One Liverpool: 2018-2021

The Long and Winding Road to a Healthier Life

'Veeee... the long & winding road to healthy life expectancy'

Healthy Life Expectancy for women 57.7 years Liverpool, 64.1 years nationally

Healthy Life Expectancy for men 57.4 years Liverpool, 63.4 years nationally

Social Contact
Accessing appropriate care
Mental well being

Inhibits due to falls over 60 per 100,000 population
Liverpool 1,112
England 821

Warm Home
Fuel Poverty
Employed

Long term unemployment Liverpool 0.16%
England 0.37%

Eating 5 or more portions of fruit and vegetables per day
Adults
Liverpool 32%
England 57%

Not regularly drinking alcoholic adults who are drinking over 14 units of alcohol a week
Liverpool 29%
England 25%

Physically active
Adults who are physically active
Liverpool 64%
England 65%

Maintain a Healthy weight
Adults who are overweight or obese
Liverpool 69%
England 62%

Not regularly drinking alcohol
Adults who are drinking over 14 units of alcohol a week
Liverpool 29%
England 25%

Self-harm
Emergencies admissions for self-harm aged 16-24 years per 100,000 population
Liverpool 4.0%
England 4.1%

School Readiness
Liverpool 74%
England 86%

Looked after children
Rate per 10,000 live births
Liverpool 7.2%
England 7.4%

Healthy Weight for 5-10 year olds in year 6
Overweight and Obese children Liverpool 25.6%
England 22.1%

Young adults in education, training or employment
6-18 years old in education, training or employment
Liverpool 86%
England 80%

Doing well at school GCSE attainment
Liverpool 50%
England 48%

Not smoking during pregnancy
Liverpool 18.9%
England 15.3%

Healthy Birth weight babies
Liverpool 2.9%
England 3.5%

Breastfeed your baby
Breastfeed babies at 6 weeks
Liverpool 32%
England 41%

Child Attendance
Attendance rates
Liverpool 96.7%
England 96.7%

Child Vaccinations
MMR vaccination
Liverpool 95.6%
England 98.8%

Key
CC = English Core Cities

Image Source: Liverpool City Council
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1 Introduction

This document sets out proposals for *One Liverpool*, an integrated, place-based strategic plan for Liverpool.

*One Liverpool* is a whole-system plan, setting out how partners will come together to deliver improved health in our city. We will collaborate to establish integrated services that will better meet people’s needs and ensure that our local health and care system is financially fit for the future.

Partners have come together around three main aims: a radical upgrade in population health and prevention; integrated community services; and sustainable acute and specialist services.

We need to take action now across all settings of care; embedding prevention, self-care and early intervention; transforming community services to enable people to get the care they need, when they need it with a broader offer that takes into account their social and economic needs and ensuring that our hospital services offer consistently high quality services that are fit for the future.

Our outcome ambitions are for all-ages and incorporate parity of esteem for mental health. We also need to tackle the long term health inequalities that leave the vulnerable and disadvantaged in our city with a poorer experience of care, fewer years of healthy life and earlier death. This has to change.

Partners will adopt a ‘One Team’ ethos, uniting primary care, social care, community physical and mental health services and the voluntary sector; utilising our collective resources and pulling in the same direction.

This plan sets out our high level aims. There is more collective needed to agree detailed operational delivery plans setting out how we will deliver the change we want to see. This will include city-wide conversations about our aims and ambitions and getting people involved in a social movement for better health.

In delivering *One Liverpool* we will need to work differently. For commissioners this means taking a strategic role in setting the outcomes the system will need to deliver and tasking providers increasingly to find the solutions. We will work together over the coming weeks to agree a plan for transitioning to these new ways of working.

It is important now that we come together with greater urgency to deliver the ambitions of *One Liverpool*.
2 Our Challenges
Liverpool faces a number of challenges in our efforts to improve health and services. A review of Liverpool’s Joint Strategic Needs Assessment (JSNA) has given us a fresh understanding of health and wellbeing need in Liverpool, providing essential insight to inform our plan.

A Growing and Ageing Population
Liverpool is resurgent after many years of economic decline; yet high levels of deprivation endure in parts of our city and people still die younger than in other parts of England.

Liverpool has a relatively young population when compared to the rest of the country, with an average age of 37.7 years compared to 39.8 years for England.

There are around 484,600 people living in Liverpool, a 9.7% increase in the population since 2001, representing a welcome shift in the long term trend of population decline. In April 2016, there were 514,630 people registered with a Liverpool GP, an increase of 7.1% (34,280) people over the last ten years. Projections suggest the increase in the number of Liverpool residents will continue to increase, with an estimated population of 510,000 by 2030. Although our population is growing, it is doing so at a lower rate than many other areas. Over the next ten years plus, the largest population increase is predicted in people aged 65 and over (27.1%), which presents a challenge for the local NHS and social care, with an expected increase in health issues affecting older people, including long term conditions, cancer, dementia and injuries due to falls.

Deprivation and Inequalities
Liverpool is one of the most deprived areas of the country, with more than 4 out of 10 people living in the 10% most deprived neighbourhoods in England. Deprivation is strongly associated with poor health outcomes, from childhood through to old age. We know that people in our more deprived communities begin to experience poor health and require care from a much younger age, leading to significant health inequalities between Liverpool and the UK as well as within our city, where the difference in life expectancy is 10 years between the poorest and most affluent wards. Liverpool is a diverse city and people can experience inequality in health, access to healthcare and quality of health services. For example, people with a learning disability on average die 20 years younger than people without a learning disability. We have a collective responsibility to tackle discrimination and advance equality.
Health and Wellbeing
A review of the health of our population tells us:

- There were 4,500 deaths in Liverpool in 2016, 1000 of which were attributable to smoking
- 1,800 of these people died young
- 1,000 of these deaths were preventable
- Our biggest killers are cancer (30%), Cardio-Vascular Disease (20%), Respiratory Disease (15%)

People in Liverpool live shorter lives than the national average, and spend a greater proportion of their life living with disability and poor health. Measures for healthy life expectancy - not just whether years are being added to life, but life added to years - highlight that our population spend a quarter of their life living in poor health.

Healthy life expectancy for men in Liverpool is 57.4 years, and 57.7 years for women. As our older population grows, our main challenge will be to achieve significant improvements in healthy life expectancy – keeping more people well for longer.
Cancer, cardio-vascular disease and respiratory conditions are the main diseases that kill in Liverpool.
The main diseases that rob people of healthy years of life in Liverpool are poor mental health, cardiovascular and respiratory disease.

Source: Public Health Epidemiology team, Liverpool City Council
**Long Term Conditions**
The majority of diseases that impact on years of healthy life in the city are long term conditions (LTCs). The number of people diagnosed with LTCs in Liverpool is above national levels for cardiovascular disease (CVD), respiratory disease, diabetes, dementia, cancer and kidney disease. We also know that these figures understate the true extent of the situation, with many people undiagnosed.

**Mental Health**
In Liverpool, over 66,000 people have a mental health condition, with depression, anxiety and serious mental illness depriving many of a good quality of life. Deprivation contributes considerably to poor mental health. For individuals and their families it can mean disrupted lives, limited life opportunities, financial hardship, poor education and employment prospects and social isolation.

**Children and Young People**
Children and young people represent 33% of Liverpool's population. The Liverpool Joint Strategic Needs Assessment (JSNA) tells us:

- There were 5.2 infant deaths per 1,000 live births in 2014-2016, significantly higher than the England rate.
- One in seven mothers smoke at the time of the delivery, compared with one in nine nationally.
- Only 54% of Liverpool mothers initiated breastfeeding and only 32% were breastfeeding 6-8 weeks after the birth of their baby, compared to national figures of 74% and 43% respectively.
- Liverpool has a high rate of A&E attendances for children aged 0-4 years, 60% higher than England.
- One in four of our children aged 4-5 years were either overweight or obese.
- Only 6 out of 10 Liverpool children have a good level of development at the end of their school reception year, compared with 7 out of 10 nationally.

Too many of the city’s children face a difficult start in life. We know that adverse experiences in early life often shape a child’s future, leading to a greater risk of social, emotional and cognitive impairment, influencing negative health behaviours, a higher risk of disease/disability and earlier death.
Understanding What Makes a Population Healthy

Good clinical care accounts for only 20% of what makes us healthy. The main factors that determine good health are healthy behaviours, socio-economic factors and our environment. This is seen in the diagram below, which sets out the things that positively influence longer, healthier lives in Liverpool.

Source: Public Health Epidemiology team, Liverpool City Council
Traditionally, the focus by the NHS has been on improving clinical care. Whilst this remains a priority, it is clear that we need to do a lot more to tackle non-medical issues. This has also been a consistent message from the public through previous engagements.

### 2.1 The System Challenge

Liverpool has a diverse and complex health and care system, with eight NHS provider trusts including 2 large adult acute hospitals within 5 miles of each other, a children’s acute trust, a women’s acute trust and four specialist trusts, located in the city but serving the wider region. The key partners within the Liverpool health and social care system are:

- Liverpool City Council
- NHS Liverpool CCG
- 92 General Practices
- Urgent Care 24
- Mersey Care NHS FT
- Liverpool Community Health NHS Trust (transacting to Mersey Care, April 18)
- Alder Hey Children’s Hospital NHS FT
- Royal Liverpool Broadgreen University Hospital NHS Trust
- Liverpool GP provider organisation.
- University Hospital Aintree NHS FT
- Liverpool Heart and Chest Hospital NHS FT
- Liverpool Women’s Hospital NHS FT
- The Walton Centre NHS Foundation Trust
- North West Ambulance Service NHS Trust
- 3,055 voluntary sector organisations; 1,332 of which are registered and some 1,723 are 'below the radar' organisations.

There is significant variation in quality and duplication in services, both clinically and non-clinically. We also have a complex commissioning system and a large, but fragmented voluntary, community and social enterprise (VCSE) sector.

Over the last five years our health and social care system has been on a journey of change and integration, driven by the need to address significant challenges in delivering better care and improving clinical standards. We have made good
progress on this journey but in the next three years a further step change is needed in order to achieve better outcomes.

2.2 The Financial Challenge
The Liverpool health and care system is facing increasing financial challenge with both commissioner and providers experiencing significant pressures.

From a commissioner perspective, LCCG has experienced a difficult recent period, needing to deliver increased levels of cash releasing savings (£13m and £26m, in 2016/17 and 2017/18) in order to deliver its financial targets. Social care and prevention has also been impacted by reductions in central government funding to Liverpool City Council, with overall funding reduced from £523.7m in 2010/11 to £246m in 2019/20, representing a real terms reduction of 64%. The current NHS provider financial position is expected to further deteriorate when the 2017/18 picture is declared over the next few weeks.

 Whilst the CCG ‘resource’ allocation is expected to rise to £918.3million by 2020/21 (from £888.1million in 2018/19) based on current allocation growth assumptions, NHS and social care budgets are subject to on-going pressure from increasing demand, new treatments, innovation and increasing costs. An initial estimate of the Do-Nothing gap for the North Mersey System was estimated at £352m over a 5 year period and current financial performance would indicate broad alignment with those trajectories.

