the anger management group and received counselling and had support from the IAG service.

“I was having a bad time with my family, having arguments all the time and fighting at school and where I live. I couldn’t concentrate at school and wouldn’t do any of the work. The IAG service and the anger group helped me build my confidence back and it felt OK being in a group for the anger course and looking at my bereavement in counselling.

“My family have noticed a positive change in my behaviour and I can concentrate more at school. My angry outbursts have got less and not as bad as they used to be. I used IAG and Counselling to help me cope better without making everyone feel distressed.”
DELIVERING JOINED-UP CARE FOR PEOPLE WITH LONG-TERM CONDITIONS

THE CHALLENGES

- 30% of people in Liverpool (141,000 people) live with one or more long-term condition. Of these, 12% (16,000) live with 3 or more conditions.
- The incidence of diabetes is predicted to grow by as much as 23% by 2030.
- Over 10,000 people are living with long-term conditions in Liverpool that are undiagnosed and unmanaged.
- The cost of emergency admissions for long-term conditions in Liverpool is over £21m.
- In 2012-13 Liverpool was in the bottom 25% of CCGs nationally for avoidable emergency admissions. Highest admitting conditions include COPD and angina.
- There are currently 14,499 people over 40 diagnosed with chronic obstructive pulmonary disease in Liverpool and 26,952 people with asthma.
- There are 18,464 people over 40 diagnosed with coronary heart disease in Liverpool, 3,936 with heart failure, 8,914 who have had a stroke and 7,848 who have atrial fibrillation.

"We need radically new approaches to support the 30% of people in the city who live with long-term conditions."

Dr Janet Bliss, GP, NHS Liverpool CCG

As Liverpool’s population lives longer there will be more people living with long-term conditions – often two or more conditions at the same time – which require ongoing treatment and care.

And, whilst there has been improvement in line with national trends, cardio-vascular disease (CVD) and respiratory disease remain two of the biggest causes of premature mortality in Liverpool. Emergency admissions rates for angina, chronic obstructive pulmonary disease (COPD) and diabetic complications remain some of the highest in the country.

So there remains room for improvement in the management of outcomes related to long-term conditions.
conditions such as management of blood pressure and cholesterol in CVD-related conditions and severity testing in COPD.

There is also wide variation in performance across the city. For instance, the number of people with diabetes receiving the nine care processes required to manage their condition varies between 20%-80% depending on what neighbourhood they live in. Cholesterol management of people with coronary heart disease varies between 61% and 73% and the number of COPD patients offered rehabilitation varies between 24% and 79% depending on the neighbourhood.

We want to reduce the variation in management of long-term conditions at primary care level and ensure patients can be supported by specialist community-based teams and access care much closer to their homes. We also aim to increase the number of patients using rehabilitation services, improve access to testing and diagnostics and improve the way patients are advised and educated about their conditions so they can better care for themselves.

New methods of commissioning services are being considered as a way of ensuring payment for services is linked to patient outcomes and to incentivise different service providers such as health trusts and GPs to ensure they work together more closely in the patients’ interests.

Evidence tells us that one of the keys to successfully managing long-term conditions is to ensure care is properly integrated so that primary care, community-based care and specialist care services are working together to support patients.

We also know that supporting people to look after themselves – through education and access to care close to home – is critical if people are to stay independent and successfully manage their conditions.

Diabetes, respiratory disease and cardio-vascular disease (including stroke) are priority areas for reorganisation and work is already underway to better structure services across these areas.

Planned care of diabetic patients is shared between primary, secondary and specialist community care. Services are commissioned separately for activity based contracts, rather than commissioned jointly for population health outcomes. Work has started on an integrated outcomes-based contract which has now been implemented and incentivises providers to work together more closely.

One of the main initiatives being developed to improve diabetes care is the establishment of 11 neighbourhood centres where patients can access specialist consultants and the range of other health professionals who might be concerned in their care, such as dietary or podiatry experts.

This way, patients will be able to access a ‘cluster’ of care more easily and care plans will take a people-centred approach and be designed with an individual’s needs in mind.

