

## A quarterly update on the One Liverpool Population Health Programme

Edition 2, Spring 2023

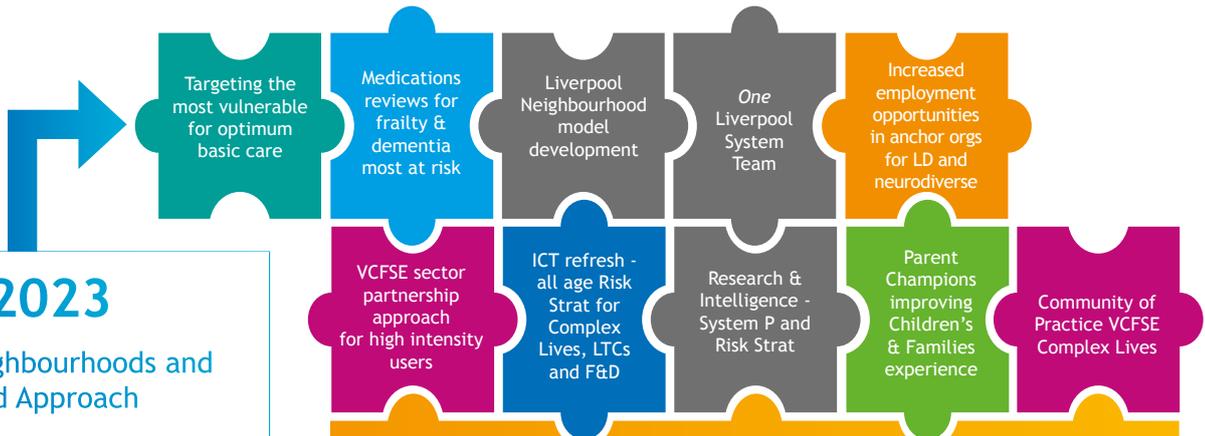
# Population Health Summit

- Joe Rafferty, as Chair of the Liverpool Provider Alliance, convened a meeting of system leaders and key stakeholders working on the Population Segments, on the 29th of March
- All programmes were asked to describe the key pieces of work they would like to deliver by Winter, and what their population segment would look like in 5 years' time
- Each segment and ICT programme now has a detailed plan, endorsed by system leaders

- We have condensed these detailed plans into the 7 themes for Winter - key priorities which need broad system support but will help alleviate pressures across a range of services ahead of winter
- These developments must also help us move towards our longer-term vision - the 5 key principles of our target operating model.



## Short term developments that move us closer to our Target Operating Model



### Winter 2023

1. Healthy Neighbourhoods and Family Based Approach
2. Broader determinant approach
3. Foundations of good care
4. Non-Criteria to reside (hospital beds)
5. High Intensity users
6. One Liverpool system team
7. Research & Intelligence led

### 5 Year Vision & Target Operating Model

1. Co-ordination around population clusters
2. Co-location & site reconfiguration
3. Development of the workforce to meet population needs
4. Promoting effective neighbourhoods
5. Long-term, qualitative interactions which improve health and wellbeing outcomes

# Summary of points discussed at the Segment Summit:



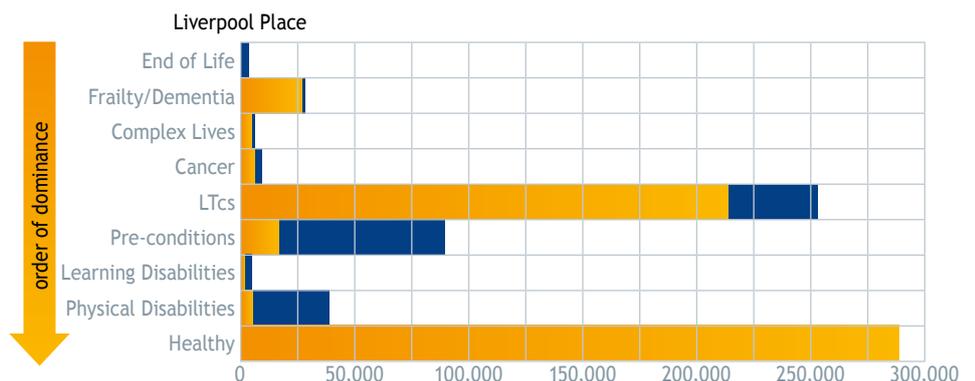
- Prevention only represents circa 1.3% of our resources; we need to scale up and make this more sustainable
- Risk and reward for system partners needs to be teased out within our plans to facilitate the pooling of resources where this is an enabler for transformation
- The VCFSE sector is a crucial partner in helping us tap into personal, social and community capital. We need to develop a close interface between the Segments/ICTs and the Strategic Health & Wellbeing Network and resource accordingly
- We need to develop user-cases based on our CIPHA and System P infrastructure
- An asset-based approach to working in partnership with families is important, targeting our approach and working as part of the neighbourhood model. Ensuring that universal services and prevention are key building blocks