In order to support transformation, NHS commissioners and providers across Liverpool (and the neighbouring areas of Sefton and Knowsley) came together to ‘Act as One’ by agreeing fixed price contracts for 2017/18 and 2018/19, in order to share the risk of managing increased demand and to support a shared plan to find longer term transformation solutions. This two year all-system deal is testament to the strong collaboration that has developed in our health system, with providers and commissioners collaborating to address the challenges we will face in the years ahead. Our aim is to build upon this trust to agree joint approaches to making best use of resources beyond 2018/19.

This partnership approach to addressing financial pressures is also demonstrated by the pooling of NHS and Council budgets within the Better Care Fund, to maximise the impact of our joint resources at the interface of health and social care. Liverpool health and care commissioners are currently exploring the opportunities that could arise from further integration of commissioning.
2.3 Our Environment

NHS Five Year Forward View
The NHS Five Year Forward View (5YFV), published in October 2014, set out the key opportunities and challenges facing the NHS and the need to take a longer term approach to planning to ensure the NHS remains clinically and financially sustainable. The Forward View highlighted three key aims:

• Better Health - improving health and wellbeing;
• Better Care – improving quality and the experience of care; and
• Better Value - maximising efficiency and financial sustainability.

The NHS planning Guidance: ‘Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21’ tasked health and care systems to develop place-based plans. In March 2017 NHS England published The Next Steps on the NHS Five Year Forward View, which provided further clarity and focus on particular areas of care – cancer, mental health and GP access; the need to manage demand and ease pressure on hospitals, with a focus particularly on supporting frail and older people. One Liverpool is informed by and incorporates the strategic approaches and must-dos set out in the Next Steps.

Health & Care Partnership for Cheshire & Merseyside
The NHS Five Year Forward View established a network of health and care system partnerships across the country. The rationale for these partnerships is to accelerate the implementation of the NHS 5 Year Forward View. One Liverpool partners are members of the Health & Care Partnership for Cheshire & Merseyside, which includes 9 local authorities, 12 CCGs, 20 NHS providers, GP Provider Federations and Place-based Care Systems.

The Cheshire and Merseyside Partnership provides strategic direction for matters that are better undertaken at a larger scale, including overarching financial stability, capital prioritisation, acute sector sustainability, prevention at scale, commissioning at scale, workforce planning, system development and clinical networks. The main focus for strategic change will be through the development of integrated, place-based systems of care, which are locally-led on a Liverpool footprint and represented in the One Liverpool Plan.

One Liverpool aligns with the plans of the Health and Care Partnership. We will ensure that change programmes delivered at scale are recognised, complemented and supported and that there is no duplication of effort or in resources to deliver.

3 Healthy Liverpool Legacy

Healthy Liverpool was the CCG’s five-year transformation programme to transform health and services in the city. The programme was established to enact the recommendations of the Mayoral Health Commission. Healthy Liverpool’s vision was to improve the health of people in the city; supporting more people to stay well for longer and providing the very best treatment and care when needed. A review of has been undertaken to understand its impact in improving outcomes and to identify lessons learnt to inform how we can effectively plan and deliver well in Liverpool.

The review of outcomes undertaken indicates that Healthy Liverpool has been successful in achieving a range of clinical service improvements, particularly programmes which have held back demand for hospital services. We have had less success in tackling the long term challenge of premature mortality and reducing health inequalities, with preventable mortality continuing to increase, and the inequalities gap as wide as ever.

Now is the time to build upon the system collaboration and maturity that has developed through Healthy Liverpool and to use this learning and the good progress we have made as springboard to go further and faster in achieving system integration and better outcomes for our city.

4 Our Vision, Aims and Objectives

The vision for One Liverpool is a whole-system vision for all partners with a role to play in delivering our objectives:

Partners in Liverpool will come together to create a ‘One Team’ ethos and a place-based system change for better health, reduced inequalities and maximising the impact from our shared resources

Our Aims

One Liverpool has three transformational themes:

- A radical upgrade in population health and prevention
- Integrated community services, bringing communities to life
- acute and specialist services sustainability

³ [http://liverpool.gov.uk/media/8680/healthcommissionerport2.pdf](http://liverpool.gov.uk/media/8680/healthcommissionerport2.pdf)
Outcome Ambitions

We will continue to strive for ambitious improvements in health outcomes for the people of Liverpool. Our ambitions are to:

1. Reduce Avoidable and Early Deaths  
2. Increase Healthy Years of Life  
3. Reduce health inequalities  
4. Improve Quality of Life and Ability to Self-care  
5. Reduce Demand for Hospital Services  
6. Establish Seamless, pro-active care; integrating services across health and social care  
7. Improve the delivery and experience of care  
8. Achieve parity of esteem between mental and physical health  
9. Ensure children have a good start in life  
10. Ensure a financially sustainable health and care system for the city

System partners are working together to set measurable targets for our shared outcome ambitions, some of which are already set through the operational planning process and others soon to be determined. The measures we will use to measure success are:

<table>
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<tr>
<th>Outcome</th>
<th>Measure</th>
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<tr>
<td>Ensuring children have a good start in life</td>
<td>Improving the infant mortality rate</td>
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<td>Improving levels of school readiness with a higher percentage of children with a good level of development</td>
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<td>Improving levels of childhood obesity (ages 10-11)</td>
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<td>Reducing premature mortality from Cancer, CVD and Respiratory Disease and improving healthy life expectancy</td>
<td>Improving the healthy life expectancy rate</td>
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<td></td>
<td>Improving the premature cancer mortality rate</td>
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<td></td>
<td>Improving the premature CVD mortality rate</td>
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<td></td>
<td>Improving the premature respiratory mortality rate</td>
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<td>Reducing health inequalities</td>
<td>Reducing the gap between Liverpool and England for the key premature mortality indicators</td>
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<td>Achieve parity of esteem between mental health and</td>
<td>Increasing the proportion of people with a Mental health condition receiving a list of physical checks</td>
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<td>physical health</td>
<td>to 60% by 20/21</td>
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<td>Increase the proportion of people accessing IAPT services to 25% by 20/21</td>
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<td>Maintain the dementia diagnosis rate at 70% of expected</td>
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<td>Improving quality of life and ability to self-care</td>
<td>Improving the average EQ5D Quality of Life score to the Right Care peer average of 70% by 20/21</td>
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<td>To maintain the upward trajectory of the proportion of people who report they are in control of their Long Term Condition, achieving 68.8% by 20/21</td>
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<tr>
<td>Social care measure</td>
<td></td>
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<tr>
<td>Reduced demand for hospital services</td>
<td>Achievement of the demand management of activity plans for planned and unplanned care by 20/21 (see appendix 3 &amp;4)</td>
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<tr>
<td>Unplanned: reduction in falls, CVD, Respiratory, Mental Health, alcohol and avoidable admissions</td>
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<tr>
<td>Planned: reduction in Gastro, MSK, CVD duplicate diagnostics and Procedures of Limited Clinical Priority</td>
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<tr>
<td>Seamless proactive care, integrating services with health and social care</td>
<td>Reducing delayed discharges by 20/21</td>
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<td>Reducing permanent admissions to care homes</td>
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<td>Increasing the number of people still at home 91 days after discharge from reablement services</td>
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**Principles:**

Working with our partners, we propose a set of principles to guide our approach to system collaboration:

- **We will empower people to take more control of their health:** supporting people to stay well; enabling people to do more for themselves and ensuring that no decisions ‘about me are made without me’.

- **We will focus on whole-person care:** integrating our response to all of a person’s needs - physical, psychological and social.

- **We will break down the barriers to integrated care:** working in unity with our partners to achieve seamless care; putting the interests of people above the needs of organisations.
• **We will simplify complexity**: improving access to the right care in the right place and providing care navigation for people who need it.

• **We will plan for the right care in the right place**: delivering more hospital-based services in our communities.

• **We will maximise community assets**: making full use of the rich and diverse assets that exist in our city neighbourhoods, recognising that health and wellbeing is influenced not only by health and care services, but also social, cultural and economic factors.

**Values**

We propose a set of core values to guide our conduct and interactions with each other, with staff and people:

• **Accountability**: We will accept responsibility for our actions. We will make decisions through evidence and sound systems and processes, and we will deliver our intentions.

• **Equity**: We will be fair in our interactions with patients, public, staff and partners.

• **Integrity**: We will act with honesty and transparency in all our actions. We are committed to a teamwork environment, where everyone is valued, encouraged to contribute and recognised for their efforts.

• **Listening**: We will actively listen and act upon feedback from our communities, staff and partners.

• **Collaborative**: We will ensure our partnerships are positive and constructive, in the pursuit of shared goals.

• **Progressive**: We encourage innovation and continuous improvement in all services.

• **Value**: We will target our resources in the most effective way to ensure maximum value. We will tackle inappropriate care; address unwarranted variation in clinical practice and use evidence of to find better ways of delivering care and support services for specific patient groups.
5 Our Strategy – One Liverpool

Despite having excellent community and hospital services, a thriving VCSE sector and high quality social services, we are not solving the city’s intractable health challenges; particularly preventable deaths and years of healthy life, and we are not making inroads into health inequalities.

We know that individuals and families with the most complex needs experience multiple interventions from different services and agencies and yet all too often remain trapped in repeating cycles of intervention. People’s lives and associated health problems are increasingly complex and require services to work together in order to be effective, but all too often individual organisations offer services in isolation.

Health and social care organisations in Liverpool have a unique opportunity to create a ‘One Team’ ethos and a place-based system change to achieve better health outcomes, uniting primary care, social care, community, physical and mental health services and the voluntary sector.

In addressing the challenge of health inequalities, our actions must be universal, but with a scale and intensity that enables us to tackle high levels of disadvantage in some parts of our city, informed by the principle of proportionate universalism ⁴.

In order to achieve this there’s a need for fundamental changes in how we commission and provide health and social care and we want to forge a new deal with wider partners and with our population.

We are working together to develop and implement the One Liverpool plan, which sets out how we will harness the collective influence and resources of the NHS, Liverpool City Council, the housing sector and other public partners, VCSE organisations and the people of Liverpool to pull in the same direction, working to a clear vision and aims to improve health and wellbeing.

- One Liverpool will be about Liverpool people and the place, above the needs of organisations;
- One Liverpool will scale up our ambitions around prevention, early intervention and self-care;
- One Liverpool will improve and re-shape primary, community and social services, building upon the Healthy Liverpool community model of care, as the cornerstone of place-based care;
- One Liverpool will implement the vision for high quality, single services for our acute and specialist hospitals;
- One Liverpool will find solutions to address the clinical and financial sustainability challenges we face as a whole health and care system.

One Liverpool has three transformational aims, which will frame how we prioritise, deliver and invest in order to deliver our objectives for better health.

6 Radical Upgrade in Population Health and Prevention

“If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.” Simon Stevens, Chief Executive, NHS England

Good health and wellbeing are about more than healthcare. A good start in life, education, decent work and housing and strong, supportive relationships all play their part. Economic prosperity is integral to closing the health gap. It can create jobs for local people, bring benefits to their children, help their family to stay well and as people get older, help them to live at home for longer. Good health is also a product of the decisions we make about what we consume and the way we live our lives. But more importantly, good health is an investment in a vibrant economy, with positive consequences on downstream health and social care costs and broader social and economic impacts.