These specialist consultants will also play a role in educating other health professionals about diabetes issues and take a lead role in helping to support and advise people who are able to self-manage their condition. There will be an enhanced set of tools available to people with diabetes to assist in self-management including information packs and structured education programmes.

Routine management of COPD and asthma is undertaken in general practice. In 2012 a Respiratory Nurses Crisis Response Team was launched so that it could visit patients in the community and assist them before their conditions got so worse that they had to attend hospital.

That service is to be expanded to weekends and evenings so that even more patients can be helped, not just to prevent episodes getting so bad that an emergency admission is required, but also to give ongoing advice so patients can better look after themselves. It is expected that an extra 85 people would avoid emergency admission by expanding these opening times.

We will also be increasing the capacity of our pulmonary rehabilitation service, increasing the referrals it receives and making it more accessible for patients. This service helps people manage their COPD and reduces emergency admissions and deaths from the disease.

Our spirometry service – which diagnoses the effectiveness of a patient’s breathing – is to be made more accessible so we can make diagnosis and monitoring more accessible. The service, which is currently available in eight sites in the city, will be made available in a minimum of 18 sites.

To manage asthma better, we will be focusing on reducing the number of severe asthma attacks.
experienced by sufferers. This will reduce emergency admissions and help keep patients well as each attack causes further lung damage. We’ll do this by instigating a systematic outreach campaign using methods such as text messaging to persuade patients to receive care and advice from a new specialist-led, asthma nurse and GP service.

For cardio-vascular disease, a range of improvements are being explored.

There is to be improved screening and prevention of stroke for patients with atrial fibrillation (irregular heartbeat) and high blood pressure.

Through simple pulse checks, we predict an increase in the percentage of over-65s who have received a pulse check in the last 12 months from 67% to 82.3% by 2018/19 so these patients can get care which will help to prevent strokes. This is the equivalent of screening an extra 11,249 people.

Using a new risk assessment tool, we also aim to increase the percentage of patients with atrial fibrillation being prescribed an anticoagulant (clot-busting drug) from 81.7% to 90.9% by 18/19. This is an extra 297 people, which could prevent nine strokes. We believe there are 4,338 patients eligible for anticoagulation who are currently not receiving it.

There will also be improved access to and expansion of a community cardiac rehabilitation service so that the number of patients receiving cardiac rehab will increase from 881 to 1,800 per year by 2018-19.

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### Long-Term Conditions – What Would Success Look Like?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Target 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing potential years of life lost</td>
<td>24.2%</td>
</tr>
<tr>
<td>Reducing avoidable emergency admissions</td>
<td>15.3%</td>
</tr>
<tr>
<td>Improving quality of life in patients with long-term conditions</td>
<td>8.4%</td>
</tr>
<tr>
<td>Increasing the number of people being offered cardiac rehabilitation</td>
<td>881 to 1,800</td>
</tr>
<tr>
<td>Increasing the cardiac rehabilitation completion rate</td>
<td>57% to 80%</td>
</tr>
<tr>
<td>Reducing coronary heart disease emergency admissions</td>
<td>18.3%</td>
</tr>
<tr>
<td>Increasing the number of people with CHD who are on a statin</td>
<td>85.1% to 88.8%</td>
</tr>
<tr>
<td>Increasing the number of patients on the pulmonary rehabilitation programme</td>
<td>238 to 700</td>
</tr>
<tr>
<td>Increasing the percentage of patients receiving spirometry diagnosis for COPD and Asthma</td>
<td>26.9%</td>
</tr>
<tr>
<td>Reducing COPD emergency admissions</td>
<td>26.9%</td>
</tr>
</tbody>
</table>
We are challenging the unacceptable inequalities faced by people with learning disabilities.

JANE LUNT  CHIEF NURSE, NHS LIVERPOOL CCG

People with learning disabilities have poorer health, die younger and do not receive the same quality of healthcare as those without such disabilities.

In addition, some may have a range of additional and very complex needs such as challenging behaviour or profound and multiple learning disabilities.

It is estimated that as much as 2% of the population are people who have a learning disability, although some will not be known to health and social services. In Liverpool, just over 2,000 adults are identified on GP registers with a learning disability.

