NHS

# Cheshire & Merseyside
## Sustainability and Transformation Plan
30 June 2016

**2,571,170**
*people*

**32%**
*Live in most deprived areas*

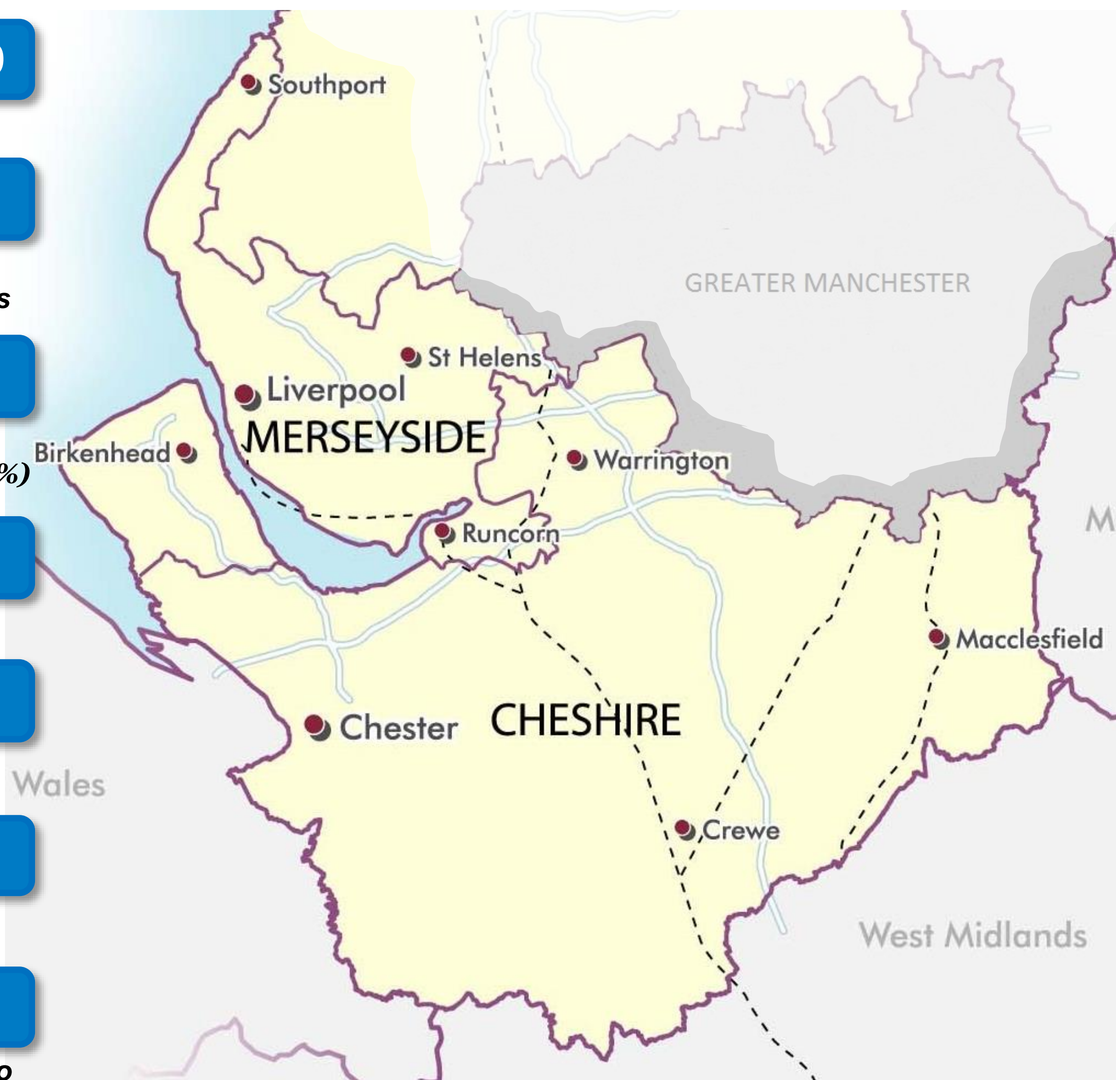
**8.3%**
*Aged 75+ (UK ave. = 7.8%)*

**12**
*CCGs*

**20**
*Providers*

**2nd**
*Largest STP*

**2**
*Proposed Devo footprints*




**Key information**

**Name of footprint and no:** Cheshire & Merseyside; No. 8

**Region:** North

**Nominated lead of the footprint including organisation/function:** Louise Shepherd, Chief Executive, Alder Hey NHS FT

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**Organisations within footprints:**

**CCGs** – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington

**LAs:** Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral

**Providers:** Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Trust

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### Introduction from STP lead

***Louise Shepherd, Chief Executive, Alder Hey NHS FT***

This plan is our radical and ambitious blueprint to accelerate the implementation of the 5YFV across Cheshire & Merseyside. The challenge of coalescing a complex group of organisations across such a large and diverse STP footprint has been a real one; we recognise that the resolve of our collective leadership and strength of engagement with local authority partners are crucial success factors. That collective will has enabled us to make significant progress, as evidenced in this document, since meeting with NHSE and ALBs on 11 May. We look forward to feedback and guidance on 20 July.

We will not let the tempo established in the past few weeks, so essential to generating commitment to, and conviction in, our STP, be dissipated. Our next steps are clear and the leadership decision making and action to fully establish our new programmes, and accelerate those already in train, are underway.

# Executive Summary

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Cheshire & Merseyside (C&M) is a **hugely diverse area** covering some of the **richest and poorest** parts of the UK. Health outcomes are closely related to levels of **deprivation** and this is reflected in below England average life expectancy for many of our local communities. Despite progress in reducing smoking prevalence, school age obesity and hip fractures we still have many challenges including **high rates of respiratory disease and early years and adult obesity, high hospital admissions for alcohol, poor mental health and wellbeing and high rates of teenage conceptions**. These are alongside high rates of diseases associated with ageing, including **dementia and cancers**. Parts of C&M are the fastest **ageing populations** in England and this impacts across C&M.

Across the region there are significant **financial challenges**, either at individual organisational level or across whole economies and each local delivery system has established its own approach to delivering improved productivity and closing the financial gap. In terms of closing the C&M affordability gap, **the 'do nothing' affordability challenge faced by the C&M health economy is forecast to be £999m**.

We have taken a locality approach to meeting our challenges, creating three **Local Delivery Systems (LDS)**. North Mersey; The (Mid Mersey) Alliance; and unified Cheshire & Wirral. After the LDS solutions are modelled there is a surplus of £49m by 2021. However, the solutions that take C&M into surplus require further analysis and challenge to convert them from sound ideas into robust plans. The surplus also includes STF allocations but does not account for the additional deficit which may be driven by social care.

Supporting this we have identified four priorities to make our health and care system sustainable in the near, medium and long-term.

- ***Demand management** and prevention at scale*
- *Reducing variation and improving quality through **hospital reconfiguration***
- *Reducing cost through back and middle office **collaborative productivity***
- *Changing **how we work together** to deliver the transformation*

To transform our services, we need **to reduce demand, reduce unwarranted variation and reduce cost**. To comprehensively address these we must prioritise the areas that we think will have the greatest impact to our system. Recognising that investment in improving the resilience of out of hospital services (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher value care delivery.

Across the STP footprint, there is an **appetite for hospital reconfigurations** to reduce unwarranted variation. This follows from the concept of a new model of population health to better manage demand such as an **Accountable Care System**, whereby the system is held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target.

In convening to develop this C&M-wide place-based plan, we have undertaken a 'current state' assessment of our existing governance arrangements. It is clear that **existing governance arrangement will require strengthening** to implement this STP. We will adhere to a set of key governance principles and arrangements which are understood, owned and led from the top with clear accountability and responsibility at all levels of the STP and underpinned by an agreed set of behaviours.

This STP will only be delivered under **strong leadership**. A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level when necessary. These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace.

**Strong PMO arrangements** will deliver the programmes at pace and on time. Strong systems of financial control and processes (open book) for securing investment in the programmes will be agreed and put in place. Gain and risk share will be clearly understood and agreed. A MoU will be agreed and signed off by all Partners and up dated when necessary.

In relation to the STP all 3 Local Delivery Systems (LDSs) are well established system-wide Transformation Programmes. As a result **each LDS already has strong and legitimised collaborative leadership and decision making arrangements**. Commissioners and Providers within each LDS are well versed in partnership working and collectively changing outcomes.

However, we have received and accept criticism from partners in local government that the nature of the collaboration and engagement process to date has not been optimal to garner wide support for the work on the STP. We have listened to, and share, these concerns. Therefore, **we are inviting local government colleagues to take a leadership role** in designing and monitoring the C&M STP engagement plans in the future. C&M leaders recognise that it is not possible to transform health and health care without understanding what our communities want and without our partners in Local Government. The engagement of **local councillors and MPs** in the LDS and STP will be central to any successful plan.

We will ensure the **devolution deals** agreed and in discussion across the two local authority sub-regions read across the STP.

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# The Cheshire & Merseyside starting point (1/3)

## The footprint is hugely diverse; health outcomes are closely related to levels of deprivation

C&M is a hugely diverse area covering some of the richest and poorest parts of the UK. Health outcomes are closely related to levels of deprivation and this is reflected in below England average life expectancy for many of our local communities. Despite progress in reducing smoking prevalence, school age obesity and hip fractures we still have many challenges including high rates of respiratory disease and early years and adult obesity, high hospital admissions for alcohol, poor mental health and wellbeing and high rates of teenage conceptions. These are alongside high rates of diseases associated with ageing, including dementia and cancers. Parts of C&M are the fastest ageing populations in England and this impacts across C&M.

**On average, people in C&M live shorter lives than the national average**

On average, people in the C&M live shorter lives than the national average and spend a greater proportion of their life living with disability and poor health, with the exception of Cheshire East.

Cheshire East has higher life expectancy than nationally, while Cheshire West & Chester has similar life expectancy to the national average, and Warrington has lower life expectancy than nationally. Warrington has high rates of premature mortality from liver disease, respiratory disease, and communicable diseases such as influenza.

All six areas in Merseyside have lower life expectancy than England in males and females. All areas have high rates of under 75 mortality from liver disease which is often associated with excess alcohol consumption. Apart from Sefton, all areas have significantly high rates of cardiovascular disease deaths and respiratory disease deaths in under 75s. Apart from Wirral, all areas have significantly high rates of cancer deaths in under 75s. These high mortality rates are all indicative of the impact of poverty, as well as lifestyle risk factors such as smoking, excessive alcohol and poor diet.

Healthy life expectancy is often described as a measure of not just whether years are being added to life, but whether life is being added to years i.e. are people living healthier as well as longer lives. On average, people living within Merseyside spend a quarter of their life living in poor health, impacting on themselves, their families and the health and care system.

Long term trends show that overall life expectancy is increasing at a faster rate than healthy life expectancy, meaning that more of our local residents are living into old age with multiple long term conditions, disability and care needs. Without real improvements in our healthy life expectancy, the number of our residents living with long term conditions and disabilities is likely to increase significantly as the size of our older population grows.

**Within this footprint, health inequalities are stark**

The most deprived LSOA (Lower Super Output Area) across C&M is County in Liverpool and the least deprived LSOA is Wilmslow in East Cheshire with males in County living to 74.6 years compared to 84.1 years in Wilmslow. Females in County in Liverpool live to 80.3 years compared to females in Wilmslow in East Cheshire living to 87.5 years.

**Each LDS has its established its own approach for tackling the financial challenge**

Across the region there are significant financial challenges, either at individual organisational level or across whole economies and each local delivery system has established its own approach to delivering improved productivity and closing the financial gap.

Whilst each LDS will focus on delivering improved productivity at a local level, the region has an established track record of working collectively. There is a long history of collaboration between Providers and Commissioners in C&M. The STP will be able to use the existing network of acute, mental health and community providers. Examples of this are the C&M Urgent Care Network, Major Trauma and Transforming Care (Learning Difficulties) and the development of a C&M policy on procedures of limited clinical value and a shared approach to commissioning support services. In 2016/17 the CCGs will be working collective to share and implement QIPP initiatives.

The organisations in C&M will also reflect the 15 key points in the Carter review in their development of the C&M STP Plan as well as within their own organisations.

On page 7, we tell the LDS stories in more detail.

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# The Cheshire & Merseyside starting point (2/3)

## We understand the key factors driving the pressures

### We have an ageing population

The local population is slightly older than the national average, with an average age of 43.0 years compared to 39.6 years in England as a whole. This rises further to an average age of 43.1 years in Sefton. Population projections indicate there will be substantial growth in the number of elderly people in C&M over the next 5 years, with around 57,500 additional people aged 60 and over. The projected increase in the number of people aged 85+ in C&M over the next 5 years is particularly dramatic, rising by nearly 20%, the equivalent of an additional 12,200 people; people aged 90+ will make up the majority of this increase, with a projected rise of over 27% between 2016 and 2021 (See Figure 2). Furthermore, the pace of population ageing is likely to increase in the coming decades.

### Deprivation is significantly associated with poor health outcomes across C&M

Deprivation is significantly associated with poor health outcomes from childhood through adult life to old age. People living in more deprived communities experience poorer health and require more complex care from a younger age. The Cheshire and Warrington local authorities are all less deprived than the England average, although all contain pockets of deprivation. Cheshire East has deprived areas mainly in Crewe, while Warrington has deprived areas around the town centre, and Cheshire West & Chester has high levels of deprivation in Ellesmere Port and in Blacon next to the Welsh border. The LCR has two local authorities that fall into the top 1% nationally for deprivation, Liverpool and Knowsley; two that are around top 10% nationally in Halton and St Helens; and two that are just outside the top 20% nationally, Wirral and Sefton. However there are also some marked inequalities within areas, for example, with some parts of Bootle and Birkenhead being particularly deprived. Cheshire West & Chester and Cheshire East are mainly better than or similar to the national picture for most public health indicators while Warrington has more of a mixed picture.

### The high unemployment rate intensifies this

Overall, C&M has higher rates of unemployment and of being economically inactive than the North West and GB. Liverpool has very high rates of people who are economically inactive as well as high unemployment rates, while Knowsley and St Helens also have high unemployment rates but are lower than Liverpool for the numbers of people who are economically inactive. Liverpool and Knowsley both have high rates of people on employment support allowance (ESA) and incapacity benefits. The Cheshire and Warrington region has lower rates of economically inactive people than the North West, England and GB. Cheshire West & Chester has quite high rates of people claiming out of work benefits given that on average it is less deprived than national.

### Mental health and physical health are not yet integrated in C&M

One in four adults experience at least one diagnosable mental health problem in any given year. Mental health problems represent the largest single cost of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS. In England, if you have a serious mental illness, you are twice as likely to die before the age of 75 years. On average, you will die 15-20 years earlier than other people. Furthermore, people with a mental illness are:

- 4 times more likely to die of diabetes
- 2-3 times more likely to die of CHD
- 4 times more likely to die of respiratory disease
- Twice as likely to die of a stroke

While significant progress has been made in C&M (e.g. securing the nationally promised investment in mental health, specific ROI areas, priority of A&E liaison in year 1, NMC for tertiary MH, reducing OATs), we can do more to address mental disorders recognising the impact of mental ill health and relationship with physical health and life expectancy.

Compared with England average, Cheshire and Merseyside has higher rates of serious mental illness. In England, if you have a serious mental illness, you are more than twice as likely to die before the age of 75 years from a range of treatable diseases. But if you live in Liverpool, you are more than three times as likely.

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# The Cheshire & Merseyside starting point (3/3)

**We have an ageing workforce profile and anticipate staff shortages**

Based upon an analysis of the workforce profile across the three main workforce groups providing health and social care the following implications can be deduced. There is an ageing workforce profile across the three main workforce categories; significant efforts will be needed to continue present health and social care careers as rewarding and worthwhile. Anticipated on-going workforce shortages, particularly in Nursing (Adult, critical care, theatres, Learning Disabilities) Acute Physicians, Emergency Care, Radiology and Psychiatry, Clinical support posts (endoscopy, health care scientists) and Child and adolescent mental health workers need to be appreciated and factored in as part of the risk challenge of meeting the ambitions of the CM STP. Consolidation of services, shared appointments across organisations will be required.

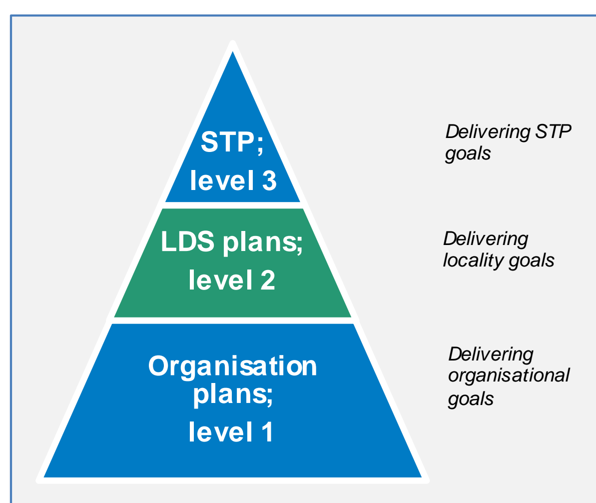
Equally, in primary and community care, we are currently operating below establishment and in some areas at 80%.

Short and medium term workforce planning has to consider how an increase in capacity in primary care workforce will be achieved against what has been a low trend change. More integrated development and co-planning across the NHS, primary and social care workforce will be essential if the workforce capacity, capability, supply and location of staff needed to ensure the delivery of the STP is to be achieved. While there is some early indications of this beginning to occur a step wise change will be required and will demand significant system leadership and collaboration.

**Devolution proposals present a challenge and an opportunity**

There are two devolution footprints within C&M, Liverpool City Region and Cheshire and Warrington. This presents challenges for the STP footprint given that patients will be flowing outside of the Devo boundaries. For instance, the Wirral sees part of its transformation solutions as working closely with Cheshire; Warrington envisages working closely with St Helens, Halton and Knowsley. We therefore recognise that no boundary can be perfect, but due to patient flows, C&M as a footprint can work. We already have experience of working at this level through C&M Clinical Senates and Networks, Specialist Services e.g. Major Trauma. By addressing our four critical decisions across C&M, we will ensure consistency of services for patients and drive out variation. In addition, C&M is quite unique in that it is able to provide tertiary and secondary services for the majority of its population.

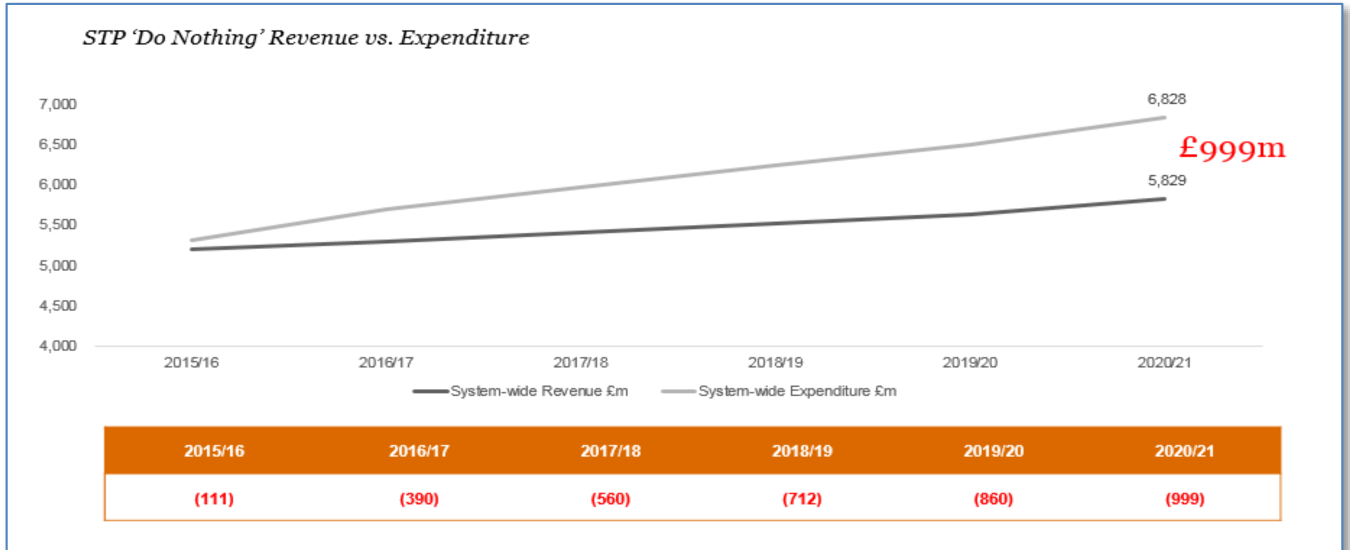
*We therefore propose that we start now to radically change the way we do things so that by 2021 fewer people will be suffering from poor health. We will take a whole systems approach and focus on people and place. We know that people who have jobs, good housing and are connected to families and community feel, and stay, healthier.*




This STP provides the key themes and direction that we are taking in order to deliver a sustainable future across the whole of C&M. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits. It's this tip of the iceberg that will see C&M return to financial balance in 20-21 – adding to the plans already in place at levels 1 and 2.

