Foreword

Our Mission Statement is: ‘Your partner in a healthier future for all’

Foreword

This document describes the strategic plan for NHS Wirral Clinical Commissioning Group (Wirral CCG) for the period 2014 – 2019. As the main commissioners of health services for the people of Wirral we describe here how we intend to meet the needs of our population now and in the future including the way we will change how these services are delivered.

In preparing this plan we have worked with our member GP practices, partners in hospitals and community settings and colleagues in the local authority and other NHS bodies to agree between us how health services should develop in the coming years and also to bring care provided by health and social services closer together in an integrated way.

Our combined knowledge has shown us that we face many challenges on Wirral looking forward. Our population is ageing; more of us are living longer with long term medical conditions; there continues be a large gap in life expectancy between the richest and poorest areas of the borough; we rely heavily on health
services provided in an acute hospital setting; too many of our senior citizens become permanent occupants in nursing or residential homes.

When we consider these facts at a time when public organisations are facing an unprecedented challenge to operate more efficiently it is clear to us and our partners that we will need to make significant changes in order to continue to provide services that meet expectation and demand, remain safe and reliable and are sustainable financially for the future.

Wirral CCG: Who we are and our Vision

The CCG is a membership group made up of the 58 GP practices on Wirral. We are different to commissioning organisations of the past in that our leadership is made up of clinicians. We practise in the GP surgeries of Wirral and continue to see first-hand what is working well and also what needs to be improved. We use this personal experience to lead the CCG both in its day to day operation and its planning for the future.

Our vision statement is:

‘Wirral CCG commits to improve health and reduce disease, by working with patients, public and partners, tackling health inequalities and helping people to take care of themselves’

This short statement reveals a lot about what we believe in. We consider that good health starts with the individual. We will promote ways for people to keep themselves healthier for longer and manage their own health needs. We say ‘partner’ because it’s our job to ensure that a health service is ready to help you should the need arise.

We must also ensure that the service is simple and quick to access, is safe and high quality and provides good value for money. ‘Partner’ also has a broader meaning to us in that we recognize that only by working together can we
improve the health of Wirral. Throughout our plan you will see reference to ‘integration’. This means professionals in hospital and community settings working together but also health, social care and other public services combining their efforts to provide solutions to the challenges we face.

We are fully aware that there continues to be an unacceptable difference in rates of disease and death between parts of Wirral. Although we have seen some improvements in these factors recently Wirral’s health is not getting better as quickly as other areas of England so the CCG remains focused on tackling this over the coming years.

We are confident that our plan sets out a clear case for change on Wirral. Over the next five years we will work with our partners to deliver transformation while remaining true to our vision. At every step we will use our experience as clinical leaders to refer back to what our patients are telling us to ensure that we continue to meet the needs of the people of Wirral.
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Executive Summary

Our strategy will require continuous and significant service review and transformation

This Strategic Plan (and its associated operational plans) have been developed in the context of very demanding requirements from government both in terms of patient and service user expectations and anticipated resource availability.

The key goal is to continue to deliver high quality services during a time of significant financial challenge and a changing NHS landscape.

The focus of the CCG will be to deliver financial sustainability; to deliver national requirements such as those outlined in the Everyone Counts: Planning For Patients Guidance; and continue to deliver improved quality, evidenced by improving safety, effectiveness and patient experience. This will be the focus for the CCG during the period of this plan and beyond.

In addition to national developments and priorities we will focus on local service redesign which will address the specific health needs in Wirral reflecting the sometimes different requirements of its registered population.
In summary we see the Wirral health care system/service in 5 years’ time as one that:

- Is patient and primary care centric and based on high quality primary care, secondary and community services
- Has rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes
- Has commissioned services which have a sound evidence base
- Provides greater equality of access to all

We will focus on the national and local priorities as appropriate, in order to:

- Prevent People from dying prematurely
- Enhance the quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Ensuring people are treated and cared for in safe environment and protected from avoidable harm

We have identified specific local priorities including:

- Meeting the needs of our ageing population
- Supporting Alcohol prevention and treatment services
- Improving Mental Health services with particular prioritisation of dementia
This strategy is at a point in time in terms of its development and alignment. Alongside the development of the CCG Strategic Plan the CCG is working with partners on the development of a system wide vision for the health and social care economy which is called Vision 2018. In recent weeks prior to submission the CCG and its partners across health and social care have begun a process designed to strengthen planning and delivery of the Vision 2018 system plan by streamlining the structure of programmes and establishing tighter governance protocols.