The Healthy Liverpool Programme is giving particular consideration to services for people with learning disabilities because they tend to die younger and experience poorer health than the general population.

We believe these differences are to a large extent avoidable so represent a fundamental health inequality.
Our vision is therefore that people with learning disabilities have the same access to the same quality healthcare as the rest of the population, that they have a positive experience of treatment and care, with better health outcomes, and when the need for specialist services arises that the need is recognised and met promptly.

We also want people with learning disabilities who display challenging behaviour to receive skilled, sensitive and competent support to maintain them in their local communities wherever possible, with less need for hospital admission or costly out of area placements.

Evidence suggests the health needs of people with learning disabilities are overlooked by mainstream services.

Mortality rates for people with learning disabilities are three times higher than the rest of the population with the cause of premature deaths not to lifestyle related illnesses but to inequality in healthcare.

Access to health checks, screening programmes and subsequent care planning can be poor and we have found that awareness is limited amongst health professionals of issues relating to decision-making, treatment and consent for patients with learning disabilities.

It is also the case that people with learning disabilities who have challenging behaviour can spend far longer as in-patients than necessary because of a lack of appropriate local preventative and skilled community-based support services.

In the future, mainstream health services in Liverpool will be better equipped to meet the needs of people with learning disabilities through understanding how to make reasonable adjustments to take into account a learning difficulty.

We will also invest in more Learning Disability Primary Healthcare Facilitator resource to support GP practices identify patients with learning disabilities and ensure they have access to health checks and screening.

This will help us improve the number and quality of annual health checks which are delivered, with clear links to an updated health action plan for each individual.

There will also be specific learning disability liaison posts within each of the NHS Trusts whose role is to ensure that there are systems and processes in place which enable the identification of people with learning difficulties as they enter either hospital and community services so that any reasonable adjustments that need to be made to enable the person to access care are undertaken.

These measures will help us ensure improved access to the full range of health services, including health promotion and advice, so reducing health inequalities experienced by people with learning disabilities and helping them live longer.

The needs and rights of patients with learning disabilities will be better understood and respected by health professionals and there will be better care co-ordination and better planning of hospital discharges.

For those with challenging behaviour who need secure accommodation and care we will enable investment in local support services. This will be aligned with additional focus on preventative and positive behavioural support teams to work alongside families and care providers dealing with challenging behaviour.

There will be fewer breakdowns of care packages for people in supported accommodation and a marked reduction in the use of costly out of area hospital placements.

People with learning disabilities and/or autism who have challenging behaviour will receive more timely support from local services and, critically, will experience greater continuity and less disruption and be able to maintain links with their home, family and neighbourhood.

The number of adults in Liverpool identified on GP registers with a learning disability.

2,000
Suzanne, a trained nurse, decided to work with people who can sometimes face exceptional difficulties. Her role revolves around improving access to healthcare for those with learning disabilities.

She says: “It’s a sad fact that people with learning disabilities die sooner and face barriers, which make it harder for them to access support. They can often be the first to ‘fall between the cracks’ in the health system.”

The important thing in her view is that the health professionals who treat people with learning disabilities understand and therefore overcome those barriers to good care.

She says: “There is a strategic role to be undertaken to ensure that training and education is given to healthcare workers so that they know how to recognise and respond to the needs of people with learning disabilities.”

Whilst staff like Suzanne can and often are powerful voices in this regard, ‘self-advocates’ have some of the most lasting impact on professionals. Inviting someone who is experiencing learning disabilities to talk to trainee medics can make a difference that endures throughout those medics’ careers.
Liverpool, along with most health systems, is anticipating a future strain on finances if future growth in resources does not match the expected increase in demand arising from an ageing population and other pressures which have been described in this document. By 2020 this gap in funding is estimated to be £120m, based on an assumed need of £1.3billion.

Although Liverpool is likely to face future financial challenges, Liverpool Clinical Commissioning Group, and the Primary Care Trust before it, has a good track record of delivering efficiency savings through effective redesign and robust financial management.