Meet the

## Segment Teams

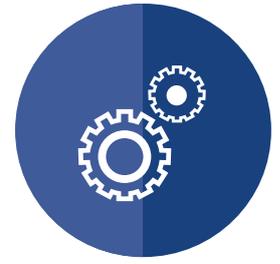
The graph to the right illustrates how the population is segmented in Liverpool. Some areas such as physical and learning disabilities have been merged. The largest is the Healthy Children & Families Segment, followed by Long-Term Conditions.

People can be in more than one segment which might be important to us understanding their needs.



SEGMENTS	Healthy Children & Families	Disabilities	Long-Term Conditions	Frailty & Dementia	Complex Lives	Integrated Care Teams
Segment Senior Responsible Offer (SRO)	Melisa Campbell (Public Health) Dani Jones (Alder Hey)	Anne Marie Lubanski (Liverpool City Council)	Jonathan Develing (Liverpool Heart & Chest) Dr Paula Parvulescu (Public Health)	Dr Matt Tedford (LUHT)	Dr Louise Edwards (Mersey Care)	Fiona Worrall Neighbourhoods Design Architect (Liverpool City Council)
Segment Delivery Lead	Alison Williams (Liverpool Place Team)	Gina Perigo (Liverpool Place Team)	Alison Brook (Liverpool Place Team)	Jane Fradley (Liverpool Place Team)	Ellie McNeil (YMCA) Claire Mahoney (Liverpool Place Team)	Pat McGuiness AD Strategic Partnerships (Mersey Care)
Segment Support Manager(s)	Vacant	Vacant	Gayle Rooke (Liverpool Place Team) Amanda Brookes (Liverpool Place Team)	Sam Clements (Liverpool Place Team)	Vacant	Dave Warwick Integration Manager (Mersey Care)

# Focus on Integrated Care Teams



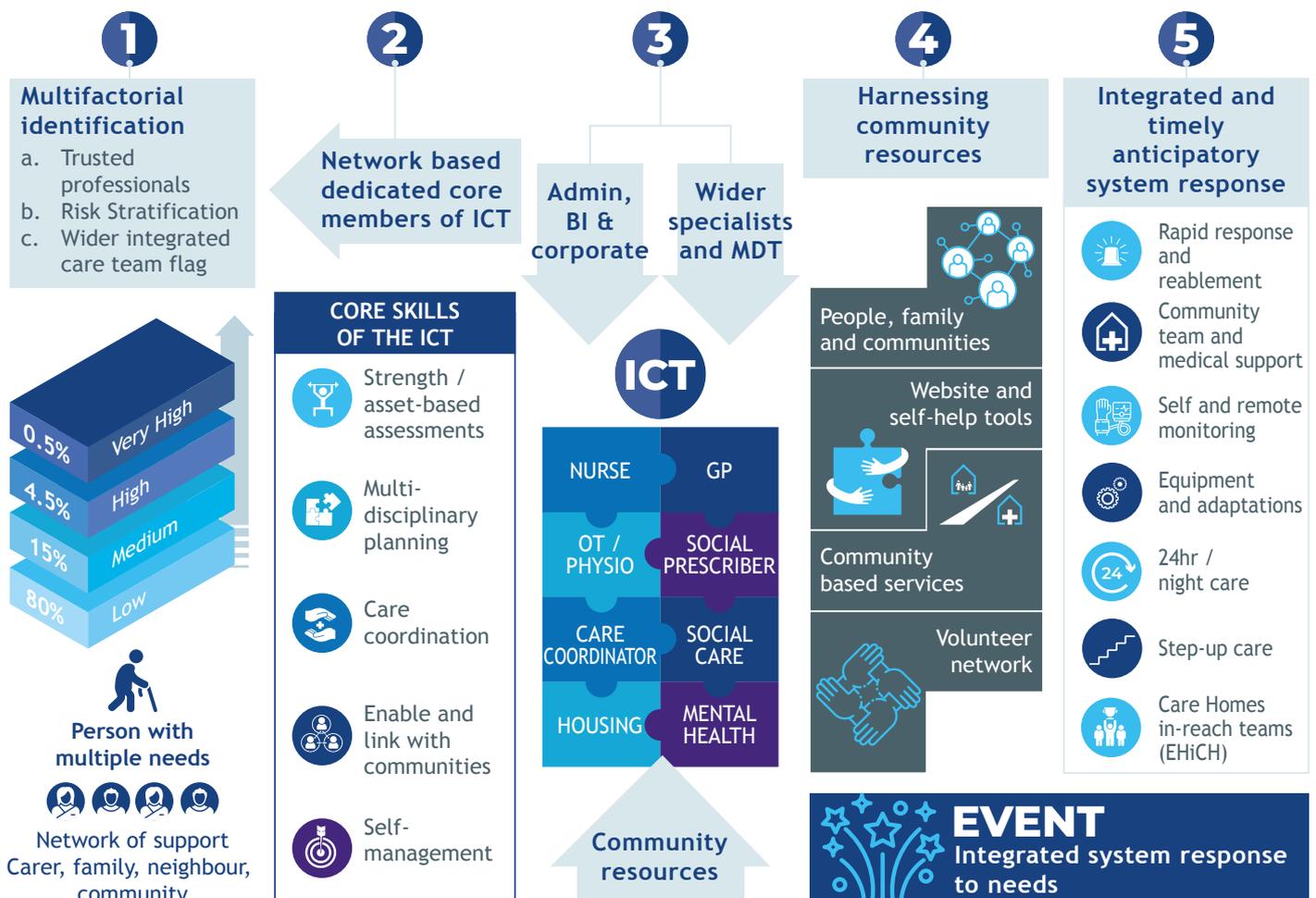
## Part of the Liverpool Neighbourhood Model