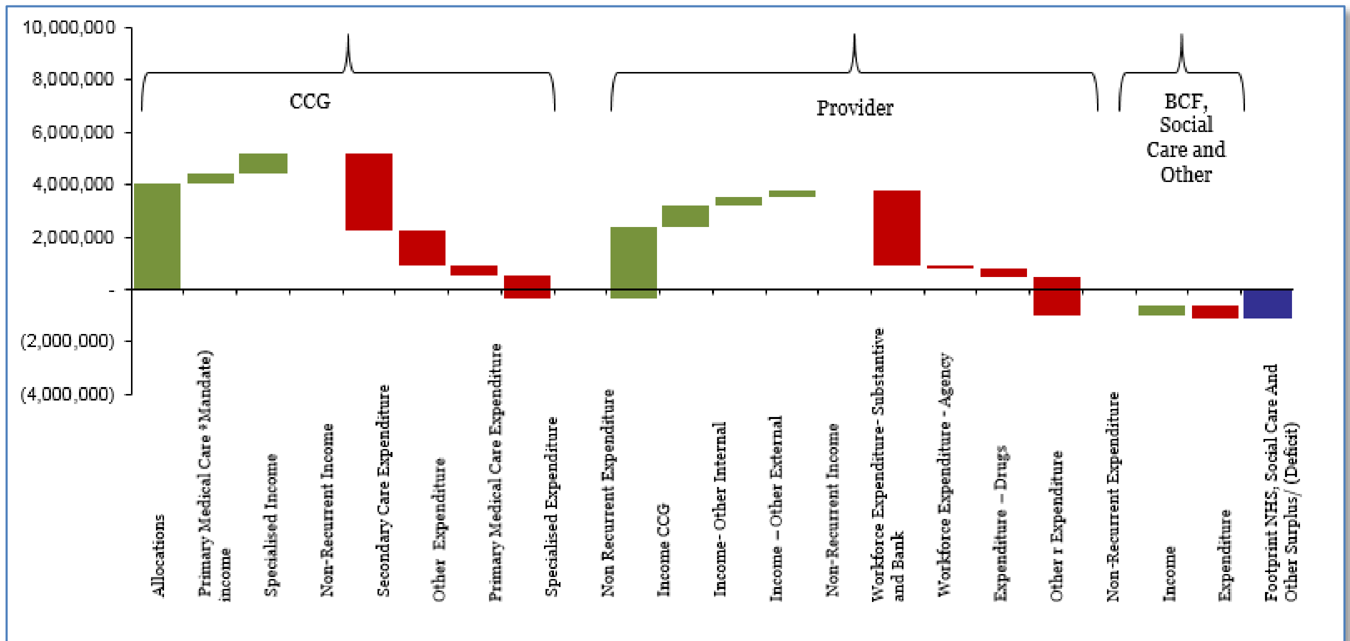
# Closing the Cheshire & Merseyside affordability gap

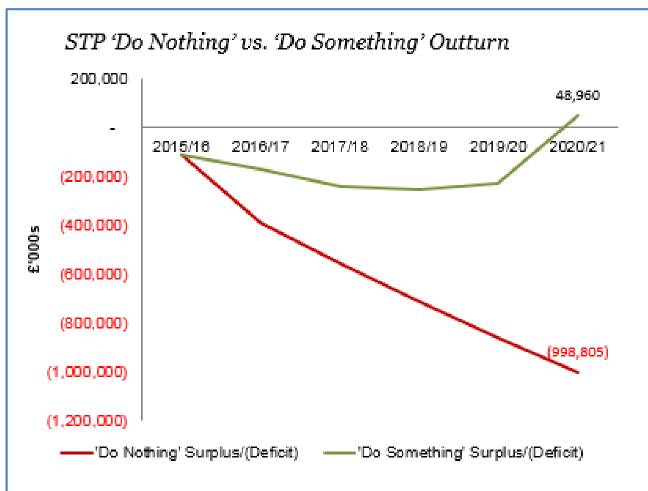
The ‘do nothing’ affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be **£999m**. The drivers of the affordability gap is a growing population that accesses health care more often, and are – positively – living longer but often with one or more long term conditions. Meanwhile, the NHS’s costs are rising more than inflation across the UK economy (to which allocations are linked). The upshot of this is that not only is the system responding to greater throughput, but also that the sum cost of activity is growing faster than allocations.




| 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|
| (111) | (390) | (560) | (712) | (860) | (999) |

This can be broken down as follows:




We have carried out financial modelling to estimate the impact of our transformation solutions delivered in LDSs – largely in our three theme areas. The adjacent graph demonstrates how these changes may potentially address the affordability challenge in 2020/21. It starts from the ‘do nothing’ health challenge of £999m, reducing to a surplus of £49m. However, the solutions that take C&M into surplus require further analysis and challenge to convert them from sound ideas into robust plans. The surplus also includes STF allocations but does not account for the additional deficit which may be driven by social care. For further detail on how we plan to bridge our financial gap, please see page 29 of this STP and refer to our STP template, separately provided.

## Local Delivery Systems’ alignment to the STP

Please see separately attached LDS plans in full

### North Mersey

North Mersey aim to *deliver a step change in health, with people living well for more of their lives and an excellent, safe health and care system which is fit for the future.*

The critical decisions for them are:

*Hospital Service Reconfiguration* - delivering better services at lower cost to create the financial and workforce capacity to enable a shift of care from acute to community settings. Our vision is for *a centralised University Teaching Hospital Campus with a single service, system-wide delivery, delivered through centres of clinical and academic excellence*”.

*Demand Management* – We already have ambitious schemes in place which are reducing demand for services, including the largest deployment in Europe of telehealth by a single health system. We will scale up what we know to be having an impact.

*Population Health* – as one of the most deprived areas of the country the sustainability of the local system depends on a radical upgrade in prevention and public health to create a healthier population and reduce demand. Our focus includes tangible actions to address the wider determinants of health, primary and secondary prevention, including a city-wide physical activity programme, blood pressure and alcohol programmes.

*Digital First* – Merseyside stands out as a leader in digital care and innovation. We have significant achievements in information sharing, assistive technology and analytics delivering evidenced based patient outcomes and improved quality of care. The Merseyside LDR sets out how we will transform the way services are delivered, through a step-change in the use of digital technology and innovation; moving to a ‘digital first’ culture with all clinical interactions captured digitally at the point of care and opening up citizen access to services and support through the use of digital technology.

### The Alliance

The Alliance has a shared vision to improve care, deliver better outcomes and deliver clinically and financially sustainable services. We will deliver radical changes in how we deliver care across our system delivered in borough with our partners. We will fundamentally shift our business models to support new models of care that reduce demand on hospital based services, enabling redesign of acute care, and promote health and wellbeing. Our key themes are well aligned to the STP:

*Acute Care (Hospital) reconfiguration* – with an emphasis on acute provider federations working together to deliver a single system of secondary care across a range of services, delivered through centres of excellence”

*Out of hospital resilience* ( Demand management) – with an emphasis on population health and standardisation reducing unwarranted variation, shifting the balance towards a person centred (care closer to home) health and wellbeing system.

*Wellbeing, Prevention and Self-care* – with an emphasis on prevention, early detection, self-care and improved wellbeing at scale.

In support of these 3 areas we will as a system look towards collaborative productivity, improved quality and outcomes, supported workforce, technological advancements with a single shared record and a focus on clinical and financial sustainability

### Cheshire & Wirral

The current provision of secondary care is financially unsustainable and given the lack of capital, we will implement new models of care across the existing four DGH sites by reviewing the urgent and planned care service models.

This will be undertaken with population health, demographics, growth opportunities and access in mind. From this evidence we will reconfigure services on existing sites so as to provide single and integrated services across C&W and within our local communities. This evidence base will also drive primary, community and mental health transformation so as to mitigate the costs of growth through demand management so as to integrate services and avoid the need for increased bed capacity. A do nothing scenario in respect of growth would indicate circa 400 additional acute beds by 2020/21.

Our triple aim is to mitigate the costs of growth, greater reliability and efficiency and reduce duplication of services and sites by vertical integration, horizontal integration and reconfiguration. The C&W plan builds upon examples of best practice including the model hospital which will develop into a model system, with a focus on reducing variation and waste, increased efficiency through greater operational transparency and control, and increased safety through high reliability processes driven by real-time clinical and operational technology platforms.

Cheshire and Wirral will invest in this real time operational performance information so that it can be used to identify and predict hospital pressures and alert status more readily. We propose to use this technology at scale to enable clinically and financially sustainable secondary care in Cheshire and Wirral.

This work is already underway with clinical alliances being formed both within and outside of C&W, for example the MCHFT and UHNM formally embarking on five year programme for partnership and collaboration called `Stronger Together` and clinical integration between COCH and WUTH. This demonstrates our ability to undertake secondary care transformation in the wider context of integrate services out of hospital.

We will undertake a dedicated piece of work to develop a shared understanding of the characteristics of accountable care as a natural consequence of integration.

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## Critical decisions to shift the dial

**We have identified four priorities to make our health and care system sustainable in the near, medium and long-term**

To transform our services, we need to reduce demand, reduce unwarranted variation and reduce cost. To comprehensibly address these we must prioritise the areas that we think will have the greatest impact to our system. Based on our knowledge of our local challenges, and as a result of engagement across the system, we have identified the following four priorities, explored in greater detail later in this STP:

1 **Demand management** and prevention at scale

Investment in improving the resilience of out of hospital services (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher value care delivery. We will explore new models for population health (e.g. **Accountable Care Systems**) for better managing demand in secondary care – particularly non-elective care. Through **proactive care management** and bolstering **primary care at scale**, we will work to shift where care is delivered in favour of more resilient out of hospital care settings. We have also identified that in tackling **primary prevention** (stopping people getting ill) and the wider determinants of health at C&M scale, we can also avoid significant future cost, particularly addressing **alcohol and high BP**.

2 Reducing variation and improving quality through **hospital reconfiguration**

To improve clinical outcomes and drive out inefficiencies we need to reduce unwarranted clinical variation across C&M. We have identified a range of initiatives across our system to improve consistency and standards by transforming the operating model. Our main areas of focus are: collaborating and **standardising specialist services across C&M**; ensuring local DGH services in Cheshire are sustainable and affordable; and simplifying access and developing a truly integrated health and care offer across C&M. We believe that some form of hospital chain model could be the right model for C&M. This sort of decision can only be informed by a **clinical service review** of our cornerstone service core configuration. This is the first action for this work programme. Furthermore, as part of this work to reduce variation and improve outcomes, we have established **7 cross-cutting clinical workstreams**, pan-C&M. These workstreams will work to to ensure that we are We are therefore individually and collectively committed to meeting operating/performance standards, constitution obligations and the ambitions of National Strategies; exploring all new models of care adequately; and considering all possible acute reconfiguration options.

3 Reducing cost through back and middle office **collaborative productivity**

While organisations can achieve efficiencies individually, there is greater opportunity when they work together to **remove duplication and deliver economies of scale**. Our collaborative productivity work will bring organisations together to identify opportunities for reducing the costs in the back and middle office. We have identified 5 priority areas which have the potential to generate significant savings over the next five years: **workforce (bank and agency), estates, procurement, non-clinical support services and clinical support services**. Our immediate next step is to validate the size of these opportunities and mobilise the work programmes to deliver these savings. We believe that this is the area where we will be able to deliver savings the quickest (in year FY16/17).

4 Changing **how we work together** to deliver the transformation

Our financial modelling indicates that our current LDS-driven approach to addressing the challenges facing the footprint will only get us so far. Joined up working is therefore required if we are to fully close our C&M affordability gap. To collaborate and integrate effectively and efficiently and deliver the benefits of the three programmes detailed above, **new collective governance arrangements will be required**. We have proposed a fit for purpose governance structure and we are currently exploring **innovative approaches to securing the required programme management and transformation resource and capabilities**. Though current governance proposals are still subject to agreement, we are committed to aligning decision-making, resulting in faster implementation, as well as increasing the transparency and accountability of existing programmes of work to ensure we deliver the benefits outlined in this STP.

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## Our three critical decisions and the LDS approach

The three themes that will drive transformation across C&M are not new or particular to C&M. They are issues that health economies have tackled over many years but so often failed to deliver on.

However, **there is now an compelling need to deliver on these ideas that have been developing**. This is reflected in the plans of the three LDSs. All three have already put in place programmes to help improve out of hospital care, to reduce the demand on our acute hospitals and to persuade people that they need to take responsibility for their own health.

Acute hospitals in each LDS have started work on aligning and sharing services, including clinical service lines, and in North Mersey, merger discussions are at an advanced stage. There is also a, mixed, history of back office collaboration and working together on city and county wide issues.

In many ways each LDS has a coherent plan that is designed to improve the delivery of healthcare in the region while meeting head on the financial challenges.

The burning platform is such that these issues now need to be addressed at scale and across the whole of the C&M health economy – by doing so we will learn more, deliver more and take advantage of scale economies.

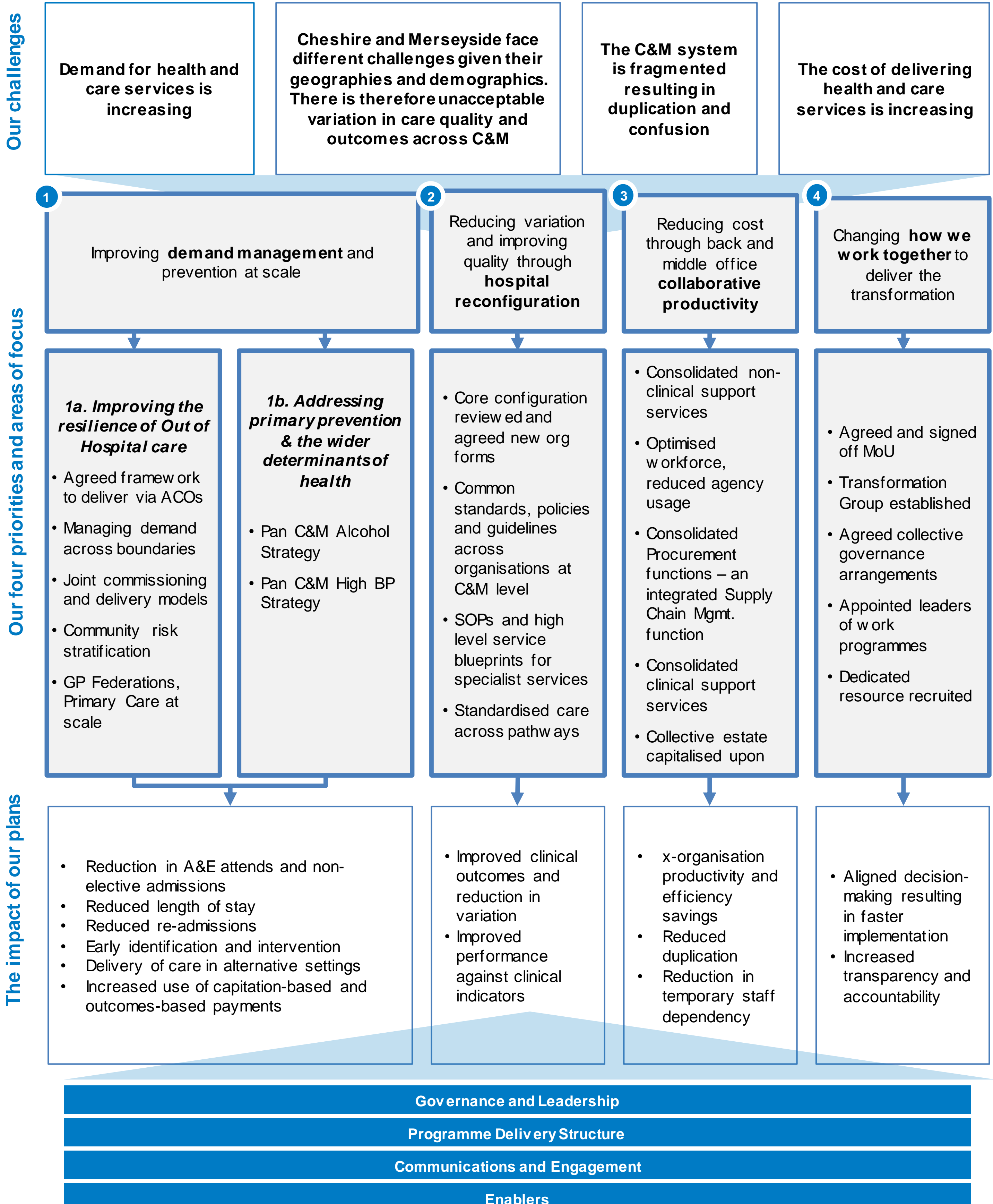
*This STP overlay will be the additional value that C&M can gain from working as a single health economy, while delivering at locality level ensuring the differences across the region are recognised.*

The table below illustrates the plans already in place within the LDSs, and the added value that a C&M view will add.

| | Existing LDS Themes | | |
|---|---|---|---|
| **Added value of pan C&M approach** | **North Mersey** | **The Alliance** | **Cheshire & Wirral** |
| **<u>Demand Management</u>**<br>• **Guidance and strategy**<br>• **Principles**<br>• **Accountability**<br>• **Scale economies**<br>• **Prevention at scale** | • Demand Management / Community Transformation<br>• Population Health – at scale | • Out of Hospital New Models of Care<br>• Wellbeing, Prevention & Self Care | • Integrated Out of Hospital<br>• Accountable Care System<br>• Prevention and Intervention |
| **<u>Acute Hospital Reconfiguration</u>**<br>• **Consolidation of clinical service provision pan C&M**<br>• **Cancer / Cardiac / Neuro Network / Maternity W&C / Urgent Care / LD / MH**<br>**<u>Collaborative productivity</u>**<br>• **Middle and Back office productivity at scale**<br>• **Reduce variation pan C&M**<br>• **Clinical support services pan C&M (Integrated Pathology, Networked Radiology etc.)** | • Delivering the agreed vision for hospital services through service reconfiguration<br>• Strategic Outline Case for merger of Royal, Aintree and LWH Trusts | • Secondary Care Transformation | • Acute Hospital Reconfiguration<br>• Unwarranted Variation |

# STP on a page

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on four priority areas and related areas of focus that we believe will have a greatest impact on our challenges and pressures to collectively address the three gaps of health, quality and finance. The delivery of these plans will be supported by a new cross-organisational governance structure that will allow us to overcome difficulties and collectively manage the transformation required.