This process will include more detailed development and agreement of the precise activity and finance characteristics of the local health economy in 18/19 to be sustainable. It will also define in greater clarity the nature and scale of improvement the individual programmes need to achieve in support of the strategy.

Therefore the CCGs key change programmes described later in this document are representative in terms of purpose and content, but will continue to be refined as partners in the system develop plans and mobilise resources. The CCG will also work closely with neighbouring CCGs so as to address wider quality and sustainability challenges.

The emerging shape of the Vision programme and its high level alignment with CCG planning is described in the governance section towards the end of the document. The intention is to harmonise effort into one single plan for the system.

Partners across the health and social care community in Wirral have met to discuss and review assumptions underpinning the development of their Strategic Plans. Partners acknowledge that whilst there may not be a fully developed set of agreed commissioning intentions, organisations have developed their plans having made informed assumptions about capacity and demand and the impact this will have on organisational activity and finances.
Executive summary

Whilst there is a shared acceptance of the broad strategic direction of travel in relation to the need to transform care outside of the traditional settings, plans to deliver this are at a very early stage of development and therefore will continue to develop in the following iterations.

Partners do acknowledge that activity and financial assumptions will vary across each organisation at the point in time of the submission of strategic plans and have agreed to commence a process of review of these assumptions over the next few months, alongside the strategic review which has taken place of the structure and processes in place to support the Vision 2018 programme.
The case for change

Wirral faces new challenges

Context

Wirral is a borough of contrast and diversity in both its physical characteristics and social demographics. There are both rural areas and townships, urban and industrialised areas in a compact peninsula of 60 square miles. The borough has parks, countryside and over 20 miles of coastline.

Wirral currently experiences a variety of challenges specific to its locality and demography, as well as future pressures which face health and social care systems nationally.

The anticipated severity of these pressures acting in conjunction means that the nature and scale of change required is significant and unprecedented.

This section describes the case for change to:

1. Improve quality of care and outcomes for patients
2. Transform healthcare provision so that it is financially sustainable
The case for change: Context

Commissioning environment

NHS Wirral Clinical Commissioning Group is a federated model comprising 3 commissioning consortia as follows:

<table>
<thead>
<tr>
<th>Division</th>
<th>Number of Practices</th>
<th>Number of Patients (approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral Health Commissioning Consortium (WHCC)</td>
<td>25</td>
<td>165,000</td>
</tr>
<tr>
<td>Wirral GP Commissioning Consortium (WGPC)</td>
<td>25</td>
<td>126,000</td>
</tr>
<tr>
<td>Wirral Health Alliance (NHA)</td>
<td>7</td>
<td>40,000</td>
</tr>
</tbody>
</table>

The configuration of each of the consortia follows with no discrete geographical boundary.

In total we look after the health needs of approximately 330,000 people within Wirral.

Local providers

NHS Wirral CCG commissions its services through a range of NHS and Non-NHS providers with the contract monitoring and negotiation process being led by clinical commissioners.

Wirral CCG commissions services from the following providers -

- Acute: Wirral University Teaching Hospital NHS Foundation Trust
- Mental Health: Cheshire and Wirral Partnership NHS Foundation Trust
- Community: Wirral Community Trust
- Social Care: Wirral Borough Council
- Primary Care: 57 GP practices

Other providers:

- 94 pharmacies
- 45 dentists
- 33 opticians
The case for change: Overview

Overview

Health services that were set up to provide care - to help sick people get well, are finding it harder to meet the changing nature of need, including an ageing population and increasing numbers of people requiring long-term care.

Services available to respond to these demands, particularly in the acute setting, are often not the most appropriate response to the care needs of patient and individuals. In many cases those individuals are the same people requiring support from local authority social services and mental health to help them stay independent and well.

Traditional models of care are currently not set up to cope with the needs of patients in a cost effective and sustainable way. Broadly speaking within a population or given locality, five percent of the population will consume 45% of the health resource. These are patients with complex chronic conditions (elderly, adults and children).

However, although these people use well over half of the care resources, they often do not receive the optimum care for their needs.

• Typically, patients have poor experience of care that:
  • Does not support their independence and control
  • Is fragmented and difficult to navigate.

And, poor outcomes:

• A poor quality of life for both the patients and their carers.
• Too many people living with preventable ill-health and dying prematurely.
• Avoidable emergency and residential care admissions/ readmissions.

So, there is a need to adapt the care system to better meet the changing needs of individuals, families and communities today - to put in place proactive, on-going and integrated care.
The case for change: 1 Quality and outcomes

Population profile

Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole.