The integrated Care Team (ICT) model has been operational for approximately 4 years. In this time, it has developed some highly innovative approaches to working with vulnerable communities and individuals. However, there is recognition that the model needs a refresh, in partnership with key stakeholder organisations and services.

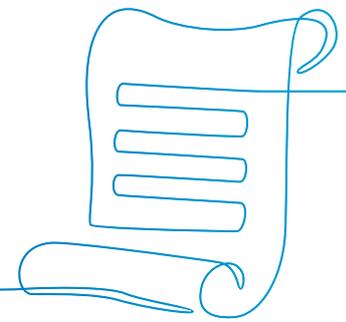
A core component of this refresh is how risk stratification can help better focus the ICTs on the population cohort that would benefit most from their intervention and support. The teams had originally used The Welsh Model to help identify

eligible cohorts, although this had some limitations in that it did not factor in mental health demand, which is actually a key part of the integrated care approach.

We are currently exploring a new tool which we hope will better identify people for the ICT caseload. This will help the services/team better focus their resources, but also to continue to monitor the impact of what they are doing, and to evolve the model as required on an ongoing basis. The 5 component parts of the ICT model are described below:



# ICT Top 10 Priorities



- 1 Utilise risk stratification/population health tools to proactively identify people within each neighbourhood
- 2 Review our current ICT Service Specification in collaboration with partners
- 3 Have a single integrated referral form across Liverpool place
- 4 Increase in ICT caseload by Winter and better sign up across those areas which are not using ICTs
- 5 Ahead of winter, ensure that key, vulnerable cohorts have easy access to social welfare advice, particularly fuel and food support services along with housing, debt management and other core offers
- 6 Implement a dedicated Communications and Marketing plan outlining the vision, key messages, and benefits to service users/ carers/staff/communities/system
- 7 Deliver multi-agency themed events regarding cost of living with representation from statutory services, community groups and voluntary services to enable local people who may be struggling with cost-of-living and its associated impact on accessing services and wellbeing
- 8 Frail elderly is a key cohort, and we will commence work on identification and enhanced support
- 9 Complex Lives - all age approach. Identify families most at risk and work alongside the segments to deliver a targeted and enhanced offer
- 10 Work to identify the gap in support for people with multiple morbidities who need a more integrated, bespoke care package from the ICTs. Take an evidence approach to modifying this model as it develops

## EXAMPLE

# ICT approach in practice: Croxteth

‘Our Croxteth’ is the result of a vision for a social movement for health.

Leaders from a range of providers, including GPs, Mersey Care, Merseyside Police, Cobalt Housing, Local Authority and Liverpool Citizens Advice, worked in partnership to facilitate a grassroots-led, co-produced project to improve local outcomes.

Collaboratively, organisations developed a participatory budgeting process, which released £50k of funding to support local ideas and projects.

In February 2022, this resulted in a vibrant community event, where 27 bidders presented their ideas to over 200 local people.

Members of the Our Croxteth Community Working Group formed the judging panel awarding 24 projects full or partial funding.