NHS

# 1. Demand management and prevention at scale

Each LDS has plans that will tackle demand, enhance prevention, bring care closer to home and radically improve out of hospital care, the highlights of which are shown below. **More can be achieved by tackling these issues across the C&M footprint**. By providing coordination, guidance, standards and clear principles, LDS's will learn from each other and C&M will achieve greater economies of scale.

**North Mersey**

Demand Management
- A one-system model for proactive community care;
- Integrated, neighbourhood services bringing together multi-disciplinary teams including social care, enabled by the transaction of all services provided by Liverpool Community Health
- Establishing an Accountable Care System with strong clinical leadership
- A new model for primary care;
    - Improving access – extended GP access 7 days a week
    - Quality scheme to tackle variation and inequalities
    - Targeted investment in capacity, skills and estate
- North Mersey model for urgent care through 7 day primary care hubs and urgent care centres
- Implementation of the Home First Model to transform hospital discharge and support independence
- Transformed and standardised pathways across all settings of care for our big clinical challenges - cancer, CVD, respiratory and mental health, embedding self-care and mental health needs

Population Health
- Prevention & early detection at scale and pace, taking a place based approach
- Effective support for self-care
- Tackling High Blood Pressure, alcohol misuse, smoking and physical activity
- All NHS and LA partners to become health promoting settings
- CVD clinical risk factor management at
- One-system 'social movement' campaigns at scale - smoking, alcohol, inactivity; anti-microbial; supported by a 'Digital no Wrong Door' source of information, access and signposting
- Addressing the wider determinants of health

**The Alliance**

Out of Hospital New Models of Care
- In Borough Integration
- Primary care at scale – federations/localities
- Mental & Physical health sustainability – implementation of taskforce recommendations.
- Dementia Care
- Integrated Community care
- Demand management

Wellbeing, Prevention & Self Care
- Making Every Contact Count
- Population health
- Improved Hypertension, Dementia, Gastro Intestinal & Respiratory
- Schools youth mental health
- Secondary prevention
- Public education
- National screening

**Cheshire & Wirral**

Integrated Out of Hospital new models of care
- Development of integrating community teams at a larger scale
- Development of wellbeing centres
- Cohesive step up step down / Intermediate care offer
- Lesson leant from MCPs and PACS models
- Digital roadmap – respective care records
- Population health management – unplanned admission avoidance
- Five year forward view for Primary care and primary care at scale so as to offer 7 day services
- Out of hospital primary and community care transformation
- Delivery of Core Standards with high reliability

Accountable Care
- Accountable Care membership Systems
- Integration of care across the whole pathway
- Value and goal alignment
- Outcome base capitated budgets with new contract mechanism
- New governance arrangements across a bigger footprint
- Reduced management costs

Prevention and Intervention
- Promotion of empowerment, self care and coproduction
- Diabetes (building on national pilot)
- Hypertension (CVD)

NHS

# Demand management can only be done effectively through a new model for population health

We recognise the importance of demand management to our plan and therefore, exploring new models for population health at the C&M level to help and facilitate the largely LDS driven work to improve the resilience of out of hospital care and moderate healthcare demand is a year 1 and year 2 priority for us.

We are committed for instance to exploring the concept of an Accountable Care System whereby the system as a whole agrees to be accountable for the quality, cost, and overall care of a defined population with the objective of decreasing the total cost of care for the population compared to a spending benchmark.

Our goal in this respect would be to achieve the "Triple Aim" of better health for population, higher-quality care and lower costs of care. We would shift the model of provision from a focus on the remedial to the preventative and expand the potential healthcare consumer universe from "sick" patients to everyone.

**The case for a new model for population health**

Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. It allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals.

Creating networks of providers that deliver care across professions will make it possible to deliver innovative person-centred models of care, based around multi-disciplinary teams. However, in order to realise the ambition for transformative integrated care, radical changes holistically and at scale will need to be made.

The current financial challenge makes integration and consolidation across organisational boundaries a necessity. The NHS five year strategy sets out the ambition for 50% of the country to be covered by ACOs by 2018. Local government leaders understand that they must take a leading role in the integration agenda, otherwise their social care departments will collapse and local people will lose out. Leading health economies are moving in this direction and they are delivering real reductions in hospital admissions; better population health through prevention; and 10-20% cost savings.

**Therefore, to bring together the demand management work across C&M, we will establish a common framework for new models of population health management, delivered locally**

We acknowledge that the LDS geographies and populations need to drive the footprints of any new demand management initiatives (e.g. ACOs). However, we will ensure that we collectively and individually deliver against a common framework of key overarching priorities so that all parts of the system are incentivised to deliver the 'right' level of care . An indicative list is detailed below.

**Action:** Our first priority will be to collectively determine and agree a set **of key characteristics or design principles** for C&M that must be complied with locally when developing new models of population health management in C&M. These principles will ensure all parts of the system are incentivised to deliver the 'right' level of care while acknowledging that each ACO will be tailored for its population and existing organisations.

| *Ambition* | *Care model* | *Delivery model* | *Capabilities* | *System fit* |
|---|---|---|---|---|
| • Commit to locality specific outcome-based targets required to meet strategic plan objectives<br>• Agreement to deliver within agreed financial settlement<br>• Delivery at pace required | • Alignment with core evidence-based principles for C&M local model:<br>• Enable conditions to be managed at home and in the community<br>• Provide alternatives to A&E when crises occur<br>• Support effective discharge from hospital<br>• Help people return home and stay well | • Built from neighbourhood teams managing health of c30-50k<br>• All key providers to be involved in management and delivery<br>• Primary care at scale at the centre of new arrangements<br>• New payment and contracting models to underpin collaborative delivery model | • Demonstration of key population health management capabilities:<br>• e.g. ACO design and setup<br>• Care delivery and coordination<br>• Data aggregation and connectivity<br>• Quality management and incentives<br>• Payments and financial management | • Inter-operability with C&M wide information technology systems (e.g. single patient care record)<br>• Alignment with C&M-wide estates strategy<br>• Aligned with workforce plans<br>• Commissioner support |

NHS

# We must develop the right models to meet local needs

**We recognise that population health models to better manage demand can take many forms**

We are aware that conceptually population health-based models of provision (such as Accountable Care Systems) are nascent, especially in the UK. We also recognise that they can take many distinct forms:

| Model | Features |
| --- | --- |
| **Primary and Community Care** | • Primary care led networks holding risk and budget for defined population<br>• Opportunities to deliver extended range of services as alternative<br>• Sub-contract with providers including acute |
| **Primary, community and acute** | • Vertical integration across settings of care<br>• Network to include providers across pathway<br>• Providers hold risk and budget for population. Risk shared across wider provider base<br>• Sub-contracts as required |
| **Whole system alliance** | • Providers and commissioners form alliance<br>• Manage risk as a system – single budget and objectives<br>• Collectively hold risk and budget for population |

Any new model we establish will need to be clear on the features and the pros and cons of these nuanced forms and ensure they are compliant with the key principles agreed.

Therefore, where the decision is taken locally to develop a new model of provision, there are a number of **key questions and considerations** to factor in:

- What is the most effective way of managing the health of the population?
- What is the most appropriate catchment area/population size/natural footprint?
- How do we ensure LAs are at the table at the outset to design the model collectively?
- How do we factor in Devolution proposals?
- What will really incentivise behavioural change in providers? This can't just be a new commissioning model.
- How will risks be shared across the system?
- Which services and population cohorts would be involved? e.g. the whole population, people aged over 65, people with LTCs etc.
- What are the key enablers? e.g. capitated budgets
- How we will model the impacts of demand reduction?
- What might this mean longer-term?

**We must understand the critical success factors for optimal demand management**

*Strategy and Vision:* There is a compelling vision and clear strategy for managing demand and delivering care across the whole system.

*Leadership and Governance:* There is an emphasis on excellent clinical and managerial leadership supported by robust governance that enables organisations across the system to continually develop and improve outcomes for patients/ service users.

*Processes:* Clearly understood management processes are in place which enable co-ordinated delivery and alignment across multiple organisations.

*Technology:* Technology is used to support the delivery of outcomes and ensure that care is centred around the patient.

*Performance Management:* Performance requirements and expectations are understood by all organisations involved in the delivery of the contract.

*Finance and risk management:* Appropriate financial and risk management controls are in place to identify and mange safety, reputational, demand and financial risks (including tax risk)

*People and Culture:* Organisations are able to identify, recruit and retain an appropriately skilled workforce.

*Sourcing and collaboration:* Providers are able to access resources from and collaborate with a range of organisations.

**This will only work with the right commissioning and contracting architecture**

Nationwide, the current model of commissioning has led to the fragmentation of both incentives and structures which has resulted in the disempowerment of service users. It is therefore recognised that to realise the benefits of our approach we need to develop and adopt different ways of commissioning that emphasise value and population health.

It is not proposed to adopt a single commissioning model for C&M but instead to enable CCGs to adopt models that suit their populations. It is expected that any contract will focus on:

- provision of care on the basis of geographically coherent populations;
- emphasising prevention, early intervention and proactive management, rather than activity;
- system outcomes and risk sharing across pathways;
- the total cost through the whole patient; and
- integration between different types of providers.

NHS

# A new model for population health will enable enhanced prevention at C&M scale

## Pan-C&M Alcohol Strategy

Reducing health inequalities by improving the health of the poorest fastest is central to our plan and enabled by new models for population health. We intend to focus across C&M on the two prevention priorities that will deliver the greatest ROI:

1. *Alcohol*
2. *Hypertension/High Blood Pressure (BP)*

### Alcohol

Alcohol is a cause of a wide range of health and social harms for individuals, their families and communities across C&M:

- Alcohol has been identified as a causal factor in more than 60 medical conditions. Most of these harms are preventable. Therefore reducing alcohol harms is likely to reduce the incidence of CVD, hypertension, liver disease, some cancers and depression.
- Excess alcohol consumption also poses considerable risks to safety and wellbeing through an increased risk of injuries, family breakdown, domestic violence, neglect and unemployment.
- Alcohol misuse across C&M costs around £994 million each year (£412 per head of population). Of these costs £218 million are direct costs to the NHS.

| Pan C&M cost of alcohol (millions) | | | | |
|---|---|---|---|---|
| **NHS** | Crime | Workplace | Social Services | **Total** |
| **£218** | £276 | £430 | £81 | **£994** |

C&M suffers from high levels of alcohol-related harm when compared to other regions (When compared to England 7 out of 12 CCGs have significantly higher rates of alcohol specific mortality, 7 out of 12 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and 9 out of 12 CCGs have significantly higher rates of alcohol related admissions (broad definition).

Alcohol misuse is a major cause of health inequalities across the region with the most deprived members of our communities suffering from the higher levels of alcohol-related harm than more affluent areas. The overall aim is to reduce the negative impact of excessive alcohol consumption on individuals and their families and reduce its associated burden on the NHS, Local Authorities (LAs) and wider society.
This will be achieved by system level actions to:

- Increase awareness of the harms of alcohol among local communities and professionals.
- Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs
- Reduce the burden on NHS, police and social care services from high volume service users

We have identified a list of key interventions which should be seen as part of a joint C&M Alcohol strategy involving NHS, LAs, Police, and the Community and Voluntary sector. The strategy will include system wide interventions to reduce alcohol-related harm (related to prevention, early identification, treatment and recovery, crime and community safety, licensing, availability and price):

- *Effective population-level actions are in place to reduce alcohol-related harms*
- *Large scale delivery of identification and brief advice (IBA)*
- *Specialist alcohol care services are available for people in hospital*

**Return on investment**

***Prevention:*** Measures to reduce alcohol availability have the capacity to have a high benefit: cost ratio of £4000 per £1 spent. Based on the NICE alcohol ROI tool, a programme to reduce alcohol availability by 10% could save around £1billion in 5 years in C&M, including £7million direct health care cost savings.

***IBA:*** If 50% of people in C& M were screened at their next GP appointment, IBA could result in a £220million net healthcare cost saving in year 5, as well as significant QALY gains and productivity gains. The overall benefit:cost ratio could be as high as £290 per £1 spent (Based on NICE alcohol ROI tool).

***Treatment and recovery:*** Hospital alcohol interventions are good value for money. Evaluations indicate that return on investment from effective alcohol care teams can be between £3.50 and £3.85 per £1.00 invested. Assertive outreach services can deliver a return of £1.86 per £1.00 invested. Investment in specialist alcohol treatment can produce a high return.

For every 100 alcohol-dependent people in treatment (cost £40,000) will save £60,000 and prevent 18 A+E visits and 22 hospital admissions.

# A new model for population health will enable enhanced prevention at C&M scale

## Pan-C&M High BP Strategy

### High Blood Pressure

High BP is the second biggest risk factor for early death and disability in England. It has no symptoms but left untreated can lead to medical complications including heart attack, stroke, heart failure, chronic kidney disease and vascular dementia. High BP is the most common LTC in the UK, affecting more than 1:4 adults, but almost half of those affected are not aware. Most causes of high BP are preventable, including being overweight or obese, poor diet, lack of exercise, drinking too much alcohol. In C&M, around 625,000 people are estimated to have high BP, but only 350,000 of these are known to their GP. Around 275,000 people are thought to be affected but undiagnosed. People from the most deprived areas are 30% more likely to have high BP.

**Case for change nationally and in C&M**

High BP accounts for 12% of all visits to GPs in England. Health checks uptake ranges from 5%-12% across CCGs (target 20%). Of those diagnosed, up to a quarter are not controlled to a minimum standard and there is unwarranted variation in care between general practices. Most CCGs in C&M have higher than average CVD prevalence (11/12). Hospital admissions rates are higher than the England average for heart attacks (7/12 CCGs) and for strokes (4/12 CCGs). Death rates are higher than the England average for heart attacks (10/12 CCGs) and for strokes (8/12 CCGs). 800 Heart attacks and strokes could be prevented every year through optimising BP treatment alone.

**A pan C&M strategy to tackle high BP**

In order to tackle high BP we need a cultural shift with cross-sector partners working as a single system. '*Saving lives: Reducing the pressure*', C&M's cross-sector strategy to tackle high BP (May 2016) sets out such an approach in 7 key strategic aims:

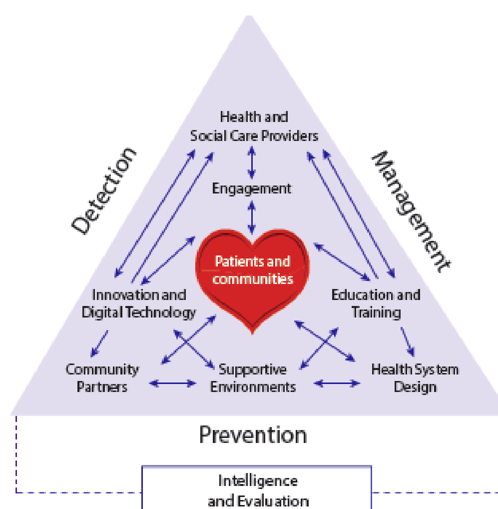
1. *Ensure most people with high BP are aware of their condition*
2. *Empower more people with high BP to control it through lifestyle alone*
3. *Prescribe appropriate medications when needed*
4. *Control more of those known to have high BP to target*
5. *Reduce inequalities in BP-related outcomes*
6. *Reduce the burden of ill-health and deaths caused by high BP*
7. *Be the most improved sub-region in England for BP outcomes*

**Return on Investment**

***Prevention:*** The biggest and most sustainable way to reduce the impact of high BP. Nationally it is estimated that 45,000 QALYs could be saved, and £850m not spent on related health and social care over ten years if England achieved a 5mmHg reduction in the average population systolic BP. The most cost effective interventions for tackling high BP include those which reduce dietary salt intake (PHE, 2014). As most high BP is due to preventable factors, interventions that address these, (e.g. Making Every Contact Count (MECC)) will positively impact on BP. MECC is estimated to give a benefit to cost ratio of around £35 gained for each £1 spent.

***Detection:*** Nationally a 15% increase in diagnosis of high BP is estimated to produce health and social care cost savings of around £120m and result in around 7000 QALYs gained over ten years (PHE, 2014). In C&M if we pro rata the total societal value of this for England (£26million per annum) to CCGs in proportion with their undiagnosed hypertension population, the annual value of a 15% increase in diagnosis of high BP is around £1.6m (potential health and social care cost savings of £867,000 and QALY gains valued at £743,000) or £8million over 5 years.

***Management:*** The cost of treating hypertension is estimated at around £199 per person per year. This is dwarfed by the financial burden of managing the consequences of untreated BP. Nationally it is estimated that 7,000 QALYs could be saved, and £120m of related health and social care costs could be saved over 10 years if England achieved a 15% increase in the proportion of adults on treatment controlling their BP to 140/90 or below. If all GP practices in C&M performed as well as the 75th best percentile for managing blood pressure in people with hypertension the potential economic value is £20m cost savings to health and social care over 5 years (£17m savings to the NHS, >£3 ½ m savings to social care).



NHS

# A new model for population health will incentivise other transformational changes to the system which improve demand management

**A new model for population health will incentivise other transformational changes to the system: primary care at scale and enhanced community risk stratification.**

Primary Care is the front door for health and care services, but an increasing elderly population, with higher demand for healthcare services, coupled with decreased relative funding and workforce, is having severe consequences both nationally and locally for GP practices. In some areas nationally, 1 in 3 GPs are planning to retire in the next 3 years. The number of newly qualified GPs seeking work will not fill this gap. Similar retirement and recruitment issues are experienced with practice and community nurses.

The partnership model of partners owning the business and its assets, places individuals under personal financial risks. Many newly qualified GPs want a salaried, portfolio career, and are not keen to enter into business ownership. Many partners would prefer to be salaried if they could free themselves from the burden of their property.

The primary care model in C&M is currently unsustainable. A place-based model of primary care at scale is required. A place-based accountable model retains the concept of list-based primary care, but empowers GPs to take advantage of the opportunities presented by working at scale within the established federations. It will work within natural communities, with General Practice clusters at the heart of integrated care provision. We aim to establish a primary care offer that is proactive, accessible and co-ordinated.

During this STP period, therefore, to address current pressures we will look to learn from the successes of other health economies on primary care at scale. For instance, by:

- Developing roles such as 'care navigators' and physicians' associates who can reduce some of the demands on GP time
- Establishing new ways of working across federations that reduce bureaucracy, administration and demand for clinical consultations
- Creating joint posts supporting multiple practices or working across health and social care.
- Implementing alternatives to face to face GP consultations, such as e-Consult and self care
- Developing social prescribing and signposting to alternative community services, and increasing the role of pharmacists and nurses

We will evaluate methods of developing sustainable GP Practices so that change can be enabled at pace.

**Proactively finding and managing risk cases in the community**

We must increasingly target people with specific conditions and/or a social care package using risk stratification, combined data sets and local knowledge.

We will then be able to develop a personalised, single care plan that can be accessed electronically by all practitioners that would need to see the information.

Learning from leading health economies suggests that we can create Integrated Care Teams around clusters of GP practices to deliver care in a more responsive and coordinated way, including volunteer support on a 1:1 and group basis.

*Example: A 'Single case manager' with overall responsibility for ensuring delivery of the care plan, different members of the integrated team will lead at different stages of the persons care depending on their changing and planned needs; the whole team will be accountable for the persons care and teams will self-manage and will be self-directing.*

With the right technology, we can increasingly look to establish virtual wards whereby case management and care delivery by members of a multidisciplinary team provides targeted and focused care and support to people who are at high risk of crisis or very high consumers of health and social care resources.

**This is just a direction of travel towards a truly integrated health and care system; the correct models for population health are the first step**

This approach in C&M will mean that multiple organisations coming together perhaps for the first time. Those who have historically been competitors will be asked to collaborate. This will be predicated on new funding, contracting and regulatory models and these contracts worth billions and potentially long-term (up to 15 years) will inevitably attract scrutiny.