In any system of care, primary prevention is the most efficient way to reduce cost and improve outcomes. We know that 40% of the NHS workload is potentially preventable, yet the proportion of health expenditure directed at prevention is around 4%.

Recent study shows that that every pound invested in prevention yields a return of £14.

A consistent message from Liverpool people in recent years of engagement has been strong support for more preventive approaches, more co-ordination across partners and partnership with patients. There has been a call to address non-medical issues which influence health, particularly social isolation, stress, anxiety and poverty.

The big challenge is how we harness resources across the city to address inequalities in healthy life expectancy and reduce the burden of disease. We believe that the most efficient way to do this is by investing more upstream and putting in place structural interventions that influence healthy choices and reshape people’s physical and social environment to support wellbeing.

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We also believe that a life-course approach is central to this aim, recognising that health outcomes in early childhood play a significant part in health outcomes in adulthood and older age.

Liverpool’s health and care system has a multitude of assets, including outstanding facilities and people who are passionate about delivering good care, but we are not maximising our collective potential to address the intractable health problems in our city. It is beyond the ability of any one organisation or sector to influence the wider determinants of health so we are calling for a much greater degree of integration. The role of Liverpool City Council is crucial, along with other public services, business, academia, and most importantly the people of Liverpool as engaged participants.

*The One Liverpool* approach to prevention will integrate the Liverpool Mayoral Inclusive Growth Plan, the aim of which is to harness the support of local businesses, employers and residents to maximise the value of the Liverpool Pound and to see the distribution of work, prosperity and opportunity spread more fairly. The Inclusive Growth Plan has six aims, all of which have the ability to positively impact upon the health of our population:

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<th>AIM 1</th>
<th>AIM 2</th>
<th>AIM 3</th>
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<tr>
<td>1. <strong>Investing in our future citizens</strong>&lt;br&gt;All our children and young people enjoy the best possible quality of life and are able to reach their full potential</td>
<td>1. <strong>People who live well and age well</strong>&lt;br&gt;Improve health and wellbeing for all, prevent ill health, promote independence and provide quality personalised care and support for those who need it.</td>
<td>1. <strong>Thriving neighbourhoods with quality homes</strong>&lt;br&gt;All residents feel a sense of belonging and wellbeing living in a safe and sustainable neighbourhood with access to a good quality home</td>
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<th>AIM 4</th>
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<td>1. <strong>A strong and inclusive economy</strong>&lt;br&gt;An increasingly modern, productive and fair economy where the benefits of growth are more equitably shared amongst all citizens</td>
<td>1. <strong>A smart, connected and accessible city with quality infrastructure</strong>&lt;br&gt;Smart, clean, accessible and integrated infrastructure that meets the needs of a modern and productive city and its residents</td>
<td>1. <strong>Liverpool - The most exciting city in the UK</strong>&lt;br&gt;Growing Liverpool’s reputation as a cultural and sporting capital and the most exciting city in the UK in which to live, visit, work, study and invest</td>
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**Our collective actions will include:**

- Preventing ill health by delivering healthy public policies and changing behaviour to increase healthy lifestyle choices. Our ‘Health in all policies’ approach aims to
make every individual’s default decision healthy, including supporting parents to make healthy choices for their children.

- Developing a chronic diseases prevention programme which delivers prevention at scale.

- Developing an integrated pre-birth – 19 healthy child programme, incorporating a programme of action for the first critical 1001 days and working with partners to maximise school readiness. Our aim is for all our children to be safe, healthy, active and happy; that they have a voice and to demonstrate our ambition by becoming a UNICEF Child friendly City.

- Strengthening arrangements to protect the health of the population to prevent and control infectious diseases, including antimicrobial resistance; screening and immunisation; emergency preparedness and air pollution.

**What do we want to achieve?**

- To reduce health inequalities within the city, and between Liverpool and the rest of England

- To increase healthy life expectancy, and particularly amongst those with the poorest healthy life expectancy

- A measurable improvement in mental and physical health and wellbeing

- More people moving into economic activity and employment

- Reduction of avoidable spending on downstream NHS and social care services.

- A sustained reduction in the infant mortality rate, narrowing the inequalities gap within the city and between Liverpool and the rest of England

- Increase the proportion of children at a good stage of development for school

- Reduce the prevalence of obesity among children in Reception and in Year 6

Prevention needs to be everybody’s business and we have to find ways of resourcing and supporting up-scaled prevention programmes in the face of continued pressures in our health and care system. This will require creativity and a long term commitment to improving healthy life expectancy.

**Our action now is to develop an integrated, One Liverpool population health plan which sets out our ambition; the measurable changes we want to achieve; evidence-based integrated programmes of delivery and how we will come together to do this.**
7 Integrated Community Services

Community services play a vital role in people’s lives, with around 100 million community contacts taking place nationally each year, ranging from universal public health functions such as health visiting and school nursing, social care and primary care. There has been a long standing ambition to shift more health care from hospitals to settings closer to people’s homes.

Our Community Model of Care, jointly agreed by Liverpool CCG and Liverpool City Council commissioners, was introduced in 2015 and is the basis for the integration of community based, health and social care services within the city. The model recognises the limitations of statutory services in delivering better outcomes and articulates a focus on prevention; self-care and an asset based approach.

The ongoing transformation of community-based care incorporates primary care, community, social care, mental health and acute services, the city’s VCSE organisations and other key players such as housing associations, schools, business, the Police and Fire and Rescue Service.

By creating effective and resilient community services, for all ages - children, young people and adults, we will enable a shift of care from our hospitals to care delivered closer to home, reducing demand for acute services and providing more upstream support to keep people well.
Implementation of the model of care through the establishment of integrated neighbourhoods and interventions including telehealth, has had considerable impact on managing demand for hospital based care and improving quality and experience for patients and carers. Although we have made good progress, we now need to increase the pace of implementation and ensure the model of care is systemised across the city.

At the heart of the community model are integrated Community Care Teams (CCTs), which bring together Community Nursing, Primary Care, Social Care, Mental Health and other professionals to deliver a joined-up approach to the delivery and planning of care. We have established a neighbourhood-based approach in all 12 neighbourhoods across the city. Our neighbourhoods have been designed around natural communities within the city, but also reflect where individuals are registered with a general practice, which we consider to be cornerstone for effective care co-ordination. We will deliver high quality list-based GP services, with practices working “at scale” as part of the integrated community model of care and delivering a consistent and universal offer for all. Success in delivering the community model will be predicated on general practices collaborating to deliver this care on a population basis.

The newly established ‘Liverpool Provider Alliance’ provides the basis for providers to work together in new ways to take this forward with renewed energy and with pace.

The Provider Alliance vision is to work together as one team to provide the best possible services for our communities. From cradle to grave, we will look to improve health and wellbeing and promote greater independence.

Building on progress made in Liverpool and informed by the evidence base from integrated care, providers in Liverpool will focus on the following areas to improve local health outcomes.

- **We will empower those with long term conditions to take more control of their own health.** 80% of people using health services are now cared for in low acuity setting, where the overwhelming control is with the person/child/family. We will enable people to do more for themselves, helped along by people who are sensitive to the strengths and circumstances of that individual and through relationships developed over time that are based on behaviour change. We will maximise the use of technology, scaling up the use of teleheath to ensure Liverpool remains at the forefront of deployment nationally and internationally.

- **We will provide whole-person care through a bio psychosocial approach.** Psychological needs and social circumstances are a strong but often overlooked driver of a person’s health needs and their use of public services. There is overwhelming evidence that developing an integrated response to people with both mental and physical health problems, in particular supporting people with common
mental health problems alongside a physical long-term condition could dramatically improve outcomes and reduce cost. Addressing people’s psychological needs can enhance their motivation to make healthier choices and take more control over their own health, particularly for long term conditions. A key initial focus will be on the homeless population, severe mental illness and people with complex alcohol problems. Local data clearly demonstrates that these groups experience poorer outcomes than the general population including significantly higher levels of premature mortality, high use of emergency care, and difficulties in accessing services.

• **We will break down existing barriers between primary, community, hospital, mental health and social care, to create a streamlined experience for patients and avoid duplication.** The integrated model of care is not about the ‘bolt-on’ of other services to providers existing service portfolio, but a genuine integration of functions and services in order to deliver significant benefits for patients. This will require aligned infrastructure, clinical governance and resources. We believe that such an approach will enable providers and commissioners to achieve significant efficiencies by deploying existing staff and teams differently, shifting resources to more preventative interventions, and stopping ineffective interventions.

• **We will maximise community assets.** We are clear that to improve health and wellbeing we will need to deliver much more of a ‘social model of health’ that addresses the broader influences on health, social, cultural, environmental and economic factors. Liverpool CCG has commissioned a range of non-medical programmes that the provider alliance will build upon, developing the existing neighbourhood structure to actively engage health and social care teams with their local communities, involving other agencies to actively work together to improve the health and wellbeing of communities.

• **We will make the health care system simpler, particularly for those with complex needs.** We will stop the practice of different specialists treating patients in isolation to their total needs by co-ordinating care through designated Care Coordinators within the locality integrated care team. Innovative approaches will be implemented to provide more specialist and targeted support where it is clear that the universal care offer is not delivering positive outcomes.

• **We will pull specialist services out of hospital settings to be delivered as close to the patient/community as possible.** Following on from the successful integrated diabetes pathway, we will work with clinicians from local acute and specialist trusts to redesign stroke, cardiology and respiratory pathways. Hospital specialists will work with community care teams to ensure people are getting timely specialist access and assessment.
Provider Alliance Priorities for 2018/19

The Provider Alliance has identified six priority themes for 2018/19:

- **Proactive care at a neighbourhood level**
- **Early specialist assessment**
- **Priority pathway redesign and implementation**
- **Mental health and physical health integration**
- **Maximise community assets**
- **Support self care and a new deal with local people**

**Proactive care at a neighbourhood level - actions:**

- We will review the effectiveness of the community care teams and develop a revised model through engaging stakeholders
- We will roll-out a new model of community care teams from April 2018
- We will specify the role of hospital specialists in community care teams

The implementation of the community care model will be based on the neighbourhood approach already adopted, which recognises that there are very different health and social care needs within the city. The basic building blocks of our model are the three North, Central and South Liverpool localities and the integrated community care teams that sit in 12 established neighbourhoods across Liverpool, each covering populations of 25-55,000.