The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next decade; between 2011 and 2021 it is estimated that this population group will have increased by 17.4%.

The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, which equates to a 29.9% increase.

The biggest decrease is in the 35-59 year age group, from 108,548 in 2008 to 82,061 in 2021.

Births reached a 15 year high in 2011.

The Index of Multiple Deprivation (IMD) places 30 of Wirral’s LSOAs in the lowest 5% in England and 23 Lower Super Output Areas (LSOA) in the 3% most deprived nationally.

The Employment domain of the IMD 2010 indicates that Wirral performs poorly on this indicator. This is an indication of the scale of the challenge faced in Wirral and the need for a focused and coordinated approach to tackling work-lessness and economic inactivity.

Wirral has a predominance of ‘Mosaic’ groups which are at the polar extremes of the income spectrum, indicating that the differential between people on very low and very high incomes is quite pronounced in Wirral.
The case for change: 1 Quality and outcomes

Deprivation

The Index of Multiple Deprivation (IMD) IMD 2010 shows that Wirral is the 60th most deprived of the 326 districts in the country and is therefore in the bottom 20% nationally. There has been no change on previous data (IMD 2007).

The IMD places 30 of Wirral’s Lower Super Output Area’s (LSOA) in the lowest 5% in England and 23 LSOAs in the 3% most deprived nationally as described in the table below.

Life expectancy

In 2008-10, life expectancy in Wirral was 77.0 for men and 80.8 for women. However life expectancy varies across the peninsula and an example of this is displayed by the map below, comparing life expectancy by Wirral Railway Station for the male Wirral population.
The gap in life expectancy between Wirral and England continued to widen in 2008-10. Amongst women in Wirral, life expectancy has actually decreased slightly for the last two time periods recorded (2007-09 and 2008-10).

The gap in life expectancy between the most and least affluent within Wirral was 14.6 years for men and 9.7 years for women (Marmot Indicators, 2012).

The Marmot Indicators (2012) also showed that Wirral had the largest gap in Disability Free Life Expectancy (DFLE) for males and females of any authority in England (20.0 years for men, 17.1 years for women).

The main contributors to the gap in life expectancy between Wirral and England were chronic liver disease for men and lung cancer for women. Mortality from chronic liver disease in Wirral men in both the under 75s, and those of all ages, is higher than England. The main contributor to liver disease is alcohol.

Diversity

Wirral Black & Minority Ethnic (BME) population issues are difficult to isolate. Information relating to ethnicity in Wirral is limited. Wirral is by no means unique in this respect; many other areas are faced with this issue due to the limitations and relative inconsistencies in the recording of BME population data.

This possible lack of local data on the health and wellbeing needs of the increasing range of Wirral BME communities can in part be addressed by reviewing national data as it is likely to present a similar picture for Wirral residents.

National and previous local evidence might suggest that BME groups may not be accessing health and social care services in accordance with their level of need or in a timely manner.

Research suggests poorer communication, undue expectation, possible stereotyping, need for further training and cultural awareness.
that can combine to impact on BME residents in relation to their service provision and access

Census 2011 shows us an increase in the BME population, from 3.46% in 2001 to 5.03% in 2011 (From 10,900 people in 2001 to 16,101 people in 2011)

More BME residents live in Birkenhead and Tranmere ward than any other part of Wirral followed by Claughton, Rock Ferry and Hoylake & Meols.

Key issues and concerns

Wirral has many very high differentials between incomes in different parts of Wirral. This produces very marked impact on health experiences across virtually all indicators.

Wirral has the largest gap in disability free life expectancy of any authority in England for males and females.

There are about 38,000 recorded carers in Wirral representing about 12% of the population compared to a national average of 10%

Dementia is a key and worsening problem for Wirral with an estimated 4,443 people over 65 living with dementia in 2011. This is projected to rise to almost 5,300 within the next 8 years.

Alcohol is a significant problem for children and young people on Wirral. Death rates from digestive diseases mainly caused by alcohol are increasing very rapidly in the most deprived areas.
30,000 over 65s reported in the 2001 Census that they were living with a Limiting Long Term Illness.

The most deprived areas have much higher emergency hospital admission rates than the rest of Wirral.

Lifestyle behaviours such as smoking and drinking too much alcohol, as well as obesity, contribute to health inequalities, and these behaviours are all more prevalent in Wirral’s most deprived areas.