If this is to work, we acknowledge that we must overcome any vested interests in working in the old way as well as any lack of trust and understanding across a health and social care divide.

Crucially, we know that the old model is no longer sustainable. We are therefore committed to the idea that Accountable Care, the key pillar of this STP, represents the best hope for a sustainable health and care system in C&M.

Effective prevention and early action can deliver a 'triple dividend' by helping people to stay well and live healthy lives, thus reducing the demand for costly services and creating the conditions for a prosperous economy.

NHS

# 2. Reducing variation and improving quality through hospital reconfiguration

**To improve care and reduce cost we need to reduce unwarranted variation**

The LDS plans shown below will drive out variation, improve standardised levels of care and lead to hospital reconfiguration. By undertaking this thinking at C&M level we will derive greater benefit and deliver a consistent clinical service across the STP footprint.

**North Mersey**

Hospital Service Reconfiguration

- Implement the vision: "To have a centralised University Teaching Hospital Campus with a single service, system-wide delivery, delivered through centres of clinical and academic excellence"
- Strategic Outline Case for potential merger of the Royal Liverpool and Broadgreen University Hospital, Aintree University Hospitals and Liverpool Women's Hospital
- Deliver specialist clinical integration, with hospital services delivered locally whenever practicable, central where necessary
- Enhance specialist excellence, including creating networks of specialist providers and establishing hub and spoke models to improve ways of working across tertiary and DGH care across Cheshire and Merseyside.

**The Alliance**

Secondary Care Transformation

- Urgent care redesign
- Planned Care redesign
- Federation' of the three acute providers
- Clinical teams to deliver single or shared services
- Rationalisation and reconfiguration of elective care
- Clinical support services collaboration
- Corporate services collaboration
- Estates rationalisation and non-pay efficiencies:

**Cheshire & Wirral**

Provider reconfiguration. A dedicated piece of work will inform:

- Current and future patient flows
- Sustainability of current provision and estates
- Re-Configuration of Acute and Mental Health Services (Service line review)
- Future workforce requirements
- Options appraisal for provider care reconfiguration -
- Impact of centralization / Hub and spoke models/ Impact on other areas of the patient pathway including (Primary Care at scale)
- Walk In Centres/Intermediate Care/Step Up Step Down/Urgent Care center's/Type 1 A&E / New model of care
- Interdependency on out of hospital and community and mental health services

Unwarranted Variation

- Develop and evidence base that demonstrate variations inn care so these can be addressed
- Cheshire and Wirral Medicines Formulary
- Agreeing standard operating procedures
- Agreeing new to follow up ratios
- Agreeing clinical criteria for admissions
- Developing central control rooms so as to reduce LoS

# We will undertake a rapid review of clinical services to understand our core configuration

Across the STP footprint, therefore, there is an appetite for hospital reconfigurations to reduce unwarranted variation and ensure the sustainability of currently unaffordable local service provision.

To date, this thinking has largely been driven at the LDS level with little consideration of hospital reconfiguration across the C&M-wide footprint.

However, we believe there is now greater benefit and the financial imperative to undertake this thinking at C&M level to deliver a consistent clinical service across the STP footprint.

**We need to understand our clinical services' core configuration**

We recognise that the current acute configuration within this footprint is unsustainable. This is perhaps most evident in Cheshire. The number of tertiary providers in Merseyside presents an atypical challenge and opportunity as well.

Given the importance and sensitivity of this area, our first task is to instigate a service by service review of the acute care model.

We will begin by initially focusing on our 5 of our 7 cross-cutting clinical service areas (not including Mental Health and the Transforming Care streams as this will not impact acute configuration).

This will be a single programme of work that will build on LDS-led reviews and work undertaken by the NW Specialised Commissioning team. However, vitally, it will ensure that decision-making on the totality of acute provision is taken in a coherent way at the STP level.

inform the acute service reviews with a focus on the standardisation of care models, reduction in variation and an explicit decision taken on the locations of acute provision based on analyses of future patient flows and travel times.

**How does this fit with an ACO approach?**

Whilst acute reconfiguration reviews have been undertaken in the past, this will be different in that the reviews will focus on how the acute provision will synergistically work within the construct of a demand management system (and potential ACO).

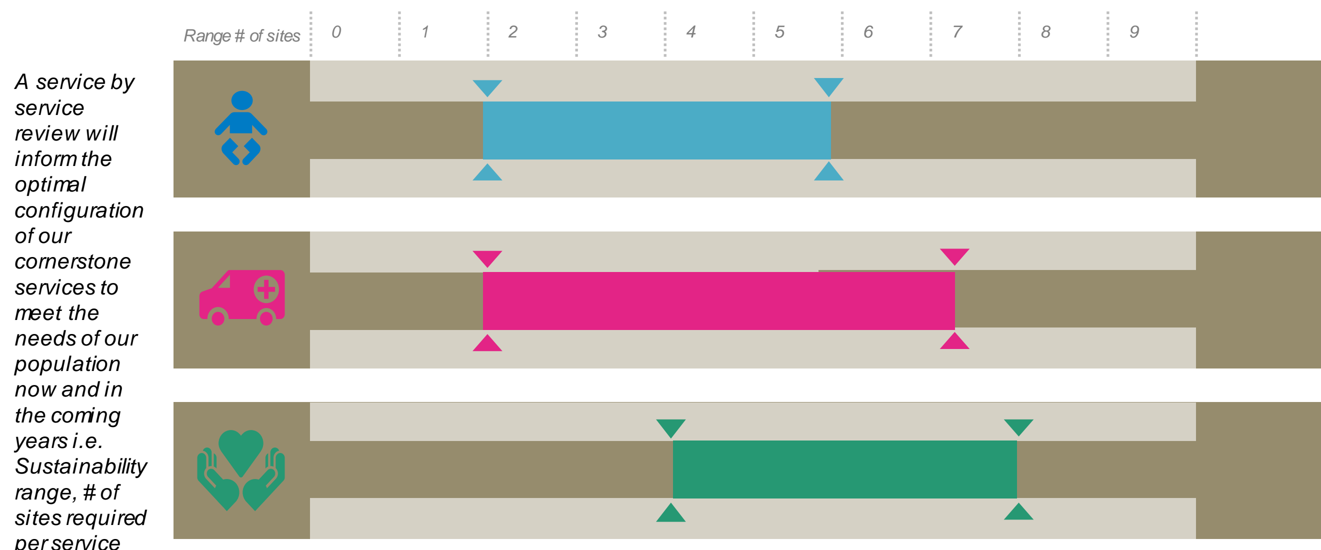
In addition, the reviews must embrace new technologies, such as TeleTracking, to create individual control centres capable of having visibility across multiple provider sites existing and operating as a single service but in a networked way.

Our vision is that the definition and specification of the local District General Hospital will be sustainably supported through a network of specialist provider services, making a virtue of Merseyside's strong cohort of tertiary centres. This big idea is underpinned by health and social care integrated at the core.

The review will be undertaken rapidly with an outcome on the direction of acute provision being available for the next stage of consultation by December 2016 (subject to further discussion and agreement).

We start from a position of understanding that the current acute provision is not viable based upon workforce, quality and finance. There is also a far greater requirement to recognise the opportunity for greater sustainability of providing specialist services on a wider footprint.

In conjunction with this, we will undertake a service sustainability audit of prescribed specialised services and develop work programme to respond to highlighted areas in the context of the broader STP and in conjunction with neighbouring STP footprints.




*Indicative output from clinical service review*

# A clinical service review will prioritise options to reduce variation and ensure sustainable future services

**Subsequent to the clinical service review recommendations, one potential option for future service provision may be through specialist service franchises/chains or foundation groups.**

There is increasingly recognition that the sustainability of services from both a workforce and financial perspective is challenging across the footprint and that chain models or franchise models should be considered.

Too often, the term hospital chain is used as an umbrella term to label any collaborative venture between hospitals. This can be a source of confusion. It will be necessary to understand clearly the nuances and distinctions between models put forward in the Dalton Review, including:

- *Buddying*
- *Learning networks*
- *Partnerships/joint ventures*
- *Franchises*
- *Hospital chains*

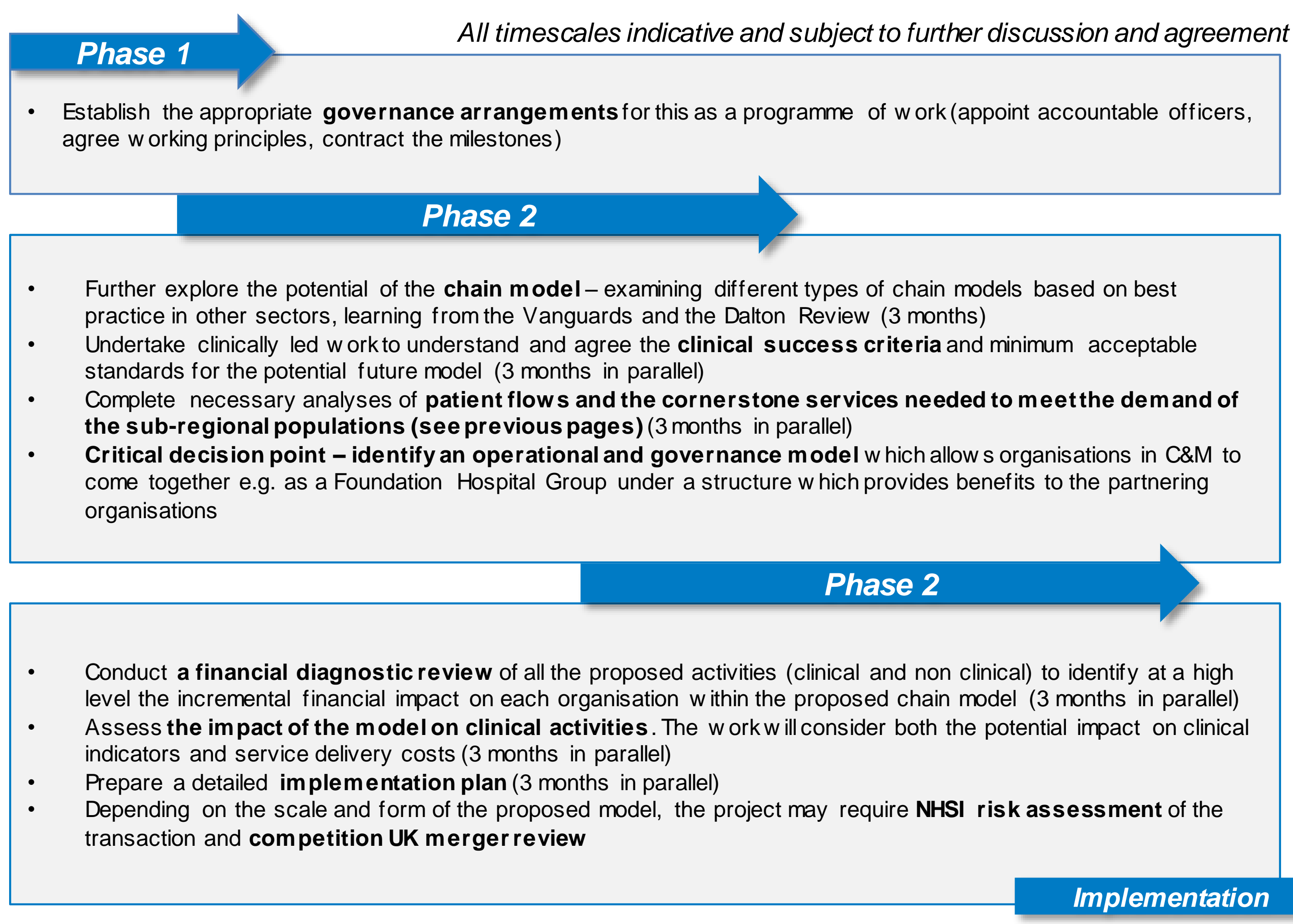
**Agreeing the right model for C&M**

As depicted below, we will undertake an accelerated options appraisal on an organisational form which will support the systematisation of clinical models and enable standardisation of pathways.

Financial modelling and clinical impact assessments will be prioritised in order to understand the clinical benefits as well as the cost drivers.

**Ensuring the sustainability of local DG services; capitalising on the footprint's specialist and tertiary expertise.**

Early conversations have suggested that the local District General Hospital could be sustainably supported through a network of specialist provider services, for instance, making a virtue of Merseyside's strong cohort of tertiary centres e.g. an Alder Hey @ model etc.



# This model enables greater standardisation and improvements to clinical outcomes across C&M

Stopping short of radically transforming the operating model, there is certainly an opportunity to standardise care across the footprint with the STP as fresh impetus.

Through taking a pan-C&M approach to the following, we can reduce unwarranted variation and improve quality: implementing common standards; creating SOPs and service blueprints for specialist services; and standardising care across pathways.

**Implementing common standards, policies and guidelines, SOPs across organisations – all of which meet with national and regional standards**

We aspire to a high-quality services across our pathways and provider organisations. We are therefore individually and collectively committed to meeting operating/performance standards, constitution obligations and the ambitions of National Strategies and policy documents e.g. those as set out in the maternity review, the cancer taskforce report and the Mental Health Five Year Forward View.

We will work to implement evidence based clinical standards of care consistently across providers at the pan-C&M level.

Our 7 clinical cross-cutting themes, with the necessary leadership and accountability, will provide the necessary framework to do this effectively across the footprint.

**Standardising care across pathways**

We will look to offer our citizens in C&M, evidence-based pathways of care which will cross acute, mental health, community and specialised care and we will adopt consistent methodology and standards.

The aim is to provide high-quality, cost efficient and integrated services across our footprint. We will initially address our 7 cross-cutting clinical areas.

In redesigning pathways, the role of commissioners will increasingly focus on the required quality, care, governance and patient outcomes. Providers will be required to respond to these requirements with integrated, efficient and patient focused pathways.

The key element of pathway standardisation will be using the NHS Right Care improvement methodology to design/re-design optimal pathways of care.

The same methodology will be applied to the design of each pathway:

1. *Identify areas of biggest opportunity*
2. *Isolate what needs to change*
3. *Understand what good looks like and what needs to be done differently*

Clinical leadership will be central to our approach and will include:

- Championing the NHS Right Care approach to others within commissioner and provider organisations and building a consensus within the teams of those organisations
- Taking an overview of whole paths of care and their interdependencies with others and acting as a critical friend to challenge groups working on elements
- Leading design and implementation of key elements of each path of care

We need to move quickly and work with existing groups to deliver the redesign of pathways at speed, but in doing so must maintain the integrity of the whole of each pathway and manage the interdependencies between them.

Public Health expertise will also be essential to ensure prevention is built in as early as possible in pathway redesign and where possible to suggest evidence based alternatives to clinical interventions.

Delivery will require not only changes in clinical pathways, but also changes in provider organisations and commissioning models longer-term that will most effectively deliver the services for our population.

**Networking services across sites, enabled by digital technology**

As a footprint, we will embrace new technologies, such as TeleTracking, to create individual control centres capable of having visibility across multiple provider sites, existing and operating as a single service in a networked way.

This is something that Cheshire & Wirral are already exploring at LDS level. They have developed a good basis for this through the Cheshire Care Record and Wirral's work with implementing the Cerner Millennium Electronic Healthcare Record.

*Note: the role of our 7 clinical cross-cutting themes will be critically important to this workstream. Please refer to the Appendix for high-level plans and current state assessments of these workstreams, some of which are very well established and have been for a number of years, others are being newly mobilised as part of this STP.*

NHS

# 3. Reducing cost through back and middle office collaborative productivity

Within organisation and across LDS there are many plans to deliver productivity savings, some badged as 'BAU' others requiring significant change. These are being delivered at locality level and many of the savings fall out of the acute reconfiguration work, or the development of primary care at scale and the streamlining of community services. Whilst the LDS plans do involve collaborative productivity, such as Whole Systems Financial plans, driving out waste, Productive Provider Collaboration, Back Office Functions and the Model Hospital, it is the pan C&M collaboration that will drive out further savings and deliver real efficiencies at scale.

**Greater benefits will be delivered by collaborating across C&M**

We can no longer rely on traditional efficiencies within organisations. The Carter Review made clear that we can no longer rely on traditional efficiencies and cost improvement programmes within single organisations.

Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries. This is how real efficiencies are identified and how greater economies of scale can be delivered.

While performance improvements within organisations remain important, we are making a move to longer term transformation and strategic planning across the health and care economy.

The overarching goal is to work together to unlock new economies of scale and remove duplication to deliver a 'collaboration premium' for C&M – effectively, an additional 'system CIP' on top of Business As Usual CIP initiatives.

Alongside this, Trusts can expect to see improved clinical outcomes and better quality services which will drive up patient experience and choice. We have outlined five initial areas for collaboration. Overleaf, we explore these areas in greater depth.

**Based on learning from other health economies, we will:**

- Develop the 5 high-level opportunity areas into plans for delivery and collectively agree the scale of the potential savings targets. Governance and programme management arrangements need to be in place.
- Define the cost bases of the individual opportunity areas and workstreams. The programme can then track the benefits delivered over time in a robust way from the outset.
- Develop an investment strategy to understand the impact across individual organisations. In some cases detailed business cases will be required.
- Get formal commitment to the programme from all collaborating organisations – and from the centre. When there is consensus that the programme and encompassing research, analysis and engagement is at a point where we can move on to implementation, funding alone will not enable transformation and to enable the effective some instances delegated authority from the centre may be required (e.g. estates disposals and receipts).

**Our priorities for the next 6 months**

In the next 6 months we plan to:

- *Establish a MoU, work programme with ToRs, appointed accountable officers, workstream leads, mapped key stakeholders*
- *Understand the quick wins (and potential savings) per opportunity area*
- *Develop the longer-term strategy for this programme of work (milestones, resources required, benefits, enablers e.g. IT)*

This approach will only succeed if the right governance and infrastructure is established. Subsequent to our STP submission, this will be our first priority.

Standardise and consolidate **non-clinical support services** (back office e.g. HR, Finance, Payroll) wherever possible

**Optimise the workforce** by reducing agency usage and developing flexible workforce models in C&M, enabled by real time acuity tools

Integrate and consolidate the **Procurement and Supply Chain Management** functions in C&M

Consolidate **clinical support services** to generate economies of scale and deliver consistent, high quality services

Capitalise on the **collective public sector estate** across C&M

NHS

# We have identified five back and middle office areas to focus on (1/2)

**1. Standardise and consolidate non-clinical support services**

At present, non-clinical support services are duplicated across trusts; tasks are repeated; there is significant variation in quality. Administrative activity impinges on clinical time and the technologies that are intended to increase productivity are not meeting their potential.

The consolidation of non-clinical support functions will lead to savings through:

- *Economies of scale:* beginning with the consolidation of highly transactional services to reduce headcount
- *Standardisation and simplification of processes:* significantly reducing the level of variation across the trusts
- *Improved technologies:* reducing required administrative effort and increasing clinical productivity
- *Effective talent management*: providing staff who deliver non-clinical support functions with the scope and authority to re-engineer existing processes.

Five options have been identified – in-sourcing to best placed C&M entities, consolidation of all the functions to a single location, setting up a C&M-owned Shared Services Centre, setting a joint venture with a private sector partner and outsourcing to the private sector.

We will establish a workstream to determine the preferred model and identify the processes in-scope for consolidation.

**2. Optimise the workforce – curbing agency spend**

Staff banks offer a more affordable and controllable way to service the demand for temporary staff than agencies. However, some staff are understandably tempted to work for agencies at higher rates, reducing the number of shifts that can be filled by the more affordable bank staff.