General practice is the cornerstone of integrated neighbourhoods as it the central point for cradle to grave care. Furthermore, the significant intelligence held on GP information systems can be used to proactively care for patients and to target resources and services to those in need. Our approach to integrated neighbourhoods is set out below:
Early specialist assessment - actions:

• **We will specify the role of hospital specialists in the community care teams.**

• **Working with general practice and hospital specialists, we will pilot specialist outreach for intensive disease management support in respiratory and heart failure by April 2019.**

• **Working with general practice and hospital specialists, we will pilot post-discharge specialist outreach for CVD and respiratory by April 2019.**

Merseyside has a number of well-established NHS Trusts with strong relationships with the public and services, networks and partnerships that have been developed over a decade or more. Mersey Care, Royal Liverpool University Hospital and Aintree University Hospital already have touch points with cohorts of patients who
have the most complex physical health, mental health and social needs in the local population. If harnessed through the community care teams, these specialists give us the predictive capability to develop a model of care that anticipates and proactively co-ordinates care for these high-end users of services. The Provider Alliance will integrate clinical specialist input so that people can be treated closer to home, re-aligning secondary care specialist community teams to our neighbourhoods, and establishing clearer pathways for patients to access specialist advice, assessment and intervention. Outpatient clinics will be reduced and increasingly run in primary care settings. We will also develop clearer thresholds throughout the system to access specialist care.

**Priority pathway redesign and implementation - actions:**

- **Provider alliance clinicians will redesign and implement a shared frailty pathway by October 2018**

- **Provider alliance clinicians will redesign and implement a new urgent care pathway by March 2019, taking into account the review of urgent care treatment centres**

- **Provider alliance clinicians will redesign long-term respiratory and cardiovascular disease pathways by March 2019.**

Provider alliance partners will work together to create shared care pathways through close working between the core NHS providers in Liverpool, developing our capability to plan care pathways prospectively as a system rather than reactively as individual providers. Working together to develop and specify optimum care pathways, we will articulate what they do for each patient group, how they do it, why they do it in that way, to what effect and how it fits, cost effectively, into everything else the health economy is trying to achieve.

Intelligence, such as that offered through Right Care identifies priority pathway areas for community-based opportunities including:

- **Gastro-intestinal** pathways, largely relating to the impact of alcohol consumption and complex needs
- **Frailty**, specifically admissions and mortality from falls in the over 65s and admissions for those with dementia.
- **Long term respiratory and cardio-vascular disease**
- **End of life**
- **Urgent care**
We have a strong foundation to build upon in the extensive clinical development work that has already been done in, many of which are ready for implementation.

Mental health and physical health integration - actions:

- We will implement collaborative care between Mersey Care community mental health teams and GP practices in Liverpool
- We will establish a network of ‘behaviourists’ linked to GP practices in Liverpool
- We will increase the use of Mersey Care Life Rooms for patients in primary care
- We will integrate IAPT (talking therapies) and long term conditions services for people experiencing common mental health problems

Through integrating physical and mental health interventions we can significantly reduce emergency admissions and offer a much better experience of care. We will provide holistic mental health and wellbeing services in community settings based on a bio psycho-social model. The service will enhance clinical collaboration across primary and secondary care through consultants aligned to practices and a new link worker role based in primary care, using community assets and the expertise of service users to co-produce interventions.

We will create a new ‘behaviourist’ role in community care teams, to break down barriers between the agencies working with people with complex needs; forming close relationships with their patients and building their confidence to change their behaviour. The behaviourists will be based in GP practices, forming strong relationships with the primary care team and being a ‘first port of call’ for advice on patients with mental health problems.

Maximising community assets - actions:

- We will establish networks of local voluntary and third sector organisations linked to the community care teams
- We will pilot enhanced liaison between hospitals and the housing sector to avoid hospital admission and facilitate discharge
- We will involve voluntary and third sector organisations in the redesign of local care pathways
We believe that public sector organisations can make better connections with communities and tap in to the strengths that are already there. We need to develop greater insight into what makes those communities ‘tick’ and find ways to enable these things to support wellbeing. We will also connect more effectively to employers, housing providers, the police, education and voluntary and faith organisations.

The Provider Alliance will develop a value network of voluntary and third sector organisations to support health in Liverpool.

**Self care and developing a ‘new deal’ with local people - actions:**

- **We will engage with local people together about self care**

- **We will increase the use of Mersey Care’s Life Rooms and other wellbeing centres to support self care and recovery from illness**

- **We will enhance self care and control with the Behaviourist role in community care teams**

Personal behaviour is a more powerful driver of good health than medical systems, doctors, hospitals or GP surgeries, and in a period of severe pressure on the public pound the NHS must become more adept at influencing people to use services responsibly and take more control over their own health.

The Provider Alliance will help re-write the script that defines the relationship between services and patients, to enable people to play a more active role in looking after their own health. We will offer patients opportunities to co-produce new pathways. Behaviourists will encourage behaviour change through motivational tools and techniques. We will provide assistive technology and innovative digital Apps where our patients prefer this approach. Through “neighbourhood collaboratives” we will work with local organisations who can add specific expertise, including the voluntary sector, housing associations and charities. Life Rooms and Recovery College offer life opportunities, encouraging independence and health and wellbeing. We plan to expand on these models in view of the resounding success they have achieved in improving outcomes.

**Our action now is to develop a One Liverpool Integrated community services operational delivery, designed to bring our communities to life. The plan will be developed in full partnership between commissioners, service providers, the VCSE sector and the people living in each of our 12 neighbourhoods. Delivery will be led by Liverpool Provider Alliance.**
8 Acute and Specialist Services Sustainability

Liverpool is exceptional in the number of acute provider trusts operating within the city and in the diversity of specialist provision. This complexity is a strength but also a challenge, due to the fragmentation, duplication and variation in services. Our commitment is to achieve the highest standards of care in our hospitals and to address these issues in partnership.

In order to achieve clinical and financial sustainability for our hospital system we have to identify further ways to deliver better hospital services at lower cost and address a range of clinical challenges, particularly with regard to workforce capacity and skill shortages. One Liverpool will address how we maintain good access to hospital care, with the right skills, 7-days a week, 24-hours a day. Trusts in the city have a good track record of providing high quality care; however, going forward, national clinical standards will be difficult for each organisation to meet independently.

Healthy Liverpool has been a catalyst for clinical and corporate collaboration, facilitating moves to streamline and improve our hospital system. Aintree University Hospitals NHS Trust (AUH) and Royal Liverpool & Broadgreen University NHS Trust (RLBUH) came together to deliver major trauma services and joint venture partnerships have been established for both Vascular and Clinical Laboratory Services. The Royal Liverpool, Aintree and Liverpool Women’s hospitals have also collaborated to deliver a single IT system and Electronic Patient Record (EPR). These positive changes to date have demonstrated that further joint working is essential to improve patient outcomes and to sustain clinical services.

In 2015 the city’s clinicians and NHS organisations agreed the Healthy Liverpool hospitals adult acute vision for a: “Centralised University Teaching Hospital Campus with a single service, system-wide delivery, delivered through centres of clinical and academic excellence”. This translated into a plan to reconfigure services across the city’s two adult acute hospitals, to establish a combined workforce delivering standardised patient pathways; establishing consistent, high quality services delivered to best practice standards and single clinical leadership. Such collaboration between hospitals has been generally supported in community feedback, providing the benefit to the patient is clear. These intentions have developed into a proposal by the Royal Liverpool and Broadgreen University Hospital Trust and Aintree University Hospitals FT to create a new single organisation, to be established from April 2019. This new organisational form will be an enabler for future clinical service changes to deliver significant patient benefits as well as supporting financial sustainability. Orthopaedics is the first major service to be prioritised for single, system wide reconfiguration, paving the way for the integration of other adult acute services over the next few years.
Alongside these plans, a new city centre health campus is beginning to take shape on the site of the new Royal Liverpool Hospital, where the new Clatterbridge Cancer Centre will also be located. The campus is focus for research and development, attracting new investment and clinical expertise to the city, and creating exciting opportunities for cutting-edge treatments and clinical trials, bringing significant benefits for local patients.

In 2016, Healthy Liverpool commenced a review of women’s and neonatal services, which concluded that due to the changing and increasingly complex needs of patients and the clinical risks inherent in the delivery of services on an isolated site, that women’s and neonatal services be re-located to a new hospital on the same site as the new Royal Liverpool Hospital. This programme continues after the conclusion of Healthy Liverpool, with North Mersey commissioners aiming to present proposals to the public through a formal public consultation later in 2018.

One Liverpool hospital service improvement programmes will incorporate Getting It Right First Time (GIRFT)\(^8\), the national approach to bring about higher-quality care in hospitals, at lower cost, by reducing unwanted variations in services and practices.

The patient flows into Liverpool’s hospitals extend to the wider North Mersey and the Cheshire and Mersey population. This is recognised by the Health and Care Partnership for Cheshire and Merseyside which is co-ordinating an acute sustainability programme on behalf of the whole footprint, focusing on emergency care, cardiology, stroke, elements of elective care and maternity services. The local hospital programmes within the One Liverpool Plan will align closely and avoid duplication with Cheshire and Merseyside programmes.

**Our action now is to develop a One Liverpool Acute Sustainability and Specialist Services operational delivery plan, to ensure our hospital services remain clinically and financially fit for the future. Delivery will be led by an alliance of acute and specialist providers and will align with the Cheshire and Merseyside acute sustainability programme.**

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\(^8\) [http://gettingitrightfirsttime.co.uk/](http://gettingitrightfirsttime.co.uk/)
9 National Service Improvement Priorities

The NHS England *Next Steps on the NHS Five Year Forward View* provided strategic direction for the main national service improvement priorities, from 2017-2019, including cancer, mental health, primary care and urgent and emergency care. The One Liverpool Plan will set out how we deliver these priorities locally, encompassing our three aims and across all physical settings of care.

9.1 Primary Care

General practice is the bedrock of effective community provision in Liverpool, as this is where the vast majority of people receive their care. However, we know that general practice is under strain due to increasing demand and acuity and we recognise that it needs to undergo substantial change to be sustainable and to continue to meet the needs of patients. There are currently 92 general practices within Liverpool, serving a registered population of circa 515,000 within 3 localities (Central, North and South). Our strategy is informed by the *NHS General Practice Forward View*, published in April 2016, which set out a plan to stabilise and transform general practice. The GP Forward View makes it clear that if general practice fails, the NHS fails, yet we spend less on general practice than on hospital outpatients, so it sets out a package of investment and reform for primary care through to 2020, including more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, improved primary care estate and integration with community and preventive services, hospital specialists and mental health care.

**Sustainability**

We will deliver high quality list-based GP services, with practices working “at scale” towards an integrated community model of care and delivering a consistent and universal offer for all. This will be achieved by developing a better mix of skills, recruitment and retention of the primary care workforce. We will:

- Increase the number of doctors coming into and remaining in General Practice
- Establish and maximise the potential of new roles in primary care, including physician associates, clinical pharmacists, paramedics and medical assistants
- Maximise the opportunities to promote self-care and an enhanced role for community pharmacy
- Work with Neighbourhood Collaboratives to promote the use of social prescribing
- Increase capacity and resilience in primary care through greater collaborative working, through primary care hubs

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• Implement digital solutions to support seamless care

Accessibility
We know that issues relating to accessing GP services can have a knock on effect across the whole system including our A&E departments, which are experiencing unprecedented levels of demand. Although we have invested in improved access this is an issue raised consistently in public feedback. We are committed to improving access and ensuring effective connections to other services so patients receive the right care in the right place. We have designed a new model of care to transform access for patients, 8am-8pm 7 days a week. This model has the following features:

• City wide GP-triage across neighbourhood footprints with each practice contributing a proportion of their appointments into a pooled appointment system for telephone consultations.
• Availability of routine and same day GP appointments at practices and Primary Care Hubs, enabling increased same day access to routine and urgent primary care seven days a week, and a single access pathway for adults and children.
• GP streaming at the front of A&E, diverting people who don’t need A&E services to same day appointments with their own GP or within the Primary Care Hub, ensuring that our A&E departments are able to focus on more seriously ill patients.