12 months on from the event taking place, the Community Working Group provides a local network for those groups who first engaged as part of the Community Fund to continue to develop local activities - acting as a springboard for collaboration and further funding bids.

We are taking the learning from ‘Our Croxteth’ to help proliferate asset-based, collaborative working principles and integrated care models into other Liverpool neighbourhoods - to ensure our services, and those of the wider system, better meet the needs of local people.

# Segment Snippets

Bitesize news from  
each of our Segment programmes..



## Healthy Children & Families

The HC&F Segment team are hosting an Oversight and Network meeting on 26th May; a key focus will be to mobilise the winter plan and how teams can best influence patient flows and outcomes. The DfE Family Hub Model is expected to launch in the coming weeks, with the first hub mobilising in the North of the city. Working with the Beyond Transformation Programme, we are establishing Children & Young People's respiratory hubs to integrate primary & secondary care teams, enable delivery of community spirometry, ensure asthma care plans are optimised and help achieve a reduction in ED attendances.



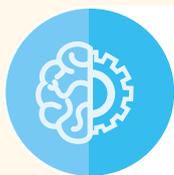
## Complex Lives

Improving access to mental health services for the BAME population is making good progress with a scoping exercise well underway - please contact [Dianna.mannhart@liverpoolccg.nhs.uk](mailto:Dianna.mannhart@liverpoolccg.nhs.uk) if you would like to contribute or know more. Data linkages with the voluntary sector is being explored and a specification for High Intensity users is being drawn up to mobilise the service ahead of winter.



## Long Term Conditions

There was a large LTC workshop on the 1st March which was really well attended and generated a number of proposals to help innovate the offer around people with multiple comorbidities. Work to mobilise an enhanced offer ahead of winter has commenced, including IV diuretics in the community to improve system demand and patient experience, and direct access to mental health from diabetes and respiratory teams (with the hope of extending into cardiology also).



## Frailty & Dementia

The segment have approved two new areas of work into the programme; Appropriate Prescribing which will expand from care homes to a wider community model and Falls Prevention, which includes a number of elements e.g. promoting strength and balance to minimise falls. We are working to keep care home residents *safely* in their homes through on going promotion of clinical escalation using the agreed pathways (Immedicare) alongside new pathways, and continuing with the winter pressures work looking at NWS conveyances from care homes. The end-of-life work programme has met recently for the first time and are currently developing the programme of work.



## Disabilities

LCC have commissioned Healthwatch to provide a structure for people with lived experience to be actively involved in decisions that affect the services they receive and life opportunities they experience, through establishing Partnership boards and Lived Experience Subgroups. The Neurodiversity Strategic Partnership Group launched on the 18th of May (and meets the statutory requirement for an autism board) the Learning Disability Strategic Partnership Group will be launched in July. Regular strategic partnership meetings to commence in September on a quarterly basis.

*The refreshed Health & Wellbeing Network has met for the first time since its remit and membership has been revised. This group brings together key people from within the VCFSE sector and is a key point of contact for place and all segments who wish to engage more effectively with the sector.*

# Primary Care Update

On the 9th May, NHS England published the following report...



*NHS England » Delivery plan for recovering access to primary care*



This plan seeks to support recovery by focusing this year on four areas:

1. Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. It is hoped this will relieve pressure on general practice.
2. Implement **Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.
3. Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
4. Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

From April 2023 all ICBs have accountability for commissioning community pharmacy, dental and optometry services.

NHS England will ask ICBs to develop their own system-level access improvement plan, which includes a summation of the actions their PCNs and practices have committed to, including confirmation of the funding and offers each want to take up, and the outcomes expected. ICBs should take these plans to their public boards in October or November 2023 with a further update in February or March 2024.

ICBs will want to ensure the actions in their plans align with the vision described in the Fuller Stocktake. An immediate critical enabler is to ensure digital telephony systems can support the future direction of PCNs and places in offering a single

system-wide approach to integrated urgent care and integrated neighbourhood teams.

To reinforce the ICB role as commissioner and in driving improvement, each element of the plan is supported by one or a combination of: (i) a new 2023/24 contract requirement; (ii) a new 2023/24 contractual incentive; (iii) reprioritised national funding; (iv) greater transparency of outcomes at system, PCN and practice level; or (v) the ability to leverage the existing standard trust contract.

Further details on the Liverpool PCNs response to the above will be shared in due course, and interface arrangements with broader services in the community and elsewhere, will be managed via the Liverpool Provider Alliance.

## In the next edition...

An update on key progress on each of the population segments and neighbourhoods.

If you would like to discuss any of the content of this newsletter or contribute to the next edition, please contact:

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