Working as a collective enhances our position. We can achieve savings through:

- *Setting up a shared bank at C&M level:* Bank at C&M level to reduce costs and have consistent and potentially shared rotas
- *Reducing demand for temporary staff:* one trust would undergo an intense productivity drive creating a centre of excellence who will share best practice across all trusts, beginning with the e-rostering system. Longer-term, we intend to operate as a single employer 'One NHS in C&M' to enable flexible workforce models and movement of staff.
- *Sharing and scaling up Countess of Chester workforce acuity models*
- *Reducing agency rates:* Collaborating to secure the best rate from a select group of agencies and a vendor management system to improve understanding of temporary staff spend
- *Increasing supply of affordable temporary staff:* by setting up a jointly owned agency, starting with high impact staff groups and expanding over time.

By 2021, we want to have built a large staff base by offering competitive rates and other non-financial benefits. The commission would be re-distributed among partnering organisations. There will be visibility of spend on bank and agency and this will be used to enter into joint negotiations with external agencies to achieve lower rates. Along with a cultural shift in framework compliance, a shortlist of preferred agencies will be chosen and rates fixed. Digital technology will be used to underpin the lean model of the organisation.

To achieve this vision, over the next 6 months we plan to create a data sharing agreement so that bank and agency data can be routinely shared. We will commission detailed baselining of spend in order to identify lowest rates.

**3. Integrate supply chain management and reduce non-pay spend**

There is currently a lack of control and visibility over inventory and non-pay spend across C&M. This has led to price variation, inefficiency and a large volume of waste. Furthermore, there is a lack of data and proper analytics to support product decisions, with clinicians aligning patient outcome/cost with products. The Carter Review indicates that certain supply chain management activity can be centralised while some responsibility is retained locally.

We want to adopt a category-by-category approach to driving down price variation as well as common systems and processes to reduce unnecessary waste and inefficiency. This can be across health and local authority services.

The role and profile of an integrated and collaborative supply chain management function will be expanded to ensure effective management of supply within each organisation. We will have the flexibility to align and fully exploit opportunities from other collaborative initiatives and national frameworks e.g. NHS Supply Chain.

NHS

# We have identified five back and middle office areas to focus on (2/2)

**(Continued) 3. Integrate supply chain management and reduce non-pay spend**

In order to achieve this vision we need to:

- *Reduce waste:* through the standardisation of processes, sharing of best practice, pro-actively challenging non-pay spend, increasing visibility over activity and driving compliance
- *Drive down unit costs:* by leveraging the combined purchasing power and using the most competitive contract terms going forward.
- *Invest in supply chain expertise:* The above will only be enabled by moving away from transaction focused local procurement teams and towards labs of supply chain experts more akin to supply chain management departments in big retail organisations.

**4. Consolidate clinical support services (Pharmacy, Radiology, Pathology, Renal dialysis)**

Challenges common across the clinical support services include: variation in costs e.g. services, medicines; peaks and troughs of demand; and system and process inefficiencies which delay turnaround/ reporting times, impacting patient outcomes.

The Carter Review, and indeed Lord Carter's review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if these services are consolidated on a regional basis.

Therefore, there are a range of future collaborative models which we are considering across the different support services in C&M, ranging from, for instance, setting up a single wholly owned subsidiary organisation for manufacturing and dispensing medicines, to outsourcing dialysis services to a satellite dialysis provider.

We plan to achieve savings by:

- *Reducing the drugs bill and improving pharmacy infrastructure services* through sourcing and contract initiatives and also through improving integration between primary and secondary care pharmacy; improving the use of e-prescribing; and reducing medicine stock-holding.
- *Investigating the collaborative pathology opportunity in C&M*: In line with national guidance, particularly from Carter, we will explore the potential in C&M for integrated and consolidated pathology services – making best use of hot and cold sites.
- *Workforce re-profiling and process improvements* to create a leaner, more multi-skilled workforce with improved retention rates
- *Sharing equipment or harmonising Managed Equipment Service (MES) contracts* by leveraging scale to negotiate better equipment contracts and investing in better equipment
- *Optimising purchase and use of consumables and reagents* by using our collective purchasing power to negotiate better contracts and to reduce waste

**5. Capitalise on collective public sector estate**

There is currently underutilisation at some sites and too high levels of activity at others. Lack of accurate estates data means strategic planning and decision making is difficult.

By 2021, we want organisations to have total transparency of information informing a footprint wide estates strategy. We will work to ensure assets are fit for purpose, flexible and will fulfil future service requirements.

The idea of collaboration within estates is not new, but collaborative productivity will allow it to happen on a new scale. This would build on important work done by private NHS estates strategy organisations who we may look to partner with.

Savings will be achieved through:

- *Reducing the level of under-utilised and non-clinical space:* by understanding the current state of all public sector estate, we can increasingly sweat our collective assets and increase throughput
- *Reducing running costs and FM costs:* through the development of a standard offer for facilities management and working as a collective to renegotiate large scale contracts (laundry, lighting, catering etc.)
- *Improving Productivity:* by investing in digital technology to improve operational productivity and implementing digital care delivery e.g. telehealth solutions

# 4. Changing how we work together to deliver the transformation

**Introduction**

There is a long history of collaboration in C&M, and there are good relationships between Providers, CCGs and Local Authorities. Most CCGs have borough-wide Transformation plans all at different stages of development and delivery.

Through existing Transformation Programmes, there is good local engagement with PPE groups, Health Watch, HWBBs and local Overview and Scrutiny Committees.

However, to deliver transformation across C&M the current delivery infrastructure will need strengthening so that the aims and objectives set out in this STP can be successfully delivered.

Successful delivery of transformation this size requires:

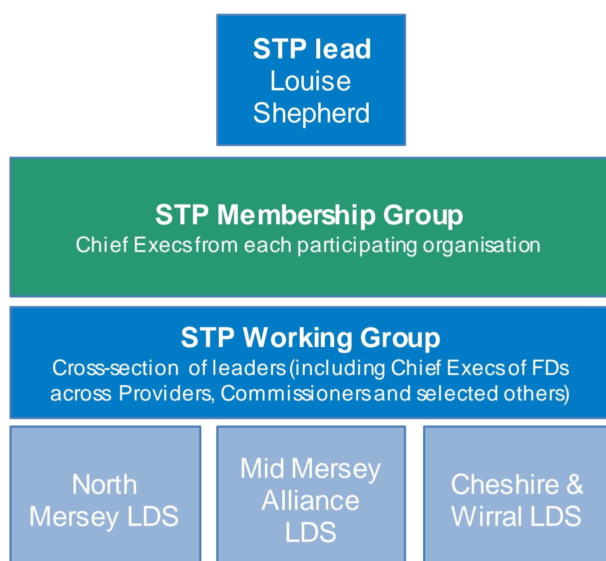
- *Strong leadership*
- *Governance enabling decision making*
- *Robust programme management*

**This STP will only be delivered under strong leadership**

A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level, while having a national network..

These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace.

To date, we have been operating under the following leadership structure:




**Governance Enabling Decision Making**

A successful governance structure will enable leaders to govern with confidence, making timely decisions using high quality management information

Effective governance of a programme is fundamental to successfully delivery and alignment with the STP strategy and direction.

We will look to define governance arrangements early and comprehensively as this will create clear roles and responsibilities at all levels and allow for effective and timely decision making throughout the transformation plan.

We have drafted the governance principles upon which these arrangements will be built:

- Governance arrangements which are understood, owned and lead from the top with clear accountability and responsibility at all levels of the STP and underpinned by an agreed set of behaviours.
- An overall vision and one C&M story which is owned and articulated by the whole Partnership
- All individual organisations will retain sovereignty
- All the committees, programmes and projects will be adequately resourced with a skilled and knowledgeable workforce.
- Strong PMO arrangements will deliver the programmes at pace and on time.
- Strong systems of financial control and processes (open book) for securing investment in the programmes will be agreed and put in place.
- Gain and risk share will be clearly understood and agreed

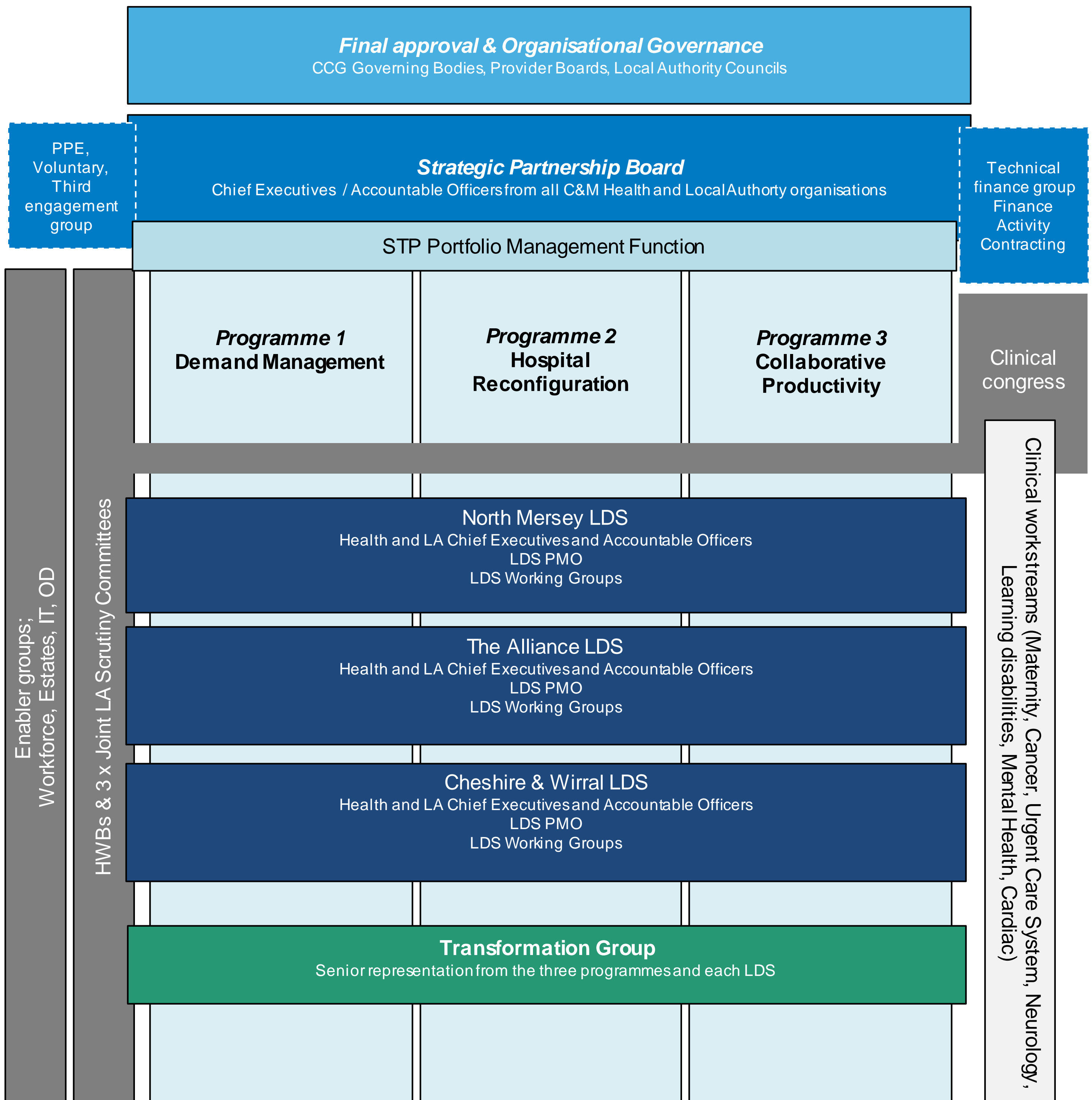
An initial step will be to develop a Memorandum of Understanding that will be agreed and signed off by all Partners. This will provide a sound footing to move forward from.

Each LDS already has its own Governance arrangements that will underpin the STP, and be responsible for the delivery of local programmes of work.

A proposed governance structure is shown overleaf. This will be developed by the Membership Group in the short term so that Terms of Reference and membership details are agreed across C&M quickly.

## Initial proposals on governance structure – subject to further work and detailed discussion, including with individual governing bodies

The structure depicted below sets out our proposed governance framework, still subject to agreement.




***Note: The governance structure depicted is yet to be fully adopted and therefore subject to change.***
*It will be adapted to take account of emerging designs and opportunities post-July 16 consultation with NHS England.*

NHS

## Proposed governance overview (subject to further work and detailed discussion, including with individual governing bodies)

**Emerging ideas around the required governance structure will need to be consulted on and agreed across all C&M organisations**

The governance structure for the STP is only just emerging, and cannot be clearly defined until the programmes of work are more mature and the key deliverables agreed.

However, using the principles on the previous page the Membership Group and STP Working Group will continue to develop the key blocks of the governance structure to ensure the programmes are able to move at pace.

Initial thinking is that the following bodies will be required:

**Strategic Partnership Board**

A Strategic Partnership Board (SPB) will be the decision making group for the overall strategy and hold the programme to account.

The membership will be the Chief Executives / Accountable Officers of all organisations, including Local Authorities.

**Local Delivery Systems x3**

3 LDSs; North Mersey, The Alliance and Cheshire& Wirral. These will be the delivery vehicles and already have emerging governance structures and leadership that will play a key role in helping the STP deliver on its ambitions.

**Transformation Group**

The Transformation group (TG) will be the engine room ensuring delivery in the most appropriate way to lever change and release savings/cash. There will inevitably be overlaps and interdependencies between the work of the 3 programmes, the 3 LDS (place based plans) and the clinical work streams. Effective Governance and leadership will mitigate any risk associated with this.

**C&M Programme Management Office**

The C&M Programme management office will be the over-arching PMO and report into the SPB. It is responsible for the monitoring of the overall programme, the risk register and the central communications team. It will also work closely with the Transformation Group and the three LDSs.

**Technical finance group**

Much of the work detailed in this STP will be predicated on robust finance, activity and contracting work. Therefore, a technical group will feed into the SPB and support as required.

**An efficient and effective Portfolio Management Function**

In order to manage the planning and delivery of a large and complex transformational change a highly effective set of PMO arrangements are required. Many a good strategy has failed because of poor execution when projects and programmes have not delivered because of weak infrastructure. Good infrastructure requires sound business processes, clear roles and responsibilities and skilled staff with dedicated time to deliver.

There is already considerable resources and expertise within C&M which, if re allocated, could start to create an efficient and effective programme management team.

There is a huge amount of work to do in the next 6 months so we will need to consider how best to establish an interim transformation function. This could be through a secondment basis, a short term contracting model or through partnering with an organisation. The critical success factors will be:

- Increased likelihood of getting cost out – energy and commitment to delivering outcomes
- Low initial investment required
- Agility – the function needs to be established almost immediately
- Links to wider network of expertise across other disciplines (tax, HR, strategy, operations, legal, corporate finance, risk, finance)
- Reduced need to recruit fixed-term posts;
- High calibre function;
- Established systems and processes ready to go; and
- A capability built for the long-term.

The Membership Group will also agree a structure and the roles and responsibilities required of a Portfolio Office, and will determine the most appropriate model.

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## Proposed immediate next steps (FY 16/17) on governance - subject to further work and detailed discussion, including with individual governing bodies

**A Memorandum of Understanding (MoU)**

This will be required to underpin the key decisions which will be required to design, development and implement the C&M STP. It is suggested that the following set of principles forms the basis of a framework

- *Context: why are we doing this*
- *Detail: what do we want to deliver*
- *Principles and Processes: how we will deliver*
- *Timescales: when we will deliver what.*
- *An escalation process: what will be required if sovereign organisations fail to sign off the Strategy and programmes*

Once the programmes move into an implementation phase the MOU will need to be revised and developed to include:

***Gain and risk share:*** the benefits derived from the strategic partnership and the investment will not necessarily be evenly distributed. The collaborative will need to agree how the financial risks and benefits are shared across sovereign organisations.

Agreed ***systems of financial controls*** and securing investment. The investment required to enable particular actives and programmes will need a rigorous process and common criteria to agree sign off and distribution. By the very nature of the programme the investment will not always be equally distributed or co-contributed.

***Design Principles*** must be developed and agreed upon to help facilitate implementation. An example of this would be to embrace standardisation, reduce variation and consolidate processes and systems whenever possible.

## Our short-term risks and mitigation

**Financial sustainability challenge**. Though the system has made a commitment to redesign services to reach financial sustainability by 2020/21, the challenge will be to release cost at scale and quickly as demand reduces. We will mitigate this by implementing a robust approach to focusing on releasing costs in the system, including collaborative productivity and efficiency opportunities. We will also mitigate by establishing risk and gain share between commissioners and providers to ensure whole system sustainability.

**Decision-making**. Though there is an emerging clarity about what needs to be done to deliver system-wide change, the challenge of delivering the decisions to effect this should not be underestimated. It is likely that a number of the decisions required may face public resistance and political challenges. We will mitigate this by strengthening our communications and engagement capability, and engage the public and other stakeholders through the process. We will also seek guidance from the national and regional bodies to support us to mitigate these barriers.

**Internal capacity**. The system has not resolved how it proposes to coordinate detailed design and the delivery of the STP. Attempting to deliver a change programme of this scale without freeing up key members of staff from other duties, or without bringing in additional resource, is rarely successful. The lack of transformation capacity and expertise within the system may result in momentum being lost. We will mitigate this by committing to establishing a whole-system programme of work that is underpinned by strong leadership and robust governance.

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## Proposed communications and engagement plan - subject to further work and detailed discussion, including with individual governing bodies

**Our plan to engage with boards and partners post-July**

The patient and public engagement plan will be influenced by national expectations and instructions about levels of communication and engagement delivered nationally and /or by STP areas. We assume there will be national guidance on key messages about the rationale for STPs and the impact of plans on the NHS and social care. We assume there will be a requirement for C&M and LDS level communications and engagement relating to the specific details and impact of our plan.

We anticipate there will be an initial requirement to engage on the 'big ideas' contained in the C&M STP. Over time, as plans are further developed there will be a requirement to engage on specific service change proposals and population health initiatives.

**How our footprint has engaged organisations and key stakeholders so far**

In relation to the STP in 5 of the 6 Local Delivery Systems (LDSs) that exist there are well established system wide Transformation Programmes . As a result each LDS already has strong and legitimised collaborative leadership and decision making arrangements. Commissioners and Providers within each LDS are well versed in partnership working and collectively changing outcomes.

However, we have received and accept criticism from partners in local government that the nature of the collaboration and engagement process to date has not been optimal to garner wide support for the work on the STP. We have listened to, and share, these concerns. Therefore, we are inviting local government colleagues to take a leadership role in designing and monitoring the C&M STP engagement plans in the future.

**Our evidence plan to involve staff, clinicians, patients and HWBs**

The development of a C&M STP and governance structure enables all parts of the system to contribute to a C&M wide plan and is highlighted on the next slide. The LDS Transformation Programmes have an established and strong focus on both public and staff engagement and inclusion. Where LDS have come together since the development of the C&M STP (for example the Alliance LDS) they have developed links to Health Watch, CCG level PPG, Health & Wellbeing Boards, Overview & Scrutiny Committee, and a Clinical Congress. It is proposed that LDS steering continue to develop their engagement strategy linking their Health Watch groups and existing CCG and Trust linked PPI groups. And LDS plans will be shared with the linked Health and Wellbeing Boards prior to June submission.

**Local government involvement will be critical to success**

C&M leaders recognise that it is not possible to transform health and health care without understanding what our communities want and without our partners in Local Government. In C&M all LDS have strong existing engagement through the 9 Health and Wellbeing Boards and other existing local arrangements. Each of the 6 Delivery systems have Local Authorities included and involvement in their plans. Governance Groups include Local Authority Chief Executives. The engagement of local councillors and MP's in the LDS and STP will be central to any successful plan. We will ensure the devolution deals agreed and in discussion across the two local authority sub -regions read across the STP.