Quality
We place a high priority on the development and sustainability of high quality primary care across the city and to that end the CCG as commissioner has invested in the Liverpool Quality Improvement Scheme (GP Specification) for improved outcomes, including:

• Reduced A&E attendances and avoidable hospital admissions
• Reducing unnecessary outpatient referrals into secondary care
• Improvement in early detection, particularly heart disease, cancer, diabetes and hypertension
• Participation in developing the Liverpool Community Model of care
• Increasing uptake rates for cancer screening and vaccinations
• Sharing resources, information and expertise to release capacity

During 2018/19 we will agree and start to implement a plan for primary care investment and transformation over the three years to 2021.
9.2 Mental Health

Poor mental health and wellbeing is a significant problem in Liverpool. It impacts on individuals and families, and more widely on communities and the economy. Our communities consistently tell us through engagement that people want greater priority given to mental health issues. Children who experience poverty are up to five times more likely to have a mental health difficulty and in adulthood are almost five times more likely to attempt suicide.

The vast majority of people receiving treatment for mental health problems are seen within primary care, but models of primary mental health care are currently under-developed. We need to develop integrated models of primary mental health care to address problems at an earlier stage and prevent a greater number of people requiring secondary mental health care.

For people with serious mental health issues, they often spend more time than necessary in acute inpatient units and there are too many unplanned out of area treatments due to a local shortage of inpatient beds.

The NHS Five Year Forward View identified mental health as a priority, with an ambition to achieve parity of esteem between mental health and physical health care. In 2016 the Five Year Forward View for Mental Health (FYFVMH) set out key objectives for adult mental health, focusing on improving access to psychological therapies; improving crisis care; meeting the physical health care needs for people with serious mental illness; improving access to individual placement support and integrating physical and mental health.

Our vision is for a mental health system in Liverpool that is focused on empowerment, self-care and recovery, with services that are responsive and accessible for people when needed. To do this Liverpool will have an integrated system, working as one across the NHS, social care and the VCSE sector. We will adopt a bio-social approach to reflect the complex health needs of our population and reflective of the fundamental change we want to see between services and the people who use them. A number of mental health high impact changes have been identified:

Supporting People in Crisis

Liverpool has nearly 3.5 times as many A&E attendances for psychiatric disorders compared to the England average, with demand increasing each year. Patients experience delays in Mental Health Act assessment and a shortage of acute mental health beds. Our priorities for addressing mental health crisis include:

- Core 24 hour mental health liaison services in our two adult acute hospitals, out of hours provision and a systematic approach to Mental Health Act

assessments, to reduce the number of people attending A&E, and to improve
the experience for those patients who do attend.

- Early Intervention in Psychosis: supporting people experiencing a first
  psychotic episode with more intensive, personalised care over the initial 3-
  year critical period

- Crisis Resolution Home Treatment: ensuring crisis response services are in
  place in the community to support people at home and to prevent
  unnecessary hospital admissions.

- Mental Health Triage: continuing to invest in mental health diversion schemes,
  including the successful street triage scheme, to reduce the number of people
  detained in police custody.

- Individual Placement Support: we have made a clear commitment to
  eliminating out of area placements for non-specialist acute mental health care
  by 2020/21.

Common Mental Health Issues
A review of need in Liverpool clearly demonstrates the link between deprivation and
common mental health issues. Although our current service model (IAPT –
Improving Access to Psychological Therapies) is now delivering improved access
and recovery, we could achieve much better outcomes by integrating mental health
and physical care, offering a broader range and choice of medical and non-medical
mental health interventions, accessed through primary care.

We will integrate mental health services in all of the city’s 12 community services
neighbourhoods, with an offer of proactive care for patients with complex and
ongoing needs. Mental health services will integrate with community, primary care
and VCSE services to support people to stay well, with greater support to GPs to
lead delivery of multi-disciplinary mental health support in primary care.

Children and Young People’s Mental Health
Mental disorders represent the single largest category of burden of ill health in
children adolescents and young adults, hugely outweighing the onsets of other
health care related problems. At any one time in the UK 10% of children aged 5-16
has a mental health problem. Demand for mental health provision for children and
young people is high in Liverpool due to deprivation and other wider determinants of
health affecting families and communities.

In Liverpool children and young people’s mental health services are delivered
collaboratively by the NHS and the VCSE sector through the CAMHS pathway,
guided by the principle of early help by increasing the focus on early intervention and
preventative services whilst ensuring specialist services remain in place at levels to
meet need.
Our offer needs to be one of ‘no wrong door’ - meaning that access to services needs to be straightforward, timely, joined up and integrated for families and professionals alike. In line with the all-age model of community care, Mental Health and Emotional Wellbeing services will be integrated into neighbourhoods, further developing the psycho- social model of delivery.

9.3 Cancer
Cancer is Liverpool’s biggest killer and cancer incidence is increasing due to an ageing population and because more people are being referred and investigated with symptoms that are suspicious of cancer.

We also know that over 40% of cancers could be prevented by changes in lifestyle. Liverpool has a low uptake of cancer screening, but if we could increase rates we could prevent some cancers; detect more cancers early and improve survival. Cancer disproportionately impacts more deprived communities and we have not yet closed the gap with the rest of England. The good news is that more people are living with and beyond a diagnosis of cancer; our survival rates are getting better, and more people are living with the effects of a cancer diagnosis and consequences of treatment for cancer.

The NHS Five Year Forward View identified cancer as a priority, and a national strategy ‘Achieving world class cancer outcomes; a strategy for England, 2015-20’ sets out 96 recommendations to achieve improved outcomes from cancer.

The Operational Planning Guidance 2017-19 highlighted the requirement to:

- Improve year survival for all cancers combined by 2020
- Offer all patients a definitive diagnosis of cancer, or all clear, within 28 days by 2020

The Liverpool health and care system will come together to achieve a number of key outcomes:

- Our population will know and understands the risk factors for cancer; and people are empowered to make positive choices around lifestyle;
- The Liverpool population is healthier; there is less smoking, less alcohol consumption, less obesity, and more physical activity within the population;
- People are less scared by cancer. People know local treatment services are good; and can access services and be seen promptly with the signs of suspected cancer;
- Cancer services are excellent; a single team delivers cancer services for each cancer type in the city. Cancer services meet national standards; patient

satisfaction is high; and services can demonstrate through audit they achieve good results;

- People, their families and carers are empowered and supported to take control of risk factors; and to live well beyond their diagnosis of cancer; to access the services that they need; and self manage;
- We make increasing use of digital/technological approaches;
- There is more ‘virtual’ working to agreed pathways, supporting clinical decision making and helping develop faster, patient centred, coordinated pathways.

We will know if we are making progress by seeing:

- A stabilisation in the increasing incidence of cancers;
- More people participating in cancer screening programmes;
- More cancers diagnosed at earlier stage, at either stage 1 or 2;
- Reduced numbers of people diagnosed with cancer via an emergency presentation;
- Delivery of cancer waiting times targets, through well coordinated, effective cancer services and pathways;
- High levels of patient satisfaction;
- Increased wellbeing and recovery; and evidence that people can live well after a diagnosis of cancer.

### 9.4 Urgent & Emergency Care

Liverpool has a relatively large number of healthcare providers and sites at which patients can access urgent and/or emergency healthcare. Whilst the city is not unique, this multiplicity of provision contributes to a local urgent care system that is fragmented and offers a bewildering array of access points and service options, often leading to attendance at A&E as the default position.

Our vision is to put in place urgent and emergency care pathways that are recognisable and clear to patients, the public and healthcare professionals, providing the right care in the right place, first time.

The NHS England Urgent and Emergency Care Review (2013) \(^\text{12}\) and subsequent strategies identified five key strategic aims for urgent and emergency care systems to achieve:

- Providing better support for people to self-care;
- Helping people with urgent care needs to get the right advice, in the right place, first time;
- Providing highly responsive urgent care services outside of hospital so that people no longer choose to queue in Accident & Emergency (A&E) Departments;

• Ensuring that people with serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery;

• Connecting urgent and emergency care services to enable to the overall system to become more than just the sum of its parts.

In 2017 the *Urgent & Emergency Care Delivery Plan* provided more detail on key deliverables, setting out a timetable from 2017-2019 to deliver a transformed urgent and emergency care system. Key areas of change are:

**Integrated 24/7 urgent care access, clinical advice and treatment**

This service, which includes NHS111 and GP Out-of-Hours services, will move from an 'assess and refer' care model to a 'consult and complete' model. As part of this NHS 111 online will establish an online triage service that enables patients to enter symptoms and receive tailored advice or a call back from a healthcare professional.

The introduction of an integrated Urgent Care Clinical Assessment Service (IUC CAS) as part of NHS111 will streamline and improve patient access to urgent care services. This will see over 50% of callers to 111 transferred to a clinician, in place by April 2018, to provide advice, a prescription or an appointment. The IUC CAS will also provide support to lower acuity 999 calls, to be dealt with by ‘hear & treat’ advice.

**GP Access**

Partners will open up additional access to pre-bookable evening and weekend appointments, to be in place by October 2018 to support continued provision of urgent care in Primary Care settings.

**Urgent Care Treatment Centres (UTCs)**

In line with national strategy UTCs will enable a standardised, high quality urgent care offer to patients of all ages. Open for at least 12 hours per day 365 days per year, UTCs will be medically led, with a multidisciplinary team treating minor illness, injury, offering diagnostics, including x-ray. UTCs are designed to provide a clear, nationally consistent, service offer, combining both “walk-in” access and booked appointments, whilst also providing an alternative location for ambulance services for patients who don’t need to go to A&E. This new model of out of hospital urgent care delivery means that in 2018/19 we will be reviewing options for how this could be delivered locally, incorporating a review of walk-in centre provision.

**Improvements in Ambulance response and long ambulance handovers**

The implementation of the Ambulance Response Programme (ARP) will ensure prioritisation of time critical response for the most life threatening conditions as well as setting response time standards for all responses. This will allow NWAS to offer a more clinically focused response for patients. Revised national targets are expected in 2018/19.
Improving flow for patients who require urgent or emergency care in hospital
A new model for ‘front door’ streaming, provides other options for treatment, including Primary Care, Frailty and Ambulatory Emergency Care pathways, and improved Mental Health liaison response, to optimise care and eliminate unnecessary delays.