Birkenhead, Tranmere, Bidston, Seacombe and Rock Ferry have between 50% and 70% of older people living in deprivation.
NHS Outcomes Framework Indicator

The chart below shows the distribution of the CCGs on each Outcomes Framework indicator in terms of ranks. NHS Wirral CCG is shown as a red diamond. The yellow box shows the inter quartile range and median of CCGs in the same ONS cluster as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

<table>
<thead>
<tr>
<th>Outcome Indicator</th>
<th>CCG and cluster distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</td>
<td></td>
</tr>
<tr>
<td>1.1 Under 75 mortality rate from cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>1.2 Under 75 mortality rate from respiratory disease</td>
<td></td>
</tr>
<tr>
<td>1.3 (proxy indicator) Emergency admissions for alcohol related liver disease</td>
<td></td>
</tr>
<tr>
<td>1.4 Under 75 mortality rate from cancer</td>
<td></td>
</tr>
<tr>
<td>2 Health related quality of life for people with long term conditions</td>
<td></td>
</tr>
<tr>
<td>2.1 Proportion of people feeling supported to manage their condition</td>
<td></td>
</tr>
<tr>
<td>2.3i Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)</td>
<td></td>
</tr>
<tr>
<td>2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</td>
<td></td>
</tr>
<tr>
<td>3a Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td></td>
</tr>
<tr>
<td>3b Emergency readmissions within 30 days of discharge from hospital</td>
<td></td>
</tr>
<tr>
<td>3.1i Patient reported outcome measures for elective procedures – hip replacement</td>
<td></td>
</tr>
<tr>
<td>3.1ii Patient reported outcome measures for elective procedures – knee replacement</td>
<td></td>
</tr>
<tr>
<td>3.1iii Patient reported outcome measures for elective procedures – groin hernia</td>
<td></td>
</tr>
<tr>
<td>3.2 Emergency admissions for children with lower respiratory tract infections</td>
<td></td>
</tr>
<tr>
<td>4ai Patient experience of GP services</td>
<td></td>
</tr>
<tr>
<td>4a(ii) Patient experience of GP out of hours services</td>
<td></td>
</tr>
<tr>
<td>4a(iii) Patient experience of NHS dental services</td>
<td></td>
</tr>
<tr>
<td>5.2i Incidence of Healthcare associated infection (HCAI): MRSA</td>
<td></td>
</tr>
<tr>
<td>5.2ii Incidence of Healthcare associated infection (HCAI): C Difficle</td>
<td></td>
</tr>
</tbody>
</table>

Worse

Better
The case for change: 1 Quality and outcomes

QOF disease prevalence

The table below shows the prevalence (number and percentage) of diseases covered by the QOF for the practices in this CCG in 2010/11. The chart shows the distribution of the CCG’s practices’ prevalence in terms of ranks. Individual practices are shown as vertical bars with the height of the bar proportionate to each practice’s population. The blue box shows the range of the middle 50% of practices in the CCG. The large diamond shows the average rank for the CCG and the dashed blue line shows the England average.

<table>
<thead>
<tr>
<th>QOF Disease Register</th>
<th>Number (%) and practice ranks chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease</td>
<td>13,769 (4.1%)</td>
</tr>
<tr>
<td>Stroke or Transient Ischaemic Attacks (TIA)</td>
<td>7,359 (2.2%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>49,411 (14.9%)</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>7,396 (2.2%)</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>11,484 (3.5%)</td>
</tr>
<tr>
<td>Cancer</td>
<td>5,894 (1.8%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,979 (0.9%)</td>
</tr>
<tr>
<td>Asthma</td>
<td>21,109 (6.3%)</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>2,632 (0.8%)</td>
</tr>
<tr>
<td>Heart Failure Due to LVD</td>
<td>1,512 (0.5%)</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>732 (0.2%)</td>
</tr>
<tr>
<td>Dementia</td>
<td>1,902 (0.6%)</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>6,326 (1.9%)</td>
</tr>
<tr>
<td>Cardiovascular Disease Primary Prevention</td>
<td>4,342 (1.3%)</td>
</tr>
<tr>
<td>Diabetes Mellitus (17+)</td>
<td>16,122 (6.0%)</td>
</tr>
<tr>
<td>Epilepsy (18+)</td>
<td>2,512 (0.9%)</td>
</tr>
<tr>
<td>Depression (18+)</td>
<td>38,138 (14.4%)</td>
</tr>
<tr>
<td>Chronic Kidney Disease (18+)</td>
<td>13,193 (5.0%)</td>
</tr>
<tr>
<td>Obesity (16+)</td>
<td>34,063 (12.5%)</td>
</tr>
<tr>
<td>Leaning Disability (18+)</td>
<td>1,500 (0.6%)</td>
</tr>
</tbody>
</table>
The case for change: 1 Quality and outcomes