**Continuing a track record of good clinical engagement**

Engaging Clinicians, Care Professionals and NHS staff.
The LDS Transformation Programmes are clinically-led programmes of change, led by clinical commissioners.

Engagement is already a hallmark of the LDS Transformation programme. The region has an established track record of working collectively with clinicians, professionals and workforce. This includes the development of a C&M policy on procedures of limited clinical value, a shared approach to commissioning support services and in 2016/17 the CCGs will be working collectively to share and implement QIPP initiatives. This can be achieved through linking into Clinical Networks and the development of a Clinical Reference Group.

The C&M STP is currently establishing a Clinical Congress to ensure clinical buy in. Prof Steve Cox, Kieran Murphy and the new Nurse Director for NHSE care coordinating a multidisciplinary congress reflecting clinicians across all LDS's, professional sectors of service delivery and commissioning within the STP area. This sub group will receive relevant LDSP's and overarching work streams for approval and comment as appropriate. The Clinical Congress may utilise the independent expertise of the Clinical Senate and other specific networks.

## Bridging our financial gap

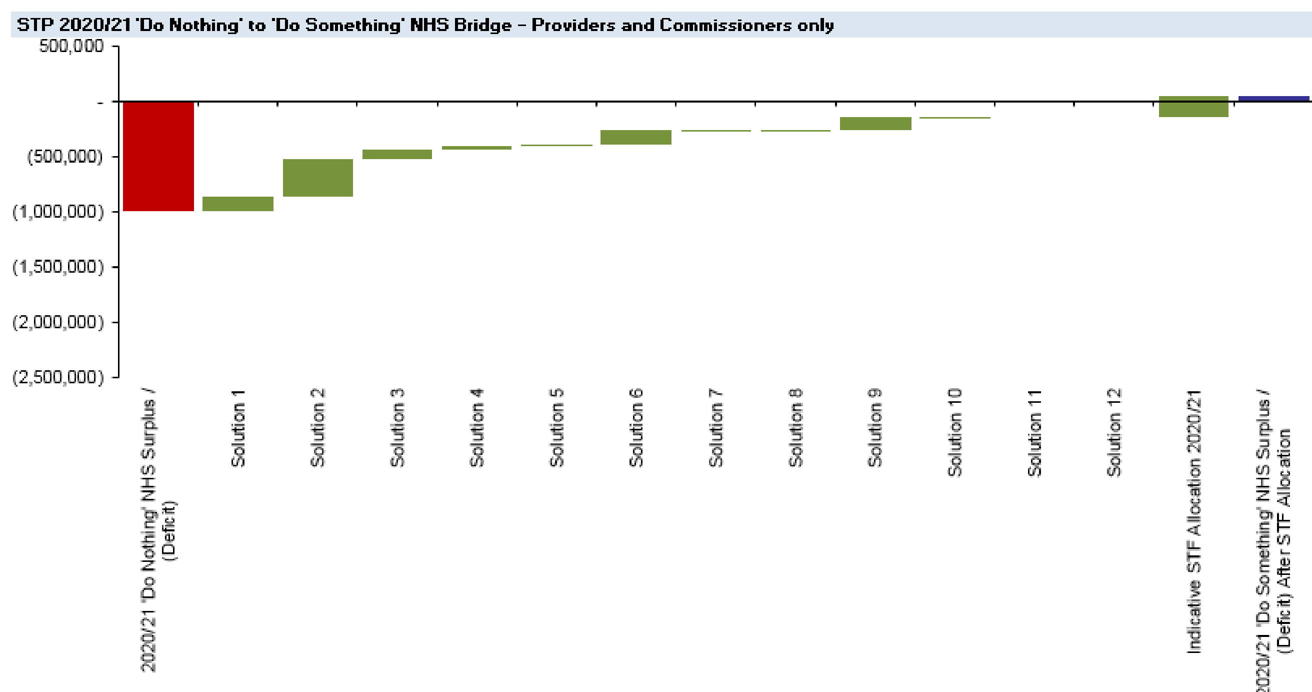
The Cheshire & Merseyside health economy faces a considerable affordability challenge over the next five years, even if reasonable 'business as usual' efficiencies are assumed to be achieved. This is estimated to be £999m by 2020/21.

We have carried out financial modelling to estimate the impact of our priorities. In particular this focuses on three main areas:

- *Demand management and prevention at scale*
- *Reducing variation and improving quality through hospital reconfiguration*
- *Reducing cost through back and middle office collaborative productivity*

The graph below demonstrates how these changes may potentially address the affordability challenge in 2020/21. It starts from the 'do nothing' challenge of £999m, reducing to a surplus of £49m once efficiencies have been achieved.

However, the solutions that take C&M into surplus require further analysis and challenge to convert them from sound ideas into robust plans. The surplus also includes STF allocations but does not account for the additional deficit which may be driven by social care.




The table below outlines the nature of each solution – please refer to our STP template for more detail.

| Solution Number | Solution Type | Detail |
|---|---|---|
| 1 | Business as usual efficiencies: Commissioner | - |
| 2 | Business as usual efficiencies: Provider | - |
| 3 | Business as usual efficiencies: Specialised Commissioner | Reduce costs of care |
| 4 | Footprint level system transformational solution | Reduce costs of system management |
| 5 | Footprint level system transformational solution | Reduce demand growth |
| 6 | Footprint level system transformational solution | Major Transformation - Acute hospital reconfiguration |
| 7 | Footprint level system transformational solution | Major Transformation - Mental Health |
| 8 | Footprint level system transformational solution | New Care Model - Neuro Network Vanguard |
| 9 | Business as usual efficiencies: Commissioner | Pathway Changes |
| 10 | Footprint level system transformational solution | New Care Model - Integrated out of hospital care |

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## Immediate next steps – first 3 months

Although this is a five year plan we are taking action now. Our plans will be embedded within our ways of working and we have established a fit for purpose delivery structure. CCGs and providers are continuing to deliver challenging QIPP and CIP plans and we have identified a number of quick wins from our plans.

| | |
|---|---|
| **Demand management** and prevention at scale | • Determine and agree key ACO characteristics and sign-off as overarching C&M principles<br>• Mobilise pan-C&M Alcohol and High BP strategies |
| Reducing variation and improving quality through **hospital reconfiguration** | • Undertake service by service clinical review to understand cornerstone services<br>• Undertake a service sustainability audit of prescribed specialised services<br>• Options appraisal of organisational forms linked to Dalton and looking beyond the health sector<br>• Mobilise cross-cutting clinical themes and develop work programmes (national standards, common protocols pan-C&M etc.) |
| Reducing back and middle office cost through **collaborative productivity** | • Establish a MoU, work programme with ToRs, appointed accountable officers per opportunity area and workstream leads<br>• Define the cost bases and understand the quick wins (and potential savings) per opportunity area<br>• Develop the longer-term strategy for this programme of work (milestones, resources required, benefits, enablers e.g. IT) |
| Changing **how we work together** to deliver the transformation | • Draft and collectively sign off an MoU – incorporating design principles, gain and risk share agreements and systems of financial controls<br>• Co-source a high-performance programme management function (analytics and PMO capabilities) |


## Acknowledgements

**The contributions of the following are appreciated in formulating the C&M STP:**

STP Membership Group

STP Working Group

STP Finance Working Group

Colleagues in Local Authorities

Colleagues in CCGs

Colleagues in Provider Trusts

Consultants from PwC

**The following documents were of particular use in informing the content of the C&M STP and some content from these sources has been imported verbatim:**

The Alliance LDS Plans

Cheshire & Wirral LDS Plan

North Mersey LDS Plan

*Overview of health and wellbeing in Cheshire and Warrington and Liverpool City Region*, Wirral Council Public Health Intelligence Team on behalf of CHAMPS and Cheshire & Merseyside Directors of Public Health, May 2016

*Supporting the Cheshire and Merseyside Sustainability and Transformation Plan: Key workforce and education issues,* Health Education England, version 0.2 23 June 2016

*STP footprint analysis pack Cheshire and Merseyside*

# Appendices


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| Neurology | 38 |
| Mental Health and Wellbeing | 40 |
| Women's and Children's | 43 |
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| **A3: Abridged LDS plans** | *For practical reasons, we have provided these as separate PDF documents* |
| North Mersey | |
| The Alliance | |
| Cheshire & Wirral | |

# Together our local priorities align with the 10 questions that nationally STPs must answer

Collectively, our priorities help address the 10 questions posed by NHS England in the submission guidance. The questions cover the full range of health and care provision so, while our priorities address them all, they are supported by local organisational and collective plans that aim to address our challenges and meet national standards and requirements.

Each of our priorities have a different focus and, as a result, address different questions. The contribution of our three big priorities to address the questions is summarised below.

Our fourth priority, how we will work collaboratively, will enable the delivery of our plans rather than directly addressing a question. As such it has not been included in the table below.

| | 1. Demand management | 2. Hospital reconfiguration | 3. Collaborative Productivity |
|---|---|---|---|
| How are you going to prevent ill health and moderate demand for healthcare? | ✓ | ✓ | |
| How are you engaging patients, communities and NHS staff? | ✓ | | |
| How will you implement new care models that address local challenges? | ✓ | ✓ | ✓ |
| How will you achieve and maintain against core performance standards? | ✓ | ✓ | ✓ |
| How will you achieve our 2020 ambitions on key clinical priorities? | | ✓ | |
| How will you improve quality and safety? | ✓ | ✓ | ✓ |
| How will you deploy technology to accelerate change? | We are building digital solutions into our plans. These are described across our priorities and in our Local Digital Roadmap. | | |
| How will you develop the workforce? | ✓ | ✓ | |
| How will you achieve and maintain the financial balance? | ✓ | ✓ | ✓ |

# Cross-cutting clinical themes

## Cancer (1/2)

**What is the rationale for this theme?**

The key hypothesis is that we need a C&M cancer strategy and that the STP provides the only credible vehicle to create the momentum and commitment to achieve this.

Cancer requires a place as a "cross-cutting" theme primarily due to two major imperatives:

*National Policy*

There has been a clear steer from the Centre that an STP must address the Cancer agenda:

Cancer is one of four National priorities where improvement is routinely deemed to be a "must do"

Significant political and policy commitment to drive the delivery of the objectives described in the National Strategy for Cancer *"Achieving World-Class Outcomes"*

This is underpinned by the continuing central guidance on the implementation plan for the Strategy, a real (if unquantified) commitment to providing real additional resources to support implementation and the on-going support for the National Cancer Vanguard

*Local (i.e. STP/LDS footprints) Population Needs*

Cheshire and Merseyside (C&M) either lags behind the English average in respect of cancer (incidence, outcome and performance measures) and/or exhibits unwarranted variation between areas in C&M in these measures

- High incidence and poor outcomes in C&M
- Poor performance against access standards
- Wide variations and inequality within C&M

This view is based on a number of premises:

- Successfully addressing the cancer deficit (definitely outcomes and patient experience, potentially financial) will require an EXPLICIT system-wide commitment to delivering the national strategy objectives in the STP footprint
- Cancer provision will be impacted by other system decisions e.g. acute surgical services reconfiguration. By having a cancer cross cutting theme able to ensure that services remain coherent (so long as all providers/commissioners are transparent about service plans and we arrive at an effective governance position re Alliance/Accountable Care Organisation)
- A vehicle for securing priority investments in cancer. This may be additional resources from the centre but it will also be a challenge to the distribution of the available resources within C&M e.g. by providing substance to health promotion/prevention activity which could otherwise be stripped of budgets
- Opportunity to build on the single service/region-wide arrangements already in place for non-surgical oncology
- A vehicle to explicitly engage across STP systems boundaries (in-flows from West Lancs and outflows from East/South Cheshire)
- The best way to gain maximum value from the significant capital investment in the new cancer centre
- Bring a focus on cancer research and how it can have a mutually beneficial relationship with NHS services (research is an important driver of the life sciences agenda and associated economic benefits that are part of the Liverpool City Region plans)

**Is there a defined programme of work?**

The structure of the Cancer Plan for C&M must (at a minimum) drive forward the 6 strategic priorities for Transformation identified in the Cancer Taskforce report, and will be overseen by the National Cancer Transformation Board (which in turn is accountable to the Five Year Forward View Board):

- Prevention and public health
- Earlier diagnosis
- Patient experience
- Living With and Beyond Cancer
- High Quality Modern Services
- Commissioning, provision and accountability processes.

The outline of cancer priorities will require considerable further engagement with the wider cancer community (Commissioners, clinical groups, patient groups, Strategic Clinical Network etc.) as well as LDS leads and their constituent organisations

The national strategy will be expected to provide guidance/learning in respect of the future governance of collaboration on and accountability for cancer activities on the STP footprint e.g. the role and form of Cancer Alliances (eventually leading to Accountable Care arrangements)

The required *C&M Cancer Strategy* will build on existing cross-C&M cancer initiatives, including; public health initiatives, the Clatterbridge-led Transforming Cancer Care programme (which includes the development of a new specialist cancer centre at the heart of the City of Liverpool), Macmillan's Living With and Beyond Cancer Programme and various pilot projects to secure earlier diagnosis. These initiatives will need to be integrated and best practice disseminated.

A key activity will be to influence the emerging to service reconfigurations that will be required to address the STP challenges to ensure that there are no unintended adverse consequences for cancer outcomes, experience and cost and that opportunities are fully exploited. A number of enabling and delivery systems will need to be further developed and a stocktake of the available skills and capacity to run a "C&M Cancer Strategy Programme to be undertaken, including:

C&M-wide system for generating intelligence and reporting on performance of

- Tracking Execution of the C&M Strategy
- In-year delivery of targets
- Developing a co-ordinated approach to service improvement (pull together network, Trust and CCG capability and capacity)
- C&M-wide outcomes and cancer intelligence function

# Cross-cutting clinical themes

## Cancer (2/2)

**Do you have your stakeholders mapped and has engagement started?**

Initial engagement has commenced, although given the late identification of cancer as a cross-cutting theme, this has necessarily been limited.

The engagement to date has tended to focus on what the cancer agenda is , has been driven by the structure of the national strategic priorities (which do resonate locally) but has not identified clear synergies/contradictions with LDS Plans.

Informal input has been received from;

CCG and Specialised Commissioners

Strategic Clinical Network

Directors of Public Health

Macmillan

Although documentation on the emerging approach has been shared with LDS leads, there has been insufficient time to obtain any meaningful input

**Are the risks understood?**

The primary concern is that lip-service will be paid to cancer improvement is the context of the enormous system challenges that will need to be addressed through the STP process, example issues may include;

Must describe of and sign up to the future governance model (key mitigation is direction of travel emerging from the Centre re Alliances/ACOs and the likely centrally driven timetable)

The STP footprint does not fit the natural cancer network. Cross-boundary dialogue (West Lancs and East/South Cheshire will be required. In mitigation the Centre will be clear that the STP footprint (or multiple thereof) will be mandated.

Key STP focus in acute trusts is organisational form and lack of clarity re future surgical configuration. This may slow the pace of delivering concerted action on cancer

Lack of clarity on the resources available to run the cancer system. Some resources are already in place, (e.g. .a Transforming Cancer Care PMO team, a LWBC project team, Cancer Network resources) – but further support required to develop a Cancer Alliance

The major mitigation will be the integration of a cancer cross-cutting theme into the STP submission and the clear national framework and set of expectations regarding cancer

**Is there a process to get decisions made and to track progress and hold people to account?**

- Involvement in developing the cancer theme to the STP is not formal. So long as it follows the National Cancer Strategy that should be non-contentious
- Future governance to deliver the C&M Cancer Strategy will be dependent on the Cancer Alliance model being developed by the Centre and for which a C&M "version" will be required
- Utilisation of what is already there; CCC PMO, cancer network will be crucial (need widespread acceptance that Alliances are NOT beefed up Networks)

**Short term milestones?**

A number of areas require baseline mapping to identify gaps in organisations and local systems. However, obvious specific objectives include;

- Establish Alliance governance structure (by Autumn)
- Agree target objectives per strategy (by CCG/provider) (Autumn) and the resulting milestone objectives quarter by quarter through the next 4 years
- Deliver all cancer access targets in every trust/commissioner by Q4 (deliverability needs to be tested as to whether it is realistic)
- Map diagnostic capacity and develop a plan to fix (Q4)
- Develop a plan to roll out the serious illness conversation methodology (Clatterbridge is leading a national initiative that should deliver quality and financial benefits locally)

**What Is The Return on Investment for this work?**

Long-term benefits will accrue from a focus on cancer throughout its pathway. However it must be recognised that investment in (say) health promotion/prevention activity may only "shift the dial" of incidence (and therefore cost) a minimum of 7 years later (well beyond the time horizon of the STP)

That notwithstanding a number of cancer activities will deliver benefit on a shorter timescale e.g. more Effective Acute Oncology service reducing emergency admissions and LoS, earlier diagnosis resulting in less treatment, more centralised cancer services will improve efficiency and effectiveness and moving towards single service city/region-wide will also help e.g. haemato-oncology, cytotoxic pharmacy production etc. should all contribute to lower unit costs

NB quantifying all this will be difficult. No attempt has been made (to date) to quantify the baseline(current) cost of cancer provision nor how forecast the future demand for cancer services is driving the formula for the estimated financial gap. This would give an indication of the extent to which we can offer to moderate cost pressures by cancer "consuming some of its own smoke". How credible such estimates would be or the cost of obtaining them is not at all clear

**Completed by:**

**SRO – Andrew Cannell, Chief Executive, The Clatterbridge Cancer Centre NHSFT**

# Cross-cutting clinical themes

## Urgent Care System (1/2)

NHS

**What is the rationale for this theme?**

Urgent and Emergency Care Networks have been tasked with the delivery of a number of deliverables by 2020/21:

- All patients admitted via the urgent and emergency care pathway have access to acute hospital services that comply with four priority clinical standards on every day of the week.
- Access to Integrated Urgent Care, to include at a minimum summary care record, clinical hub and 'bookability' for GP content; with mental health crisis response in hospital and part of the Ambulance Response Programme.
- Improved access to primary care in and out of hours.

*UECN direction of travel*

- Focus on implementation
- Alternative care to the front door of A&E and instead of high cost services
- 111 going to a digital platform and maximise the impact and opportunities
- Roll out of ambulance response programme
- Focus on keeping patients at home
- Community response to integrated Urgent and emergency care.
- Primary Care will be key
- Cohesive service redesign for Stroke, Severely ill children, Stemi, Vascular surgery, Major Trauma including 7 day service implementation by Sept 2017

**Is there a defined programme of work?**

The four initial priorities for the UECN are:

1. Ambulatory care
2. Urgent care centres
3. Ambulance to hospital handover delays
4. Stroke services

Urgent Care Centre minimum specification proposal document has been developed for discussion and approval at the July UECN Board meeting.

Enabling activities:

The development of a Cheshire and Mersey Urgent care data set to inform the activities of the UECN board and support SRGs. To be developed to include understanding of patient demographics and flow given current configuration of the Urgent care system.

Consistent approaches to system escalation and

capacity demand management

Consideration of issues to be dealt with at a local level with regards to redesign of primary care and the flexible use of workforce and design of new more flexible and organisationally mobile roles

**Do you have your stakeholders mapped and has engagement started?**

The Cheshire and Merseyside Urgent and Emergency Care Network (UECN) was officially launched at a stakeholder event in November 2015. A number of options were presented to delegates regarding the membership of the Network Board and the possibility of appointing sector representatives to reduce the number of attendees required at meetings.