For 2014/15, the CCG has the second highest efficiency target in the country at £27.1 million, which represents 3.6% of its budget. We are on track to deliver these efficiency savings this year and our target for 2015/16 is £25.8 million. This successful drive to achieve efficiencies, whilst continuing to improve local services means that these savings can be invested to support the transformation ambitions of the Healthy Liverpool Programme.

Liverpool CCG is planning to invest at least 10% (£70m) of its annual budget in transformation programmes across the health economy, between 2014/15 to 2018/19.

To kick-start this programme of investment, the CCG Governing Body has created a Healthy Liverpool Transformation Fund of £90m to be made available during the two year period 2014/15 and 2015/16. Informed by the comprehensive engagement we will have with Liverpool people and stakeholders, we will develop a detailed financial plan that will target these additional resources in order to maximise the impact of our transformational programmes.
THE HEALTHY LIVERPOOL ROADMAP

“We want people in Liverpool to get involved at every level; helping to shape our plans and telling us about their experiences of care.”

DAVE ANTROBUS  GOVERNING BODY MEMBER, NHS LIVERPOOL CCG

The Healthy Liverpool Programme has undertaken substantial engagement with a wide range of stakeholders, including clinicians, patients and the public, in the last 12 months. This early phase engagement was intended to support and influence the development of the case for change and to begin considering future models of care for health and care services.
We will soon commence a further, intensive period of engagement with patients, people who live and work in Liverpool, with NHS and partner organisations and other groups with a general or specialist interest in the future of health and care services in the city. Over the latter part of 2014/15 we will be facilitating a city-wide debate about the Healthy Liverpool case for change and asking for detailed feedback about what you think about:

- the ambition of our proposals;
- the proposals for transforming our local system around the three settings of care; living well, community services and hospital services;
- the priorities we have proposed to transform mental health; to support healthy ageing, long-term conditions, care for children and young people, people with learning disabilities and cancer.

This next phase of engagement will be supported by an awareness-raising campaign to ensure that everyone with an interest in the future of Liverpool’s health and care system is equipped with the information they need to provide informed feedback.

The winter 2014/15 Healthy Liverpool Engagement Programme will inform the ongoing development of options which will come together in a detailed business case which will be published next year. Depending on the nature of the proposals there may be a formal public consultation on elements of these proposals, which would take during the second part of 2015.

In order to achieve our vision, the people of Liverpool have to be at the centre of decisions made about their own health and well-being; this is the essence of person-centred care.

We will assess all service change proposals to ensure they pass four stringent tests, to ensure:

- there is strong public and patient engagement in relation to the proposals;
- they are consistent with current and prospective need for patient choice;
- there is a clear clinical evidence base to instigate the changes;
- there is support for the proposals from clinical commissioners.

We want to speak to as many people as possible in the coming months to understand their experiences of health and care services in Liverpool and to get their views on what our priorities should be. A dedicated website has been set up – www.healthyliverpool.nhs.uk – where people can find further information and you can get in touch with us in a number of ways:

**HAVE YOUR SAY**

Write: Healthy Liverpool, Liverpool CCG, 1 Arthouse Square, Seel Street, Liverpool L1 4AZ

Email: healthy.liverpool@liverpoolccg.nhs.uk

Phone: 0151 296 7000

Twitter: @HealthyLvpool

Everything we do will contribute to social value and sustainability for health and the local economy.

PROFESSOR MAUREEN WILLIAMS  DEPUTY CHAIR, NHS LIVERPOOL CCG
REFERENCES AND ADDITIONAL SOURCES

13.1 STATISTICS AND DATA
10. Local prevalence data, extracted from GP Practice Systems August 2014.

13.2 POLICIES

13.3 ADDITIONAL SOURCES
**A**  
**A&E** - Accident & Emergency - where people receive treatment for medical and surgical emergencies, which are likely to need admission to hospital.

**Acute hospital** - these are hospitals that usually provide short-term treatment, for patients with any kind of illness or injury that requires urgent attention.

**Cardio-vascular disease** - is a class of diseases that involves the heart, the blood vessels (arteries, capillaries, and veins) or both.

**Care plan** - a care plan is an agreement between a patient and their health or care professional to help them to manage their health, day-to-day. It can be a written document or something recorded in a patient's notes.