Summary

In arriving at our strategic priorities, a rigorous prioritisation process was agreed by the Wirral Health and Wellbeing Board and the JSNA Executive Group. The prioritisation process was undertaken between October and December 2012. It was systematic and transparent, supported by public and stakeholder consultation, which helped identify the most important priorities for local people. These were:

- Ageing Population
- Alcohol
- Mental Health
- Poverty
- Life Skills

Subsequently a prioritisation methodology was agreed and working principles established. The process identified a priority order and the Health and Well-being Board subsequently agreed the three strategic health priorities for Wirral to be:

- Coping with the demands and pressures of an ageing population
- Dealing with the health impacts from high incidence of alcoholism
- Reducing physical health inequalities of those suffering mental health issues
The case for change: 2 Financial sustainability

Overview

The Wirral health economy faces significant financial pressures - those experienced currently requiring additional support, and those anticipated into the planning period for which there is unlikely to be support available from external sources.

This means that the basis upon which Wirral provides and funds services will need to change radically so that it can continue to provide for the care needs of the community now and into the future.

The starting point is that our current funding position requires a significant proportion of non-recurrent support. Therefore year on year unrestrained growth in expenditure is not a sustainable basis for the CCG and wider system to plan against.

Existing clinical models of service provision across the economy manage current demand sub optimally and produce outcomes for patients which are below the standards we aspire to for our population. Significant investment is going to be required to redesign and rebalance the system so that it is both effective and affordable.

Future funding is however likely to be flat in terms of growth meaning that the system needs to look very different to protect the integrity and viability of services and the organisations responsible for their provision.

For us to manage pressures in a sustainable way the shape and size of existing providers will need to change dramatically, with more care being provided outside of acute settings and greater emphasis on community partners to manage and reduce overall demand entering into the care system.

We will need to work collectively across the health and social care system to share resources and remove unnecessary duplication. Patient centred care provision will mean cross organisational boundaries and funding mechanisms need to change to facilitate and incentivise this.
Wirral CCG’s spending 14/15

Wirral CCG plan to spend £444m of recurrent funds this year on healthcare provision.

The diagram below illustrates the CCG’s spending on health by high level category of care –
The case for change: 2 Financial sustainability

Funding allocations

Funding for the CCG’s programme of expenditure is anticipated to remain flat over the planning period to 2018/19 as shown below (excluding impacts of Better Care Fund). Note that the CCGs high level financial plan assumes a contribution of 4% annual efficiency across all spend areas. Efficiency not realised will add to the pressures below.

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Allocation Growth</td>
<td>2.14%</td>
<td>1.70%</td>
<td>1.80%</td>
<td>1.70%</td>
<td>1.70%</td>
</tr>
<tr>
<td>Assumed Cost Efficiency</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Total</td>
<td>6.14%</td>
<td>5.70%</td>
<td>5.80%</td>
<td>5.70%</td>
<td>5.70%</td>
</tr>
</tbody>
</table>

Pressures

Pressures on the system are expected to continue to rise at a faster rate than funding. The CCG is anticipating pressures using the following growth assumptions –

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflation</td>
<td>2.50%</td>
<td>2.90%</td>
<td>4.40%</td>
<td>3.40%</td>
<td>3.30%</td>
</tr>
<tr>
<td>Medical Technology (New Prescribing)</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Demographic Pressures</td>
<td>0.14%</td>
<td>0.15%</td>
<td>0.15%</td>
<td>0.15%</td>
<td>0.15%</td>
</tr>
<tr>
<td>Non-Demographic Pressures (e.g. Acute Demand)</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Non-Demographic Pressures (e.g. Out of Hospital Demand)</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>Specific Developments - e.g Better Care Fund Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative Cost pressures</td>
<td>6.64%</td>
<td>7.05%</td>
<td>8.55%</td>
<td>7.55%</td>
<td>7.45%</td>
</tr>
</tbody>
</table>
The case for change: 2. Financial sustainability

Forecast gap in funding

The combination of inflation and activity growth will accelerate the gap between funding and required expenditure, particularly if assumed efficiencies are not managed year on year.

Unmet efficiencies in one year are then compounded in the next by growth itself and the inflated costs prevailing in the second year.