Monthly UECN Board meetings are held and the membership of the Board is drawn from Executive Directors and Senior Clinical Leaders from System Resilience Group member organisations and partners across the area:

- 9 SRG Chairs
- NHS England
- Acute Trust Representative (Cheshire)
- Acute Trust Representative (Merseyside)
- Mental Health Trust Representative
- Community Health Trust Representative
- Clinical Commissioning Group Representative (Cheshire)
- Clinical Commissioning Group Representative (Merseyside)
- North West Ambulance Service / 111 Provider
- Local Authority Representative (Cheshire)
- Local Authority Representative (Merseyside)
- Cheshire & Merseyside Strategic Clinical Networks Representative
- Chair, Cheshire & Merseyside Major Trauma & Adult Critical Care OD
- Director of Clinical Development & Director of Nursing, Greater Manchester Academic Health Science Network
- Health Education England
- Stakeholder updates are circulated to stakeholders after each Board meeting.
- An urgent care quality review was held on Tuesday 2 February 2016, with the aim of highlighting good practice and also to help focus collective attention on any specific areas/pathways in Cheshire and Merseyside where it is felt that action is required.
- The UECN hosted a workshop on 11th May that aimed to share within and between Local Delivery Systems and SRGs initial priority areas and ideas for addressing operational pressures in winter 2016/17 and to identify areas for common work.

# Cross-cutting clinical themes

## Urgent Care System (2/2)

NHS

**Are the risks understood?**

Barriers so far identified

1. There are different arrangements in place within each local Authority footprint for supported discharge arrangements in respect to short term step down in both volume and availability
2. The differing readmission rates by health community infer variable arrangements regarding community support and discharge support
3. There are different arrangements of services in urgent Care Centres and WiCs although this is bearing addressed by a common statement of purpose for UCCs
4. In some areas a section 136 place of safety is still designated as the local ED
5. There is a lack of shared understanding of current patient movements and the impact of current configuration of Major Trauma centres and Emergency departments on patient flow.
6. Lack of consistent information sharing between sectors and providers

There is not currently an UECN risk register in place. Activities of the board thus far are focused on resolving the issues stated above. These issues and mitigations will be reported against a suitable risk framework.

**Is there a process to get decisions made and to track progress and hold people to account?**

SRGS through UECN Board. The UECN has a role to support SRGs and provide a point of thought leadership to resolve such issues that need at scale change. These issues are brought to the boards attention following escalation via the SRG Chairs network. Consensus decisions and/or recommendations are then communicated.

The UECN is accountable to the stakeholders and NHS England.

**Short term milestones?**

Planning submissions to date are template driven against the narrative aims of the Keogh review of Urgent and Emergency care. The priority areas identified have actions

which have been cascaded out to each SRG. The delivery plans are being locally managed and implemented. With the exceptions of Stroke services and Urgent Care centre specification.

Stroke service redesign is being led by the stroke network and the sub regional stroke boards.

The UECN is working to develop a regional specification and standards for Urgent Care Centres based upon the work undertaken by Halton in establishing and exemplar service.

**What is the Return on Investment for this work?**

The structure of the UECN programme has to date been developed to support the delivery of the Keogh review of Urgent and Emergency care. There are national standards with regards to this and quantitative assessment has been made of the effectiveness and economic viability of the future service model.

There has been no additional work to calculate ROI at a regional level.

**Completed by:**

**SRO – Cliff Richards,**

# Cross-cutting clinical themes

## Transforming Care (For people with Learning Disabilities)

**What is the rationale for this theme?**

The requirement to implement the national service model by March 2019 and close inpatient beds, starting with the national planning assumptions set out in Building the Right Support. These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to1:

• 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population

• 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

The plans are consistent with Building the right support and the national service model developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.

The plans focus on a shift in power to ensure people with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We will build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

**Is there a defined programme of work?**

Yes, a well-developed Programme exists. There are four domains to the plan (co-production, bed closures, developing a new service model and funding arrangements.)

Because the plan follows a national service model the scope of the programme is well defined and the outcomes are nationally defined.

**Do you have your stakeholders mapped and has engagement started?**

The plans have strong stakeholder engagement: providers (inpatient and community-based; public, private and voluntary sector) have been involved in the development of this coherent plan. Wider stakeholders have been engaged in the development of the plans, for example, Employment, Housing, education, third, voluntary and independent sector providers.

**Are the risks understood?**

The key grouping are:

- Financial
- Workforce
- Governance
- Political
- Information Governance

**Is there a process to get decisions made and to track progress and hold people to account?**

The C&M TCP board is accountable to carers and individuals with a learning disability, C&M HWBBs, C&M STP Board and NHS England North TC board for delivery of its local plans. Critically each Delivery Hub will engage with, seek support from and approval of plans from the relevant local governing bodies/committees , learning disability partnership boards (LDBPs) and Health and Wellbeing Boards. This will include engagement with children and young people services and strengthening networks in the hubs and across Cheshire & Merseyside.

C&M has a strong history of working in partnership to improve care for people with learning disabilities across the C&M footprint which has enabled many of the key partnerships to be brought together and engage in the development of this plan.

**Short term milestones?**

There are four domains to the plan (co-production, bed closures, developing a new service model and funding arrangements.) that include the short term milestones that need to take place. A full Programme Plan is available from phil.meakin@nhs.net if required.

**What Is The Return on Investment Rationale for This Work?**

The main driver is to improve the quality of service and model of care for people with Learning Difficulties rather than delivering significant cost savings. However when implemented this will result in better quality of life and prevent admission to more expensive in-placement provision.

The cost to the system (Health and Local Government will move from £209,012m in 2015/16 to approximately £173,307m.

**Completed by:**

**SRO – Alison Lee, Chief Executive of NHS West Cheshire CCH**

# Cross-cutting clinical themes

## Neurology (1/2)

NHS

**What is the rationale for this theme?**

The theme has two components:

1. Achieve a clinically and financially sustainable **integrated neurology service** by enhancing the community support, clinical pathways and advice and support for primary and secondary care;
2. Implement a **whole system spinal services network** embedding the national back pain pathway.

It is driven by common sustainability challenges faced by neurology and spinal services across England:

- High levels of need, with demand pressures exacerbated by worried well (neurology) and patient pressure for surgery (spinal);
- Small specialties, with insufficient consultants to provide free standing services in every DGH;
- Variations in quality and practice;
- Commissioning divided between CCGs and NHS England.

In **neurology,** Merseyside and Cheshire already have a well developed service through the satellite services in every general acute hospital (clinics plus ward consultations) and community services provided within its catchment by the Walton Centre. This enables a high standard of neurology provision to be available equitably and locally across a wide geographical area, with ready access to specialist services at the centre for those who need them. The Vanguard will build on this by integrating services more effectively, through increased support for patients with long term neurological conditions in the community and enhanced advice and support for primary and secondary care.

**Spinal** services in Merseyside and Cheshire face similar challenges to those elsewhere. There is already collaboration developing between the Walton Centre, Royal Liverpool and Warrington services on surgical management; the Vanguard will implement the national back pain pathway in each locality focused on the Centre to provide more appropriate, timely, consistent and cost effective care, from the initial GP presentation onwards.

**Is there a defined programme of work?** (Clear goals and priorities and defined workstreams)

For **neurology**, the Neuro Network model consists of:

- Centre: 7 day acute inpatients, specialist diagnostics, subspecialty/MDT clinics
- DGH satellite services from visiting neurologists plus support: outpatient clinics, weekday ward consultation service, supported from the centre by DGH referral pathways, 7 day advice line, telemedicine and second opinion/specialist neuroradiology reporting via PACS
- Community: nurse clinics, advanced neurology nurse (ANN) support, homecare drugs, home telemetry, supported from the centre by GP referral pathways and ready communication between community and specialist neurology services for advice and practical help
- Standards and clinical governance: common standards across network delivered services, with a single clinical governance structure, developing and using clinical outcomes as available.
- The Neuro Network **spinal** model consists of:
    - A network for the provision of spinal surgical procedures, managed from the centre with partner services in secondary care, working to common standards, and outcome measures, with MDT discussion of complex cases and all specialised surgery undertaken in a centre fully compliant with national specialised serviced standards;
    - Implementation of a single whole system patient pathway through a network of all providers of spinal services, with common and audited service standards and outcome measures.

**Do you have your stakeholders mapped and has engagement started?**

Stakeholders have been mapped; commissioner partners have been engaged in the planning; and several patient and carer engagement events have been held and are informing plans.

**Are the risks understood?**

Key challenges identified for implementation of the Neuro Network models are:

- The complexity of instituting whole system behaviour change;
- Competing priorities/potential organisational disincentives for partner organisations;
- The likely impact on financial flows and implications for reimbursement mechanisms; and
- The stop-start short term nature of funding commitments from NHS England.

A full risk register is in preparation.

**Is there a process to get decisions made and to track progress and hold people to account?**

A Programme Board with director level membership from partner commissioners (including specialised) and clinical/delivery leads is in place. It has been agreed that this will report to STP governance arrangements once established.

# Cross-cutting clinical themes

## Neurology (2/2)

**Short term milestones?**

*Neurology year 1 outputs:*

- Headache pathway implemented in 2 CCG areas;
- Advanced neurology nurses appointed, training package validated and training well advanced;
- Nurse advice line fully in place;
- Functional neurology service established;
- Pilot telemedicine service operational;
- Toolkit for establishing and running a satellite service prepared (Moorfields lead).

*Spinal year 1 outputs:*

- Spinal surgery network in place and plans well advanced towards a single service for North Mersey;
- Toolkit for defining back pain provision for a CCG locality complete and in use;
- Implementation of back pain service model in first CCG locality;
- First community pain management programme for back pain in line with national guidelines;
- Governance approach for back pain services defined.

**What is the Return on Investment for this work?**

The total investment planned in the Neuro Network Vanguard is £5.0m, covering the costs of change and double running for the new elements of the models - £1.75m in 2016-17 and £3.25m in 2017-18 (subject to progress and renewal of funding by NHS England).

In return, the Neuro Network will provide:

*In neurology:*

- a solution for the national problem of sustainability,
- reduced variation in care,
- health benefits of improved health outcomes for neurological disorders, improved local access, earlier diagnosis and treatment, more proactive, effective and efficient management of long term conditions, and improved continuity of care, and
- a recurrent annual saving against the underlying trend growth by 2020-21 of £0.8m, by: avoiding a level of consultant referrals for headache, acute admissions for (suspected/) epilepsy, and A&E attendances by patients with other long term neurological conditions; reducing neurological lengths of stay in DGHs; and reducing health service utilisation by patients treated for functional neurological conditions;

*In spinal services:*

- consistent, clinically evidenced care for back pain,
- health benefits of more rapid access to effective definitive management with reduced overall waiting times (RTT), a significant reduction in the rate of non clinically evidenced procedures, and ensuring surgery is undertaken only in units meeting national standards,
- a recurrent annual saving against the underlying trend growth by 2020-21 of £2.5m, by: avoiding a level of consultant referrals for back pain, with increased diversion to less costly physiotherapist led care; reducing the use of ineffective injection treatments; and leading to more conservative use of certain more complex surgical interventions.

**Completed by:**

**SRO – Stuart Moore, Director of Strategy & Planning, The Walton Centre**

# Cross-cutting clinical themes

## Mental Health (1/3)

**What is the rationale for this theme?**

One in four adults experience at least one diagnosable mental health problem in any given year. Mental health problems represent the largest single cost of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS. In England, if you have a serious mental illness, you are twice as likely to die before the age of 75 years. On average, you will die 15-20 years earlier than other people.

People with long term illnesses suffer more complications when they also develop mental health problems, increasing the cost of care by an average of 45%. For example, £1.8billion additional costs in diabetes care are attributed to poor mental health.

Mental disorder is responsible for the largest proportion of the disease burden in the UK (22.8%), which is larger than cardiovascular disease (16.2%) or cancer (15.9%). Those with mental disorder experience a range of increased health risk behaviour including poor diet, less exercise, more smoking and more drug and alcohol misuse. These give rise to reduced life expectancy and higher levels of physical illness several decades later. For instance, 42% of adult tobacco consumption in England is by those with mental disorder. However, those with mental disorder are less likely to receive interventions to address or prevent such health behaviour, despite clear evidence of the increased risk they experience and the availability of evidence-based interventions. Research also consistently shows that people with mental disorder have higher rates of physical illness and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors such as smoking, obesity, substance abuse, and inadequate medical care. This not only results in increased in long-term treatment costs, but societal costs in term of productivity loss, making people with mental ill health more vulnerable to social exclusion, poverty, unemployment and multiple social and family difficulties thereby exacerbating the inequalities they already experience.

People with a mental illness are:

- 4 times more likely to die of diabetes
- 2-3 times more likely to die of CHD
- 4 times more likely to die of respiratory disease
- Twice as likely to die of a stroke

The Government's mandate to NHS England for 2016-17 sets out goals to:

- Close the gap between people with mental health problems, learning disabilities and autism and the population as a whole.
- Embed access and waiting time standards for mental health services, including:
  - 50% of people experiencing first episode of psychosis to access treatment within 2 weeks; and
  - 75% of people with relevant conditions to access talking therapies in 6 weeks; 95% in 18 weeks.
- Increase the number of people with learning disabilities / autism being cared for in the community not inpatient services, including implementing the actions outlined in "Transforming Care".
- Agree and implement a plan to improve crisis care for all ages, including investing in places of safety.
- Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children's and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018.
- Implement agreed actions from the Mental Health Taskforce.

The announced 2020/21 Sustainability and Transformation funds of £5,326m for Cheshire and Merseyside represent the full amount of funding expected to be available for the local health systems from all sources in 2020/21. Amongst other commitments, this funding is intended to deliver:

- recommendations of the Mental Health Taskforce
- Future in mind - improving outcomes for children and young people
- access and wait targets for eating disorders services
- peri-natal access commitments

£250m a year recurring over next 5 years has been previously announced for mental health transformation. It is assumed this is included in the total allocation described above.

This equates to £12.65m per year for five years (5.06% of national monies, assuming allocation as per CAMHS transformation CCG allocations) for mental health services in Cheshire and Merseyside, if we are to ensure our population is not disadvantaged.

**Is there a defined programme of work?**

Through collaborative working between the mental health Trusts in Cheshire and Merseyside, evidence-based workstreams have been developed which:

- Reduce pressure on acute physical services; and
- Improve outcomes in mental health, through:
  - Prevention and early identification
  - Better mental health for people with physical health conditions
  - Improved services for people with severe mental illness

# Cross-cutting clinical themes

## Mental Health (2/3)

Cheshire and Merseyside mental health trusts will contribute to the development of Accountable Care Organisations (ACOs) within respective footprints and will explore how mental health services can feed into integrated teams without disrupting pathways.

The 8 North West specialist mental health NHS and Foundation trust organisations have submitted a response to NHS England's invitation to be a 2016/17 New Care Model Site for Tertiary Mental Health Services (supply chain). It is our intention and agreement that, whilst remaining fully integrated with our 3 geographical STP areas, we will work on clinical pathway consistency and standardisation across a North West footprint.

**Do you have your stakeholders mapped and has engagement started?**

Collaborative working between Mersey Care NHS Foundation Trust, Cheshire & Wirral Partnership NHS Foundation Trust and 5 Boroughs NHS Foundation Trust is being undertaken. Chief Executives have been meeting on a regular basis and each Trust has now identified a senior management lead who will ensure delivery of agreed workstreams at an organisational level. Within the programmes of work for each workstream, stakeholder analysis will be completed.

Are the risks understood? (Barriers to delivery are acknowledged, and mitigating plans in place)

The NHS provider sector faces a significant challenge to organise to continually improve care within a severely constrained financial envelope, whilst simultaneously dealing with increasingly acute and complex demand due to demographic factors and the impact of budget cuts in the wider health and care system.

The distinctive challenges faced by MH providers are often not recognised, by commissioners or regulators, with providers squeezed financially by acute trust dominance and absorbing increasing demand inside block contracts. There is a risk that mental health does not receive the required level of investment from the STP monies i.e.. 'a fair share' and that mental health service users will, therefore, be disadvantaged in Cheshire and Merseyside

There are challenges in respect of workforce planning and recruitment due to national shortages of junior and middle-grade doctors in certain specialties and of nurses in specialist areas, or particular geographies e.g.. Macclesfield. The demands of 7 day working and other clinical standards may exacerbate recruitment challenges.

It may be a challenge to ensure that the Digital Roadmap work currently being undertaken is appropriately aligned with STP workstreams as a result of timeframes for each programme being independently set.

**Is there a process to get decisions made and to track progress and hold people to account?**

Chief Executives from Mersey Care NHS Foundation Trust, Cheshire & Wirral Partnership NHS Foundation Trust and 5 Boroughs NHS Foundation Trust are meeting regularly to agree local mental health priorities and transformation schemes and ensure that there is a collaborative approach to contributions made to the wider Cheshire and Merseyside Sustainability and Transformation Plan. Decisions are taken within this Chief Executive forum, both on a face to face basis, and virtually.

In addition, across each Local Delivery System footprint, local governance arrangements have been established in relation to mental health transformation:

- North Mersey – Mental Health Transformation Board (Mersey Care, Liverpool, South Sefton CCGs and Southport and Formby CCGs, local authorities and independent sector membership).
- Alliance – Mental Health Footprint meeting (Chaired by Halton CCG, with membership from 5 Boroughs Partnership NHS Foundation Trust, Warrington, St. Helens and Knowsley CCG's). Numerous working groups with local authority membership.
- Cheshire and Wirral – Mental Health Integrated Provider Hubs (IPH) have been established to develop an outcomes based contract across care pathways rather than commissioning episodes of care. This approach enables the Integrated Provider Hubs to transform and integrate the pathway across all levels of service and allows commissioners to commission outcomes for the overall population. A Programme Assurance Board is already in place in West Cheshire and local governance arrangements will be established in other CCG areas.

**Short term milestones?**

The year 1 plan is currently being developed, based on the priorities and transformation schemes recommended within national guidance and building on local transformation plans underway with each provider, which focus on:

- Reducing variations in clinical practice – through the development of consistent care pathways, developing standard approaches to key processes such as assessment, access, discharge and caseload review.
- Improving patient safety – including a commitment to 'zero suicide'
- Improving effectiveness – through a focus on care pathways with clear outcomes and evidence-based practice

In year 1, a priority will be the establishment of fully functioning mental health liaison services across Cheshire and Merseyside. About half of all patients being treated for physical health problems in acute hospitals have a co-morbid mental health problem, such as depression or dementia. The substantially increased cost of care for these patients is equivalent to about 15% of expenditure in acute hospitals. Evidence suggests that a dedicated proactive liaison psychiatry services can substantially reduce this burden of additional costs and improve outcomes, particularly for older inpatients.

**What is the Return on Investment for this work?**

The evidence base relating to return on investment for this work is drawn from the economic evaluation from Centre for Mental Health and Greater Manchester mental health and wellbeing strategy.