Optimising Hospital to Home pathways
Community health and social care partners are working together to implement local Better Care Fund plans, including the eight high impact changes for discharge, to reduce the assessment of longer term care needs in hospital and to ensure patients are able to return home safely. All Health and care system partners will work together across the city to:

- Support people to access the right services to meet their urgent and emergency healthcare needs.
- Develop workforce plans to support better services; aligning skills and competencies of staff to meet need, providing opportunities to integrate services and proactively manage peaks in demand.
- Deliver the NHS constitutional standards in respect of the 4-hour emergency access standard and ambulance ARP performance standards.

10 High Impact Priorities
In support of the work by the Provider Alliance to develop detailed delivery plans, Liverpool CCG has undertaken a review of clinical and non-clinical interventions that have the capacity to deliver high impact change to achieve our outcome ambitions.

The review incorporated the Commissioning for Value approach which is embedded in NHS RightCare, the NHS England programme committed to delivering the best care, making the NHS’s money go as far as possible and improving patient outcomes. Local RightCare data\(^\text{13}\) shines a light on variation and performance and supports local health economies to have discussions to agree a starting point for change. NHS RightCare has a three stage, evidence-based methodology, of ‘Where to look’, ‘What to change’ and ‘How to change’ which provides a robust process for service redesign and prioritisation.

The review doesn’t encompass all the options available for consideration, particularly around interventions that address the wider determinants of health. However, it does incorporate national clinical priorities, other ‘must do’s we are charged as a system to deliver and areas that respond to what we know about local health need.

The review and ranked the importance of priorities against a set of criteria, including commissioning planning and strategy, quality, outcomes & performance and affordability and finance. The outputs of the review are not commissioner intentions, but intended to inform the joint development of detailed delivery plans. However, there are significant areas of transformation that are already in progress and which need to be delivered in 2018/19, including:

- Local proposals for Urgent Care Treatment Centres and improved primary care access;
- Review of Child and Adolescent Mental Health Services (CAMHS);
- Review of Continuing Health Care
- Consultation on proposals for the women’s and neonatal services delivered by Liverpool Women’s Hospital

The action now is for partners to develop operational delivery plans for each of our aims, informed by national service improvement priorities and locally determined priorities to deliver the greatest impact in improving health outcomes and future sustainability.

The operational delivery plans will be specific for years one and two and outline higher level deliverables for year three. This will ensure we have the ability to review, refine and refresh our plans in response to evaluation and to changing requirements.
11 Delivering the CCG’s Core Responsibilities

NHS Liverpool Clinical Commissioning Group (CCG) is responsible for planning and buying most NHS services for the people of Liverpool. The CCG’s Constitution sets out our duties and how we make decisions. Going forward, our intention as commissioner for the majority of health services in Liverpool is to take a strategic approach to drive improved outcomes and maximum value, in order to release funds to support prevention and new integrated models of care.

11.1 Integrated Commissioning

Integrated commissioning is where commissioners pool budgets across health and social care, with the aim of cutting across organisational boundaries, improving health and well-being and providing better value for money.

In order to support the One Liverpool aims we will consider the benefits and options for further integrating commissioning across health and social care.

Liverpool was an early pioneer of integration, with one of the first Section 75 pooled budget agreements in 2008 and a number of joint appointments.

Liverpool CCG and Liverpool City Council have a positive track record in integrated commissioning, including the Better Care Fund, which is facilitating community services integration; programmes such as the Integrated Community Reablement and Assessment Service (ICRAS) and the enhanced care home programme; prevention programmes including Liverpool’s Physical Activity Partnership; and Special Educational Needs & Disability (SEND) services and Mental Health & Emotional Wellbeing services for children and young people.

The direction of travel in Liverpool is for larger, integrated providers, so it is important that we have strong, integrated commissioning in order to hold providers to account for the improved health and wellbeing we want for our population. We will also need to consider how we address issues where the scale of commissioning is greater than Liverpool, on a North Mersey or a Cheshire and Merseyside footprint.

Liverpool CCG and Liverpool City Council are already working to develop options for the future shape of integrated commissioning, guided by shared objectives for improved outcomes and opportunities to reduce fragmentation and improve efficiency.

We will produce a joint commissioning plan from 2018/19, setting out the scope of our shared programmes, aligned with the One Liverpool Plan. We will also review with other CCGs and with the Cheshire and Merseyside Health and Care Partnership where it would be appropriate to commission some health services across a bigger footprint.
11.2 Our Commitment to Quality

We define quality care as safe, effective, positively experienced, timely, effective and efficient care, recognising finite resources and the need to use them well to maximise impact. A health and care system that achieves major gains in these areas would be better at meeting patient need. Patients would experience care that is safer, more reliable, more responsive to their needs, more integrated and more accessible and they would be more likely to receive a full array of preventive, services and also acute and chronic services. This is our ambition as a system and this underpins this strategy.

We recognise the ‘3 lines of defence’ model as applied to the control of quality with providers, with Trust Management being the first line of defence, CCGs (as Commissioners) being part of the second line of defence and regulators such as the CQC or NHSI being part of the third line of defence.

The Kirkup Report\textsuperscript{14}, published in January 2018, reviewing the period October 2010-November 2014, highlighted significant quality issues, patient harm and a poor culture within Liverpool Community Health NHS Trust. Much remedial work has been undertaken and the services provided by Liverpool Community Health have improved greatly in terms of quality. The findings stated that commissioners did not take adequate steps during that time period to identify quality problems and that a number of other external organisations could have identified the problems afflicting the trust earlier had they looked critically at the information available to them.

As a system we will consider how integrated working can support the right conditions to ensure that this could not happen again. Healthcare professionals - their ethos, values and behaviours remain integral to delivery of quality, with organisational leaders ultimately responsible for quality of care. Our aim is that an integrated health and care system will create a positive environment for providers and commissioners to better focus collectively on quality and address shortfalls in the provision of care in a timely and proportionate way. We will work together to further develop an open and transparent culture; to ensure we learn from things that do not go as we would have expected and we improve our joint systems and processes to further support continuous improvement in quality. We need also to further develop how we listen and act upon the insight gained from service users, patients and the public.

Partners will agree a single set of quality measures to underpin our shared aims, which could include new measures to test whether the system is behaving in a way that aligns with our shared principles and values.

\textsuperscript{14} https://improvement.nhs.uk/news-alerts/independent-review-liverpool-community-health-nhs-trust-published/
11.3 Managing Risk
Partners manage risk at organisational level across a spectrum of common themes – quality; safety; sustainability and business risks associated with running an accountable organisation - financial, ethical, reputational and information technology. Whilst organisations will continue to have their own risk frameworks One Liverpool provides an opportunity to adopt an integrated approach to managing the whole-system risks that impact on all, but which no single organisation can fully influence or mitigate. Amongst the shared risks to be addressed:

- Financial sustainability
- Quality and safety
- Achieving constitutional standards
- Public and stakeholder support for system change
- Achieving system outcome ambitions
- Workforce sustainability

We will develop a system approach to managing our shared risks. This action is linked also to ensuring the system has an effective governance infrastructure in place.

11.4 Delivering for Today - 2018/19 Operational Plan
Each year NHS operational plans are refreshed, informed by annual planning guidance15. The guidance for 2018-19 puts an increased focus on the development of system-wide plans to support greater collaboration, in order to improve services and manage budgets at system level.

The November 2017 budget announced additional NHS revenue funding for 2018/19. The planning guidance, issued jointly by NHS England and NHS Improvement, sets out how these funds will be distributed and the expectations for commissioners and providers in updating their operational plans for 2018/19.

The guidance protects investment in national priorities, including mental health, cancer services and primary care. This means a continued commitment to deliver the cancer waiting time standards, achievement by every CCG of the Mental Health Investment Standard, service expansions set out by the Mental Health Taskforce and General Practice Forward View commitments, which are set out in section 9.

Commissioners are required to submit a full suite of operating plan returns demonstrating performance targets for NHS constitutional standards and other operational measures. The key operational performance targets for 2018/19 are set out at Appendix 2.

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For activity planning purposes we have gone beyond 2018/19 and created a three year activity plan that reflects the impact of the schemes that could be taken forward in the One Liverpool plan. The 2018-2021 draft activity plan is at Appendix 3.

12 Financial Sustainability

NHS Liverpool Clinical Commissioning Group begins 2018/19 in a relatively stable position following delivery of an in-year break even position in 2017/18 in accordance with NHS England Business Rules. It has however been a difficult 18 months for the CCG requiring significant increase in level of cash releasing savings (£13m and £22m, in 2016/17 and 2017/18 financial years respectively) in order to achieve its financial requirements.

The pie chart below shows how the CCG’s resource allocation plans to be spent in 2018/19. In line with most health economies, the vast majority of expenditure is with the ‘Acute’ Sector, with almost equal amounts for community, primary care, prescribing expenditure, mental health and continuing healthcare.

![2018-19 Planned Programme Expenditure](chart.png)

**Financial Challenges**

The NHS continues to face a period of unprecedented change and financial challenge, which drives the need for both commissioners and providers to deliver both improved productivity and quality, and to ensure that resources are targeted as effectively as possible to maximise value.

Liverpool's health and social care economy continues to face a significant financial challenge; and across Cheshire and Merseyside this challenge is estimated to be
£900 million by 2021, with an estimated £352m required for the North Mersey Health & Care system between 2016/17 and 2020/21 financial year, which represents a significant challenge to the sustainability of the entire health and social care system, requiring significant transformation and reduction in costs.

NHS provider organisations in North Mersey are also currently experiencing a range of financial pressures demonstrated by the relative financial position in 2017/18 (as at month 10) and is subject to change by the end of the financial year given the relative year to date position compared to forecast outturn performance.

<table>
<thead>
<tr>
<th>Surplus/(Deficit), provider positions include STF</th>
<th>Full year</th>
<th>Month 10 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £m</td>
<td>Forecast £m</td>
</tr>
<tr>
<td>Aintree University Hospital NHS Foundation Trust</td>
<td>(2.4)</td>
<td>(3.2)</td>
</tr>
<tr>
<td>Alder Hey Children's NHS Foundation Trust</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Liverpool Community Health NHS Trust</td>
<td>(1.4)</td>
<td>(1.4)</td>
</tr>
<tr>
<td>Liverpool Heart and Chest Hospital NHS Foundation Trust</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Liverpool Women's NHS Foundation Trust</td>
<td>(1.8)</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Mersey Care NHS Foundation Trust</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>St Helens And Knowsley Teaching Hospitals NHS Trust</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>The Clatterbridge Cancer Centre NHS Foundation Trust</td>
<td>0.8</td>
<td>0.9</td>
</tr>
<tr>
<td>The Royal Liverpool and Broadgreen University Hospitals NHS Trust</td>
<td>(3.4)</td>
<td>(10.1)</td>
</tr>
<tr>
<td>The Walton Centre NHS Foundation Trust</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Total providers</strong></td>
<td><strong>(3.0)</strong>*</td>
<td><strong>(10.2)</strong>*</td>
</tr>
</tbody>
</table>

**Financial Resources**

The CCG receives its funding based on a national formula, which takes into account the demographics and relative needs of our local population. In 2018/19 the CCG will have a total recurrent ‘resource’ allocation of £888.1 million which we expect to rise to £918.3 million by 2020/21. The following table summarises our allocations for the next three years including the ‘delegated’ primary care commissioning budget from NHS England and Running Cost Allocation.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Recurrent Allocation* (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018/19</td>
<td>888.1</td>
</tr>
</tbody>
</table>
The CCG currently receives more funding than the formula would allocate and as such the CCG is ‘over target’ which means that we receive minimal levels of ‘growth’ funding in each financial year to fund inflationary and other funding pressures. The following table summarises the respective ‘distance from target’ for the next three years and the impact on the growth allocation to the CCG.