**Chronic Obstructive Pulmonary Disease (COPD)** – is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

**Clinical Commissioning Group** - these are the organisations, led by GPs, set up by the Health and Social Care Act 2012, to plan and design local health services. They do this by "commissioning" or buying health services including:
- planned hospital care
- urgent and emergency care
- rehabilitation care
- community health services
- mental health and learning disability services

**Clinician** - a health professional, such as a doctor, or nurse, involved in clinical practice.

**Commissioner** - organisations or individuals authorised to buy health services for the benefit of patients accessing the NHS. Commissioning is about getting the best possible health outcomes for the local population by assessing local needs and then buying services on behalf of the population from hospitals, clinics, community health services etc. Clinical Commissioning Groups are commissioners for certain types of care.

**Core Cities** – England’s 9 largest cities outside of London, including Liverpool, joined together to give a united voice for the importance of cities in delivering the country’s full economic potential, creating more jobs and improving people’s lives.

**Critical care** - the specialised care given to patients who are critically ill and whose conditions are life threatening.

**Dementia** - a broad category of brain diseases that cause long-term loss of the ability to think and reason clearly that is severe enough to affect a person’s daily life.

**Determinants of Health** - the different social, economic and personal factors determine a person’s quality of health. This could include education, housing and income.

**Diagnostics** – tests which patients undergo to help doctors find out what’s wrong e.g. a blood test.

**District nurse** - provide care within the community to service users such as wound management, medication advice, palliative care and catheter and continence care.

**Evidence-based** - emphasises the use of evidence from well-designed and conducted research in healthcare decision-making.

**General Practice** - part of primary care services, general practice includes your family doctor (a General Practitioner GP) and other health services including nurses that care for you often in GP surgeries and in your home.

**Health Inequalities** - avoidable inequalities in health between groups of people.

**Health outcome** – a change in the health of an individual or group of people which can be attributed to an intervention. For example, the survival of a patient treated for cancer.

**Healthy Liverpool Programme** – the city-wide programme which aims to transform health and care services over the next 5 years.
**Health and Well-Being Board** – a forum where key leaders from the health and care system work together to improve the health and well-being of their local population and reduce health inequalities.

**Integrated care** – a term also used to mean ‘joined-up care’ (see below).

**Intermediate care services** – the range of services provided by the NHS and Local Authorities to help people, generally older people, to avoid going into hospital unnecessarily and help them be as independent as possible after leaving hospital.

**Joined-up care** – the whole range of health and social care services working together to meet people’s needs. For example, caring for elderly people in their homes.

**Joint Strategic Needs Assessment** – the Joint Strategic Needs Assessment is developed jointly by Local Authorities and CCGs. It looks at the wider determinants of health to establish current and future health needs of the local population.

**Liverpool Health Partners (LHP)** – LHP is the organisation responsible for planning the services, research programmes and teaching activities carried out by the University of Liverpool with its NHS health partners.

**Long-term conditions** – are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes or dementia.

**Multi-disciplinary team** – a team of health professionals with different areas of expertise who meet to determine the care plan for an individual service user or patient.


**North West Coast Academic Health Science Network** – one of 15 academic health science networks in England. It works as part of the NHS to enable innovative products to spread quickly and successfully through the health and social care system.

**Paediatric services** – this refers to healthcare services for babies, children and adolescents.

**Palliative care** – an approach that improves the quality of life of patients and their families facing problems associated with serious illness and care at the end of life.

**Primary care** – services which are normally the main or first point of contact for a patient. For example: GP surgeries, dentists, pharmacists, and optometrists.

**Portal** – a website that serves as a gateway or a main entry point to IT systems.

**Provider** – individuals and/or organisations who provide a service to the NHS e.g. hospitals, clinics, community health bodies.

**Social Care** – the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

**Specialised services** – services that are provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. Specialised services account for approximately 14% of the total NHS budget. The commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England.

**Telecare** – use of technology to enable care to be provided remotely for patients. For example, a consultation with a GP by video or by telephone, or where patients are monitored remotely such as when a fall sensor in a patient’s home triggers an alert to a central team.

**Urology** – surgical specialty that investigates and treats the urinary tract system.
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