# Cross-cutting clinical themes

## Mental Health 3/3

NHS

**What is the Return on Investment for this Work?**

The evidence base relating to return on investment for this work is drawn from the economic evaluation from Centre for Mental Health and Greater Manchester mental health and wellbeing strategy.

| | C&M Indicative Investment Costs (£m) | C&M ROI (£m) |
|---|---|---|
| Reducing pressures on acute physical services | 33.9 | 49.29 |
| Improving outcomes in mental health | 9.79 | 70.29 |
| **Total** | **43.69** | **119.58** |

In addition, further schemes will be developed to deliver a high access, low wait, efficient mental health system, maximising use of identified mental health transformation monies. This will include significantly reduce OATs placements in 2 years.

| | National Cost £millions (Centre for Mental Health) | Note : Economic Case | Assumptions | C&M Indicative Investment Costs (£m) | C&M ROI (£m) |
|---|---|---|---|---|---|
| ***Prevention and early intervention*** | | | | | |
| Improve the identification of perinatal depression and anxiety (via screening & assessment) and provide psychological therapy | 53 | 2/3rds of costs recovered within 5 years | Assume population of England is 54m, therefore C&M (population 2.4m) is 4.5% of England | 2.39 | 1.57 |
| Screen 5 year old school children & provide parenting programme where a need is indicated | 51 | £3 savings over 7 yrs for every £1 invested | GM costs used (C&M = 88%) | 0.14 | 0.22 |
| School based MH Curriculum (social & emotional learning) | | | GM costs used (C&M = 88%) | 4.40 | 39.03 |
| Increase provision of Early Intervention | 77 | Costs recovered in full within 1yr | Population as above | 3.47 | 3.47 |
| Population level suicide awareness training and intervention | | | GM costs used (C&M = 88%) | 0.44 | 24.96 |
| ***Better mental health care for people with physical health conditions*** | | | | | |
| Single point of 24/7 access to MH Crisis Care including extended provision of liaison psychiatry to all acute hospitals & access to IAPT | 119 | £2.50 savings for every £1 invested | Population as above | 5.36 | 13.39 |
| Provide collaborative care for most costly & complex 10% of people with long-term conditions and co-morbid MH | 290 | Broadly cost-neutral to NHS | 30% population have LTC, of these 30% have comorbid mental health condition (220k in C&M). Therefore 20,000 people in most complex 10%. Population as above | 13.05 | 13.05 |
| Provide a specialist MUS service | 127 | Broadly cost-neutral to NHS | Population as above | 5.72 | 5.72 |
| Improved services for people with severe mental illness | | | | | |
| Expand employment support via provision of IPS for people with severe mental illness | 54 | £100m savings over following 18 mths | Population as above | 2.43 | 4.50 |
| Increase community-based alternatives to acute inpatient care for people with severe mental illness at times of crisis | 63 | £106m savings pa | Population as above | 2.84 | 4.77 |
| Increase interventions to improve the physical health of people with severe mental illness | 67.5 | £100m savings over several years | Population as above | 3.04 | 4.50 |
| Supported housing step-down facility to enable prompt discharges from psychiatric care into the community | | Net savings of £22,000 per person per year | Cohort of 200 people (£556 pp per wk for 4 weeks) | 0.44 | 4.4 |
| **TOTALS** | | | | **43.69** | **119.58** |

**Completed by:**
**SRO – Sheena Cumiskey**

# Cross-cutting clinical themes

## Women's and Children's Services (1/3)

NHS

**What is the rationale for this theme?**

*Background*

The Cheshire and Merseyside Women's and Children's Services Partnership (referred to hereafter as "The Partnership") has been chosen as an Acute Care Collaboration Vanguard site as part of NHS England's New Care Models programme. The Partnership is also one of seven pioneer sites to develop choice and personalisation in maternity services following the National Maternity Review.

The Women's and Children's Services Partnership will develop a high quality, clinically and financially sustainable whole system model of care for women's and children's services. The Partnership will initially focus on gynaecology, maternity, neonatal and paediatric services.

*Drivers for change*

The drivers for change that bring the Partnership together are:

- increased demand on services and the presentation of women, babies, children and young people with more complex needs.
- inequity of service provision and access.
- variation in the experience of people who use these services.
- variation in clinical outcomes, safety and quality.
- over reliance on hospital based care.
- organisational boundaries fettering change.
- workforce challenges in regard to training, recruitment, retention, retirement, skills mix and deployment of staff.
- inability of services to deliver seven day working and meet regulatory and other clinical standards in their current form.
- commitment to implement National Maternity Review recommendations. financial sustainability.

*Aspiration*

The Partnership is bringing together people who use these services with clinicians (from the relevant clinical networks), providers and commissioners (NHS England, Clinical Commissioning Groups and local authorities) to work in partnership beyond statutory and organisational boundaries to develop new models of care and provision of services across organisations in Cheshire and Merseyside, designed for the population with a focus on the needs of the individual.

The Partnership will ensure that new models of care are designed and implemented to close the three gaps in health care: the health and wellbeing gap, the care and quality gap, and the funding and efficiency gaps. This will provide for women, babies, children and young people:

Equity of access – women, their babies, children and young people would have access to services of the same high standard in Cheshire and Merseyside.

Safe services – standardised care pathways and clinical protocols are adopted across the whole system; services are integrated across provider organisations and the workforce is deployed to meet national standards and obligations.

Consistent high quality outcomes and improved experience –variations in outcomes and experience are reduced.

Improved and informed choice and decision making – by working together through collaboration, co-operation and co-production and removing organisational barriers, women, their babies, children and young people will be more engaged in decision making about the services that are offered to meet their needs.

Clinically and financially sustainable services – combining resources, expertise and working as one will allow services to be better organised to deliver the best value for money and to be able to meet the needs of the population now and into the future.

The work of the Partnership fits with the STP as it will:

- Redesign and reconfigure women's and children's services through provider collaboration, clinical commitment and the creation new, delivery, commissioning and contracting frameworks.
- Standardise pathways and service models so that the right care is received in the right place at the right time, repatriating activity from tertiary to secondary and secondary to community and primary care settings.
- Improve health and wellbeing of women, babies, children and young people through engaging with non-traditional partners using health as a social movement.

**Is there a defined programme of work?**

Our programme can be divided into three phases taking us through to 2017/18, these are:

- engagement in and design of the new models of care and delivery for maternity, neonatal and acute paediatric services by the people who work in these services, the people who use these services and the organisations who deliver and commission these services. We are currently in this phase.
- formal public consultation on these new models of care, as they will result in the redesign of services, and decision making by commissioners and providers on the agreed model of provision and delivery.
- implementation of the new models of care, formal establishment of the Partnership as the collaborative body to coordinate, integrate and oversee provision and set shared objectives across women's and children's services through three clinically managed operational networks.

Each work stream has a clear work plan that follows these three phases. The priorities for the work streams are:

*Neonatal* – (i) service redesign and reconfiguration (ii) single service model for neonatal surgical pathway (iii) single neonatal transport service.

*Paediatrics* – (i) reconfiguration of acute services across organisations (ii) development of care closer to home (iii) health as a social movement.

# Cross-cutting clinical themes

## Women's and Children's Services (2/3)

NHS

*Maternity and gynaecology* – (i) service redesign and reconfiguration (ii) implementation of national maternity review recommendations (iii) development of care closer to home.

*Cross cutting themes* – (i) prevention – empowering patients (ii) new workforce models (iii) creation of single service models across organisations (iv) technologically enable services (v) central capacity and demand *management* system.

**Do you have your stakeholders mapped and engagement has started?**

Stakeholder mapping, analysis and engagement has commenced.

There are 28 organisations who have signed up to the work of the Partnership. These organisations were signatories to the initial Expression of Interest for the Vanguard and have also signed a Memorandum of Understanding in regard to the programme of work.

The Partnership has established three clinical working groups (maternity (incorporating obstetrics and gynaecology), neonatal (building on the existing North West Neonatal Operational Delivery Network) and acute paediatrics) to design the new care models and recommend how they would be implemented. These networks have excellent engagement from clinicians, commissioners and managers across the region.

The Partnership has also engaged with and has the support of the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatric and Child Health, Royal College of Nursing, The King's Fund, NHS England's National Clinical Director for Children, Young People and Transition to Adulthood, Children's Hospitals Alliance, Sopra Steria, Public Health England, The Baby Box Co. and the Rugby Football League/Super League.

The Partnership is also actively engaging with patient groups such as BLISS and SANDS and also with other voluntary and community sector groups.

**Are the risks understood?**

The Partnership is developing a Risk Register that will identify risks, controls and assurance mechanisms using the methodology and approach employed by NHS Halton CCG.

Examples of potential barriers and mitigating actions include:

- Financial – Barrier: Resources for the Programme Management Office, resources to implement change. Mitigating actions: Working with the New Care Models team to obtain additional resources, resources secured from LWEG for paediatric training model and from NHS England for choice and personalisation pioneer site. Discussions with non-NHS partners such as Sopra Steria and Baby Box Co. for additional resources for health as a social movement initiative.
- Political – Barrier: potential for opposition from MPs and local authority elected members. Mitigating actions: Communications and Engagement Plan in place. Pre-engagement communications and briefings with MPs, Health and Wellbeing Boards and Overview and Scrutiny Committees sent.
- Engagement with people who use the services/wider public – Barrier: potential for opposition to service changes, potential to breach duties under Equality Act 2010 and other legislation. Mitigating actions: Communications and Engagement Plan in place. Pre-engagement work with interested parties. Equality Impact Assessment being used as a 'live' document. Working with NHS England Assurance Team.

Engagement with organisations that commission and to make or adhere to decisions – Barrier: potential for resistance to change, lack of engagement and failure actions: Mitigated by governance arrangements within the framework of the STP. Working groups engage commissioning and provider representatives. Alignment with other local change programmes such as Healthy Liverpool and Liverpool Women's Hospital NHS Foundation Trust's Future Generations

**Is there a process to get decisions made and to track progress and hold people to account?**

The Partnership is working under a joint governance approach that will evolve as the programme moves through the three phases cited above. By the end of 2017/18 we intend to have in place new models of care with decision making consolidated into a formal partnership of organisations, with services delivered through a networked approach across organisations. This will be underpinned by new contracting approaches - alliance, federation or prime contracting – which will be developed by the Partnership.

For the engagement and design phase, we have established an Executive Leadership Group (ELG) to oversee the strategic direction and to support and manage significant risks to the partnership and individual organisations. The ELG have agreed a Memorandum of Understanding (MoU) that sets out the nature of the change programme and the commitment of partner organisations to the Vanguard. In June 2016 the ELG became a Programme Board that will be supported by NHS Halton CCG and report into the agreed Cheshire and Merseyside STP governance arrangements.

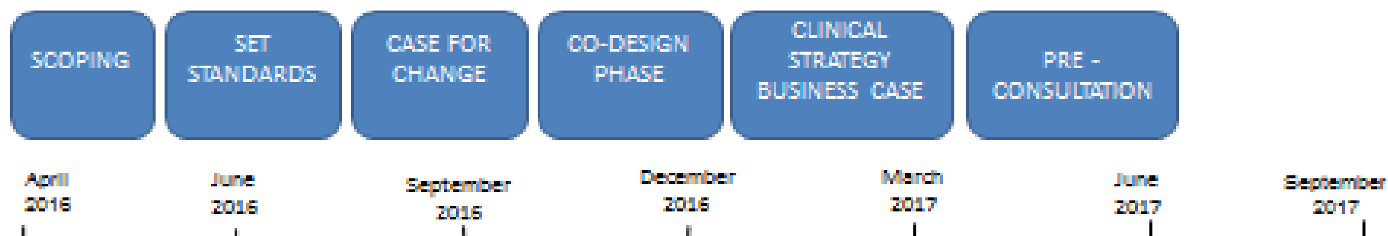
We will enhance the governance arrangements to support consolidated decision making as we move into the consultation and decision making phase of our programme. Our Communications and Engagement Strategy sets out how we will engage local authorities through Health and Wellbeing Boards and Overview and Scrutiny Committees, we also intend to engage with local Members of Parliament (MPs) as part of the programme. This will support the Partnership moving forward with engagement, pre-consultation and formal consultation as set out in our proposed programme timeline. Final decisions on the agreed model of provision and delivery will be made through the governance arrangements established by the Cheshire and Merseyside STP.

# Cross-cutting clinical themes

## Women's and Children's Services (3/3)

The final phase of the programme will be the implementation of the new models of care. Decision making will be consolidated through the formal establishment of the Partnership as the collaborative body to coordinate, integrate and oversee provision and set shared objectives across women's and children's services through clinically managed operational networks.

CHESHIRE & MERSEYSIDE WOMENS AND CHILDRENS PARTNERSHIP TRANSFORMATION PROGRAMME




PRE - ENGAGEMENT

- Establish Networks
- Recruit clinical leads
- Implement governance
- Map current services
- Determine future project groups
- Determine future demand and capacity

- Review quality standards
- Pathway reviews
- Best practice & research review

- Develop evidenced based case for change for all services

- In partnership design new models of care and options for service delivery

- Finalise clinical strategy and business case

**What is the Return on Investment for this work?**

The services being reviewed within the Partnership cover a full range of complex system pathways with interventions taking place in primary care, tertiary, secondary care, community services and local councils. There is a complex pattern of costs, income flows and savings across specialist services and CCG commissioned services within community, primary, secondary and tertiary care. Financial models have been developed that have allowed the partnership to:

1. Establish a baseline of costs and income, based on information provided by local Trusts, for assessing the comparative costs and financial benefits of the proposed models against the counterfactuals (i.e. usual NHS alternative or existing models)
2. Apply reasonable assumptions to estimate these costs and financial benefits.
3. Identify implications for the models/elements of these and gaps in knowledge/assumptions to be further analysed or tested in the evaluation

The table below details the current proposed ROI:

| *£M unless stated* | | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|---|
| **Gross savings** | | **0.250** | **1.750** | **3.570** | **5.650** | **8.050** |
| **Revenue costs** | From Vanguard/STP | 1.006 | 2.500 | 1.900 | 0.300 | 0.200 |
| | From Local Contribution/In Kind | 1.000 | 1.000 | 1.000 | 0.455 | 0.455 |
| | **Total Revenue Costs** | **2.006** | **3.500** | **2.900** | **0.755** | **0.655** |
| **Net savings** | | **-1.756** | **-1.750** | **0.670** | **4.895** | **7.395** |
| **Capital costs** | Other Source | | | | | |
| | **Total Capital Costs** | **0.000** | **0.000** | **0.000** | **0.000** | **0.000** |
| **5-Year Return on Investment (total revenue funding)** | | **86%** | | | | |

Within the values described in Table 1 above the Partnership has secured £175k for quarter 1 2016/17. Initial indications are that this value (£175k) will be available for each quarter of 2016/17 as a minimum. The full value required for 2016/17 is £1,006k is subject to revised Value Proposition to The New Care Models Team due in 30 June 2016. The table also details the future requirements to allow the project to continue at pace being £2,500k, for 2017/18 and a further £2,400 over the following three years.

**Completed by:**
**SRO – Simon Banks**

# Cross-cutting clinical themes

## Cardiology (1/2)

NHS

**What is the rationale for this theme?**

The rationale for having cardiology provision as a cross-cutting theme:

- Cardiovascular disease (CVD) affects the lives of millions of people and is one of the largest causes of death and disability across Cheshire and Merseyside (C&M). Emergency admission rates for CHD remain higher in C&M compared to England.
- Although coronary heart disease mortality has improved over recent years, C&M still has higher than average spend per capita and poorer outcomes when compared nationally. Although there is a high rate of primary PCI, the mortality from STEMI is higher than the rest of England.
- Reducing geographical variation in care, through optimising and accelerating treatment pathways with agreed service standards and clinical protocols, could save the lives of more patients with a heart attack.
- Reducing inequalities between patients in access to and outcomes from cardiology services, by ensuring services are provided in an integrated and consistent way across the region.
- Evidence that placing a greater emphasis on more holistic preventative and proactive care, such as investing in lifestyle profiling, targeting high risk patients and cardiac rehabilitation can have a significant impact on demand for services and improve health outcomes.

**Is there a defined programme of work?**

The vast majority of acute cardiology patients present through emergency departments and are admitted to acute hospitals across the region. specialist secondary cardiology care is delivered at DGHs, but all tertiary care is delivered by cardiologists employed and based primarily at Liverpool Heart and Chest Hospital. Patients who require further specialist investigations, cardiac surgery, percutaneous coronary interventions (PCI), or complex pacing require a transfer to LHCH.

There is a clearly defined programme of work to redesign CHD services across the North Mersey region as part of the Healthy Liverpool Programme. There are five clinical work-streams supporting this focusing on:

1. Chest pain
2. Syncope and pacing
3. Cardiac rehabilitation
4. Healthy imaging
5. Breathlessness

Each group is chaired by clinical leaders from these disciplines from all the Liverpool hospitals and reports to a steering group led by Liverpool CCG. They are focusing on delivering quick wins to provide proof of concept as well as longer term patient benefits and efficiency gains.

Chest pain is the work-stream with the greatest potential impact on future service provision and efficiency. The aim of this work-stream is to improve access to specialist care for the whole range of acute coronary syndromes (ACS). Improved care for patients will be achieved by reducing transfer times, variations and duplications in their pathway.

This, in turn, should improve outcomes while improving efficiency by having one hospital admission and one procedure. This will reduce unnecessary admissions and reduce length of stay at the DGH. In addition, there is the potential to significantly reduce investigations and diagnostic costs in areas such as repeat bloods, echocardiography and angiography. As well as removing duplication, having a standardised rapid diagnostic pathway with enhanced specialist cardiologist support will improve outcomes.

The learning and practice from this pilot will be developed and introduced system-wide across the geographical footprint of C&M.

**Do you have your stakeholders mapped and has engagement started?**

All acute stakeholder organisations across Cheshire and Merseyside, together with key commissioners have been engaged in the Strategic Options Appraisal work undertaken by LHCH looking at their future reconfiguration and location of cardiology services. In addition, two stakeholder surveys have been conducted by an independent company to understand what currently works well and where services need to improve. Patient groups have also been involved. The future focus will be on how seamless, integrated cardiology care can be delivered across the whole C&M region in the most efficient, effective way.

**Are the risks understood?**

An initial risk-benefit analysis has been carried out looking at the various options for the reconfiguration of care from the 'do nothing' option to the maximum integration of all core cardiology services and spend across North Mersey. Again, this work can be replicated on the wider region but the four key risks related to each option are anticipated to be the same for the whole of C&M:-

- Gaining consensus to proceed consistently across all areas and managing competing agendas and aligning commissioners
- Self- interest and financial constraints – there will be winners and losers unless the financial model is integrated to facilitate change
- Lack of leadership to develop cultural and transitional arrangements to align roles and workforce to the new models of care
- The practicalities of delivering wide-scale change within the constraints of the current infrastructure and geographical spread of resources

Is there a process to get decisions made and to track progress and hold people to account?

A CVD Steering Group led by Liverpool CCG, which has representation from acute trusts, mental health, primary care and commissioners, is in place and meets monthly. This is part of the Healthy Liverpool Governance infrastructure to oversee implementation and there is a detailed project plan.

# Cross-cutting clinical themes

## Cardiology (2/2)

Governance arrangements for the wider C&M pathway work will need to be agreed and implemented as part of the STP delivery arrangements.

**Short term milestones?**

- Develop a set of shared information to understand future capacity and demand and gaps in local and regional service provision and priority areas
- Establish a C&M cardiology pathway governance structure
- Agree target areas of focus across C&M
- Agree a single cardiology pathway and model of care by April 2017
- Agree the new commissioning and financial model to support this
- Establish facilities for early transfer (24 hours) of acute coronary syndrome patients or direct paramedic transfer.
- Implementation of weekend ACS lists at LHCH by September 2016.
- Establish some quick wins across Liverpool from the CVD 5 pathways and roll out by 31st March 2017

Agree the concept of a wider 'Heart Attack Centre' and an implementation plan to deliver this within the confines of current geographical spread and infrastructure

**What is the Return on Investment for this work?**

There is evidence to demonstrate that reducing variability, improving access to specialised services, reducing unavoidable admissions at A&E and delivering more out-of-hospital care will lead to efficiencies as well as improving patient care and outcomes.

Some analysis of these benefits has been modelled for the Healthy Liverpool CVD programme but this will have to be developed further and expanded for the wider C&M footprint.

Some of the initial cost benefits for North Mersey would indicate savings for commissioners of in excess of £1,000,000 secondary to reduced duplication of angiography. In addition there is an estimated reduction in LOS of 3-4 days secondary to rapid transfer protocols of ACS patients. Additional capacity will offset a proportion of these savings. Savings from the other workstreams have yet to be estimated. Reduction in readmission from appropriate cardiac rehabilitation, early transfer for primary pacing and single pathways of investigation for other conditions are likely to result in significant efficiencies.

**Completed by:**

**SRO – Jane Tomkinson CEO LHCH and Debbie Herring, Director of Strategy and OD**