<table>
<thead>
<tr>
<th>Liverpool CCG</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated registered population</td>
<td>530,479</td>
</tr>
<tr>
<td>Total CCG Allocation Growth %</td>
<td>2.78%*</td>
</tr>
<tr>
<td>CCG Allocation Growth £</td>
<td>£12.4m</td>
</tr>
<tr>
<td>Final closing CCG Distance from Target – Over / (Under)</td>
<td>+3.54%</td>
</tr>
</tbody>
</table>

Financial Targets
The key requirements of business rules for CCGs for 2018/19 are below:

- CCGs have been required to deliver a minimum of a ‘cumulative’ 1 percent underspend in 2017/18 and 2018/19. However, all CCGs are required to aim for an ‘in-year’ breakeven position, with expectations set for the minimum level of improvement in deficit CCGs.

- For 18/19, all CCG’s are expected to plan against fixed in-year control totals. The control total for each CCG has been set by NHS England to take account of the business rules, the 2017/18 expenditure profile and the additional funding allocation for 2018/19 for each CCG.

- As NHS Liverpool CCG current cumulative underspend is equivalent to 2% (circa £16.4m excluding 17/18 0.5% national headroom element) the requirement for the CCG is to maintain as a minimum its ‘in-year’ break even position for 18/19 financial year.

- As in previous years, CCGs should also plan for a minimum 0.5% contingency to manage their in-year pressures and risks;

- However in a change to previous assumptions, based on updated planning rules, the requirement for CCGs to hold a 1% ‘headroom’ (consisting of a combination of the national risk reserve 0.5% and the requirement to use a further 0.5% of CCGs’ allocations solely for non-recurrent purposes) has been lifted and can
support the overall financial plan of the CCG.

These ‘Rules’ have been extended as the basis for planning assumptions for future financial years and result in the values as per the table below:

<table>
<thead>
<tr>
<th>Business Rule</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative Surplus *</td>
<td>16.4 (2.01%)</td>
<td>16.4 (1.98%)</td>
<td>16.4 (1.94%)</td>
</tr>
<tr>
<td>In-Year Surplus / (Deficit)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>4.4</td>
<td>4.5</td>
<td>4.6</td>
</tr>
</tbody>
</table>

* excluding national risk reserve of 0.5%

Financial Outlook
Based on the allocations described above and other, more detailed planning assumptions, the CCG’s financial outlook over the next three years is summarised below. Expenditure assumptions include an assessment of financial savings being required in each of the financial years based on the following planning assumptions:

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tariff Price Inflation</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Tariff Efficiency</td>
<td>(2.0%)</td>
<td>(2.0%)</td>
<td>(2.0%)</td>
</tr>
<tr>
<td>Prescribing Inflation / Growth</td>
<td>5.4%</td>
<td>5.4%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Activity Growth (as applicable)</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Continuing Care Price Inflation (as per LA)</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Continuing Care Activity Growth</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Current planning assumptions have been extended as the basis for future financial years and provide the overall headline assumptions from a CCG planning perspective.
### Total ‘Programme’ Revenue Resource Limit

<table>
<thead>
<tr>
<th></th>
<th>2017/18 *</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(CCG Resource Allocation + Delegated Primary Care)</td>
<td>£854.9m</td>
<td>£877.6m</td>
<td>£892.3m</td>
<td>£907.9m</td>
</tr>
<tr>
<td><strong>Non-Recurrent</strong></td>
<td>£2.5m</td>
<td>£2.5m</td>
<td>£4.0m</td>
<td>£4.0m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£857.3m</td>
<td>£880.2m</td>
<td>£896.4m</td>
<td>£911.9m</td>
</tr>
</tbody>
</table>

* 2017/18 – Based on confirmed allocations for comparison purposes (does not include additional in-year non recurrent allocations of £6.1m above plan)

### Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2017/18 *</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>£419.7m</td>
<td>£428.0m</td>
<td>£436.9m</td>
<td>£446.1m</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>£84.3m</td>
<td>£86.2m</td>
<td>£86.3m</td>
<td>£86.5m</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>£91.5m</td>
<td>£95.7m</td>
<td>£95.6m</td>
<td>£97.2m</td>
</tr>
<tr>
<td><strong>Continuing Care</strong></td>
<td>£33.2m</td>
<td>£35.1m</td>
<td>£36.1m</td>
<td>£37.8m</td>
</tr>
<tr>
<td><strong>Delegated Primary Care Commissioning</strong></td>
<td>£72.5m</td>
<td>£75.0m</td>
<td>£77.2m</td>
<td>£79.9m</td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
<td>£86.6m</td>
<td>£91.5m</td>
<td>£96.5m</td>
<td>£101.7m</td>
</tr>
<tr>
<td>Other Primary Care</td>
<td>£20.2m</td>
<td>£25.3m</td>
<td>£27.2m</td>
<td>£27.2m</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Other Programme</td>
<td>£37.0m</td>
<td>£39.2m</td>
<td>£36.3m</td>
<td>£31.2m</td>
</tr>
<tr>
<td>Contingency</td>
<td>£4.5m</td>
<td>£4.4m</td>
<td>£4.5m</td>
<td>£4.6m</td>
</tr>
<tr>
<td>Non-Recurrent Headroom (1%)  *</td>
<td>£7.8m</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Total Programme Costs</td>
<td>£857.4m</td>
<td>£880.6m</td>
<td>£896.6m</td>
<td>£912.2m</td>
</tr>
</tbody>
</table>

* In 17/18 Non-Recurrent Headroom includes both the 0.5% ring-fenced for national system risk reserve and 0.5% for local transformation purpose, no longer required from 18/19 onwards

### Cash Releasing Efficiency Savings Requirements

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Level of Savings Requirements</td>
<td>£22.1m</td>
<td>£6.4m</td>
<td>£9.0m</td>
<td>£14.2m</td>
</tr>
</tbody>
</table>

### Running Costs

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running Costs allocation</td>
<td>£10.6m</td>
<td>£10.5m</td>
<td>£10.4m</td>
<td>£10.4m</td>
</tr>
<tr>
<td>Running Costs Expenditure</td>
<td>£10.5m</td>
<td>£10.1m</td>
<td>£10.2m</td>
<td>£10.1m</td>
</tr>
<tr>
<td>Difference</td>
<td>£(0.1)m</td>
<td>£(0.4)m</td>
<td>£(0.2)m</td>
<td>£(0.3)m</td>
</tr>
</tbody>
</table>
In order to achieve our ambitions we need financial resources to flow differently within the local health and care system. From a whole-system perspective we need to do further work to identify the scale of the financial gap through to 2020/21 and to agree shared solutions. The One Liverpool plan for an upgrade in prevention, new models of integrated community care and streamlining hospital services will help close the gap, although they will, in part, be dependent on non-recurrent investment.

**Our action now is to produce an integrated financial plan setting out the actions we will take to address the financial gap.**

### 13 Enablers

We have identified a number of enablers that will be crucial in supporting an integrated partnership to achieve our shared aims.

**Workforce**

The health and care workforce is the most important enabler in the delivery of One Liverpool’s aims and ambition. We need to take a strategic approach across all parts of the health and care workforce to ensure that people are trained and equipped to deliver new models of care and that we have the right skills and flexibility to adapt to changing population and service needs.

Workforce constraints present the greatest risk to clinical sustainability locally. We know there are significant skill shortages, some of which are common to all areas of provision and others specific to particular settings of care. For example, a particular challenge is the high turnover of care workers and nursing staff in social care settings.

The key pressures are generally well understood across the system and a range of approaches are being developed to tackle the challenges, including aligning our efforts with the workforce programme led by the Health and Care Partnership for Cheshire and Merseyside. However, there is not yet a unified, strategic approach to workforce planning for Liverpool.

**There is an opportunity now to develop a fully integrated workforce plan that takes account of the development, recruitment and retention needs of the whole health and care workforce.**
Leadership and Governance

Improving health outcomes is a complex challenge which is bigger than the contribution of any single organisation. We will need to establish effective system leadership and clear lines of accountability to unite local organisations to deliver One Liverpool. A One Liverpool governance system will enable integrated leadership, based upon collaboration and the principle of subsidiarity.

Current integrated governance arrangements include the Provider Alliance, with membership from all organisations who are involved in joint community service delivery (GPs, social care and the voluntary sector) and pathway partners (acute trusts, UC24 and care homes) who are linked to or impacted by community services.

The Provider Alliance reports to the Integrated Care Partnership Group established by Liverpool City Council, and the Joint Commissioning Committee that reports to the Health and Wellbeing Board. We will also need to consider the partnership and governance arrangements for Liverpool place-based prevention and hospital sustainability programmes. Current integrated governance structures are represented below:

Partners will review current governance arrangements to ensure they are effective in supporting the integrated partnership and delivery of the plan.
Estates

The One Liverpool vision is for long-term sustainability of the city’s hospitals, community and wider public estate, ensuring our shared assets are used more effectively and flexibly to accommodate the changing needs of services as they are redesigned.

Liverpool is fortunate to have an established infrastructure of good quality 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. Recent investment in significant capital improvements - the new Alder Hey, the Royal Liverpool hospital and the Clatterbridge Cancer Centre, provide opportunities to shape the city’s hospital estate infrastructure for the next twenty years.

Despite investment, there are significant number of challenges with existing community and acute estate - under-utilisation, a legacy of high levels of maintenance, some estate which is no longer fit for purpose, and under-utilised opportunities for capital release through surplus land and property.

The Liverpool Strategic Estates Plans, developed in 2015, is currently being refreshed. Its focus predominantly is on improvement and full utilisation of Liverpool’s community assets to support the delivery of more care by integrated neighbourhood teams and creating the space to address the current over-reliance on services in hospital settings. The plan will also support the establishment of local Urgent Care Treatment Centres (UTCs) for the treatment of minor injuries and illness and the associated review of walk in centres.

The NHS General Practice Forward View, published in April 2016, stated the need for improvements to provide the capacity and flexibility to transform primary care, as a key driver for new community models of care. Despite investment in new neighbourhood health facilities across the city, approximately 20% of primary care estate is not fit to provide modern healthcare. Bids have been submitted for capital investment through the Estates and Technology Transformation Fund for two new/improved facilities in the north and south localities of the city. We will also ensure that any practices in need of modernisation will fully utilise improvement grant funding available through NHS England.

The Liverpool Strategic Estates Plan will set out short, medium and long-term plans to support new models of care and sustainability of the city’s health and care public estate.
Digital Transformation

Liverpool is a leader in digital care and innovation, with significant progress made in information sharing, assistive technology, digital maturity and advanced analytics to support patient outcomes. Our plans are to deliver a connected health and social care economy driven by key technologies to support both healthcare professionals and service users to make the best use of our resources. The digital programme has three core ambitions:

- Digitally Empowered Individuals
- A Connected Health and Social Care Economy
- Exploiting the Digital Revolution

In 2016, NHS England launched the Global Digital Exemplar (GDE) Programme. In Liverpool City we have four GDEs - Royal Liverpool, Alder Hey and Mersey Care, which is testament to our commitment to digital transformation in recent years. Our GDEs are working closely together to spearhead future innovation and best practice.

A robust approach to Information Governance and the technical capability to share electronic patient records are the essential foundations for safe integrated and paper free services. The iLinks programme has developed a unique, large scale collaboration of information sharing involving 164 stakeholder organisations that has enabled over 8 million shared records to be accessed. This programme will continue to drive interoperability, reducing the use of paper in the system and supporting common standards for a single information exchange.

Digital transformation can only succeed through access to local expertise, sources of funding and a digitally capable workforce. The local system is accessing NHS, national and European funding and working with local SMEs' to innovate and support the local economy to grow.

The NHS Five Year Forward View and Personalised Health and Care 2020 (National Information Board) set out the need to develop patient facing digital services. Liverpool has developed a person held record system and is currently working with national agencies to develop capabilities to allow patients digital access to records, apps and other services online via a verified identity.

A ‘digital no wrong door’ programme is working to deliver easy to use digital tools to support self-care, to access online support or make appointments for front line services.

IT and data systems form the spine of the NHS and are fundamental to its everyday operation. Ensuring that the local IT infrastructure is both secure and fit for purpose to support and increasingly digitised service is essential. By designing infrastructure...
to expand and respond to future demands and maintaining high levels of security with updated cyber threat detection the programme will ensure that we continue to enhance digital services whilst keep services and data safe.

Strategic plans for digital transformation are already embedded in the North Mersey Digital Roadmap which we will continue to implement.

**Public Involvement**

One Liverpool partners will work together to involve and inspire patients, public, staff and partners to get involved in shaping our plans. We will also talk to people about how we can help them to take better control of their own health and wellbeing.

The extensive engagement conducted through Healthy Liverpool provides useful insight which has supported the development of *One Liverpool* and provides a strong basis for future conversations.

We will up our game in the scope and intensity of engagement in support of *One Liverpool*; sharing information widely, offering opportunities for face to face conversations and using a wide range of channels to seek views.

We will also seek to reassure people that our plans are locally-driven and ambitious for better health.

**Partners will work together to develop proposals for conversations to inform One Liverpool, engaging staff, local people and other stakeholders.**
14 Next Steps

The One Liverpool Plan is just the first step in the process to establish an effective integrated system of care. We will act with focus, pace and with a clear roadmap to establish an integrated partnership for transformation. The diagram below sets out milestones in 2018/19 to establish detailed plans and new ways of working.

15 Conclusion

*One Liverpool* sets out how Liverpool health and care system partners will deliver real changes in health outcomes, building upon the achievements and lessons learnt from *Healthy Liverpool*.

One Liverpool represents a change in the way partners will work together to make things happen and we will forge better relationships with patients, public and stakeholders.

We will bring renewed energy, pace to system integration in order to deliver the changes we have committed to make, for improved healthy years of life, better services and a sustainable health and care system.
Appendix 1 – Summary of Healthy Liverpool Outcomes

Healthy Liverpool’s vision was to improve the health of people in the city; supporting more people to stay well for longer and providing the very best treatment and care when needed, underpinned by a number of ambitious outcomes, to:

- reduce avoidable mortality by 24%
- increase the measurement of quality of life from 65-71% for people with long-term conditions
- reduce avoidable hospital admissions by 15% by 2018/19
- be in the national top 10 for patient in-hospital experience
- be in the top 5 for out of hospital experience

A review of progress in achieving the key outcome ambitions of Healthy Liverpool has been undertaken in order to understand where we have achieved progress in outcome improvement and to identify lessons learnt.

Outcome 1
Deliver a $24.2\%$ reduction in premature avoidable mortality by 18/19*

Although this outcome is no longer directly measurable, we can use the measures for premature deaths from cancer, CVD and respiratory disease as a proxy.

The premature cancer mortality rate in Liverpool decreased between 2010/11 and 2014/16 by 9%, but has increased slightly since and the gap to England narrowed slightly; 28.2% in 2010/11 to 27.1% in 2014/16.

The premature CVD mortality rate in Liverpool has decreased by 21%, but has plateaued in recent years. The gap to England has reduced by 32.1% to 24.5%

The premature respiratory mortality rate in Liverpool has increased by 10% since 2009/11 and the gap with England has widened from 43.2% in 2009/11 to 49.1% in 2014/16.

The preventable mortality rate in Liverpool increased between 2013/15 and 2014/16, although the gap with England has narrowed from 35% in 2009/11 to 33.5% in 2014/16.
Outcome 2
Deliver a 15% reduction in avoidable emergency admissions (against expected growth) by 18/19

Avoidable emergency admissions reduced by 11% between 15/16 and 16/17 and we have seen a further 2% reduction in 17/18 YTD month 9. Comparing 15/16 with the 12 months to Dec 2017, the following specific decreases have been observed:

- Alcohol specific emergency admissions are down 18% (291 less admissions)
- CHD emergency admissions are down 12% (211 less)
- Chest pain admissions are down 10% (239 less)
- Stroke emergency admissions are down 9% (81 less)
- Emergency admissions to hospital from people in care homes are down 2% (57 less)
- Emergency admissions for falls are down 9% (223 less)
- Overall bed days are down by 5% between 15/16/ and 16/17. However, complex case bed days are up, attributable to deaths in hospital, care home patients, hip and back fractures, stroke and mental health.

Outcome 3 and 4
Improve patient experience in hospital and primary care to the top 10 in England

The rate of patients reporting a good or excellent overall experience of primary care has remained at 88.6% between 2014 and 2017. Liverpool benchmarks 1st out of 11 Right Care Peers for overall experience of primary care and is ranked 31st out of 207 CCG’s.

Current hospital overall patient experience shows most trusts improving between 12/13 and 16/17 surveys, with all achieving above the national average.

Outcome 5
Improve the quality of life of people with long term conditions to 71% by 18/19

The average Quality of Life score for Liverpool has increased from 65.1% in 12/13 to 67.7% in 16/17, whilst England has decreased from 74.3% to 73.7% in the same period. However, Liverpool still ranks bottom of 11 Right Care Peers in 16/17.

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16 NHS RightCare is a national programme using medical evidence to help local health economies understand how money is spent to deliver the best care and to focus on areas of greatest opportunity to improve healthcare.
## Appendix 2 - Operational performance targets for 2018/19

<table>
<thead>
<tr>
<th>Indicator</th>
<th>March 2019 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral-to-treatment (RTT), % completed within 18 weeks</td>
<td>92%</td>
</tr>
<tr>
<td>Referral-to-treatment (RTT), no. waiting more than 52 weeks</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostics tests, % waiting more than 6 weeks</td>
<td>1%</td>
</tr>
<tr>
<td>Cancer waits, % seen within 2 weeks of referral</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer waits breast symptoms, % seen within 2 weeks of referral</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer waits, % first definitive treatment within 31 days</td>
<td>96%</td>
</tr>
<tr>
<td>Cancer waits, % treatment within 62 days</td>
<td>85%</td>
</tr>
<tr>
<td>AED, the % waiting less than 4 hours</td>
<td>95%</td>
</tr>
<tr>
<td>Mental Health, the 5 of people diagnosed with dementia out of expected</td>
<td>70%</td>
</tr>
<tr>
<td>Psychological therapies, % of people accessing IAPT out of expected</td>
<td>4.8%</td>
</tr>
<tr>
<td>Psychological therapies, % of people moving to recovery</td>
<td>50%</td>
</tr>
<tr>
<td>Psychological therapies, % of people waiting less than 6 weeks</td>
<td>75%</td>
</tr>
<tr>
<td>Service Description</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Psychological therapies, % of people waiting less than 18 weeks</td>
<td>95%</td>
</tr>
<tr>
<td>Early Intervention Psychosis (EIP) receiving care package within 2 weeks of referral</td>
<td>55%</td>
</tr>
<tr>
<td>% of children and young people with a mental health condition seen by an NHS funded community service</td>
<td>33%</td>
</tr>
<tr>
<td>% of the population with access to evening and weekend appointments</td>
<td>100%</td>
</tr>
<tr>
<td>E-referral coverage</td>
<td>92%</td>
</tr>
<tr>
<td>Number of personal health budgets</td>
<td>100</td>
</tr>
<tr>
<td>% of children waiting less than 18 weeks for a wheelchair</td>
<td>100%</td>
</tr>
<tr>
<td>% of people with learning disabilities with a health check</td>
<td>18.6%</td>
</tr>
</tbody>
</table>
Appendix 3 – Draft 2018-2021 Activity Plan

First Outpatient Attendances (Acute)

Three-year Impact

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact</th>
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</thead>
<tbody>
<tr>
<td>Growth</td>
<td>19,248</td>
</tr>
<tr>
<td>Cancer Colorectal</td>
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<tr>
<td>Planned Care Allergy</td>
<td>-108</td>
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<tr>
<td>Advice &amp; Guidance</td>
<td>-6,957</td>
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<tr>
<td>Gastro</td>
<td>-5,270</td>
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<tr>
<td>Double Count</td>
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Follow-Up Outpatient Attendances (Acute)

Three-year Impact

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<tr>
<td>Growth</td>
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<td>Cancer Colorectal</td>
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<td>Gastro</td>
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Follow-Up Outpatient Attendances (Acute)
### Day Case and Elective Spells (Acute)

#### Three-year Impact

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<tr>
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<td>Gastro</td>
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### Non-Elective Spells (Acute)

#### Three-year Impact

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<td>Respiratory</td>
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<tr>
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<tr>
<td>Pulmonary Rehab</td>
<td>-673</td>
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<tr>
<td>CVD</td>
<td></td>
</tr>
<tr>
<td>AF (Stroke Adm)</td>
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<tr>
<td>Cardiac Rehab</td>
<td>-15</td>
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<tr>
<td>Chest Pain</td>
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<tr>
<td>Diabetes</td>
<td>-262</td>
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<tr>
<td>Heart Failure</td>
<td>-174</td>
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<tr>
<td>Syncope</td>
<td>-99</td>
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<tr>
<td>Community</td>
<td></td>
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<tr>
<td>Care Homes</td>
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<tr>
<td>CCTs</td>
<td>-545</td>
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<tr>
<td>Telehealth</td>
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<tr>
<td>Mental Health</td>
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<td>EIP</td>
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<tr>
<td>Liaison</td>
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<td>Childrens</td>
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<tr>
<td>Paediatric Asthma</td>
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A&E Attendances (All Types)

Three-year Impact

<table>
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<td>Respiratory</td>
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<td>Pulmonary Rehab -673</td>
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<td>CVD</td>
<td>AF (Stroke Adm) -14</td>
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<td>Diabetes -262</td>
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<td>Double Count</td>
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Accident & Emergency Attendances (All Types)