The worst case is one where no action is taken and inflation and growth compound year on year over the planning period.

This would produce a significant gap in funding, estimated at £140m in 18/19 as illustrated below.

(As a system, social care pressure also needs to be factored for).
The case for change: 2 Financial sustainability

The challenge to balance CCG funding

The impact of unchecked cost inflation and activity growth will add an estimated £140m of spending requirement, meaning that in 18/19 the CCG would require a budget of approximately £595m.

Assuming growth in allocations and full achievement of 4% efficiency will still leave a remaining estimated gap of £36m to balance the CCGs finances.

Plan for balancing CCG finances to 2018/19 (£m)
The case for change: 2 Financial sustainability

Implications

The high level financial forecast indicates that the system needs to deal with the pressures using a very different clinical and commercial model. Delivering efficiency alone will not be sufficient to meet rising costs and growth which are roughly equivalent to 30% of the original baseline 14/15 budget.

There is a recognition that the solution will involve greater collaboration and integration across health and social care to manage demand in a different way. This will be facilitated and incentivised by the use of the Better Care Fund (implications described later in the Plan section).

In summary, to be affordable and sustainable the system as a whole requires a cohesive and single plan which will seek to service demand using less clinical intensive resources and outside of traditional acute settings. We will harness and build greater capacity within primary care and community partners to avoid and redirect care appropriately, with increasing emphasis on people being enabled to take greater responsibility for their care needs.

Further explanation is provided within the Plan section later in this document.
Our Vision for 18/19

Building care around the needs of patients

Context

The Wirral Health & Social Care Economy requires significant transformation over the next 5 years in order to meet the challenges faced.

The vision for transformed delivery is for care to be built around the needs of the patient population, providing support for patients to look after their own health and wellbeing, whilst improving access to appropriate services as required.

This will comprise a system of wider integrated primary and community based services, supported by a smaller but more specialised acute care setting. Services delivered within the community will include specialised care that was previously provided within a hospital setting.

Wirral CCG is committed to incorporating the concept of “Hospitals without Walls” in developing an integrated care model. The hospital setting will be supported to develop a higher level of speciality and technology to support more complex
conditions with the opportunity to develop into a specialist hub across the region for particular specialities as appropriate.

The economy’s vision will ensure that commissioning of health and social care will be provided on an integrated basis ensuring the best alignment of physical and mental health care services.

In this section we will describe an overview of our vision for the future, beginning with the patient and working back to the characteristics we feel are important to make this a reality.

The Wirral Vision in 2018/19 will be based on the creation of a sustainable and high quality health and social care economy built around the following key characteristics:

- Wider primary care, provided at scale
- Integration of care
- Access to the highest quality urgent and emergency care
- A step change in the productivity of elective care
Our vision through our patients’ eyes

Through a patient’s eyes in 2018...

As a Wirral resident, I will be able to understand how and when to access healthcare, or find this information easily. I will be able to ring 111 if I am not sure of the best service to meet my needs, and will be able to find a directory online which will explain what local services are available to me, and how I access these.

If I am suffering from a minor illness, such as a cough, cold or headache, it is very unlikely that I will need to visit my GP Practice. I will be able to find information on the internet that is reliable and easy to understand, and will explain how I can take care of myself, or I will be able to visit a local pharmacy any day of the week to talk to someone about the best way to treat my illness and look after myself so that I can get better as quickly as possible.

If my pharmacy cannot help, or I have a minor injury or illness that I cannot treat myself, then I will be able to visit a Walk-in Centre and see a senior nurse without needing an appointment - it is not likely that I will have to wait any more than 20 minutes. The nurse will more than likely be able to treat me on the spot without needing to send me to any other services, and will be able to prescribe medication if this is what I need.

The nurse treating me at the Walk-in Centre will be able to see a summary of my GP record, and so will know instantly if I am allergic to anything, or if there is anything they may need to take into account.

They will also be able to see if I need to have any basic tests done that may be useful to my GP in managing any long-term health needs that I may have, for instance, if I am eligible for a flu vaccination, or if my blood pressure needs to be monitored. My GP will receive the results in a couple of days, and it will save me making an appointment.
I understand that the Emergency Department is for emergencies only, and is not the best place for treating minor injuries and illnesses. I will understand that if we all treat it in that way, it will be there quickly for me and my family and friends if we ever do need access to urgent or emergency healthcare.

My GP Practice will continue to be the first place that I contact if I am suffering from a long term health condition, or if there is something that is affecting my health that cannot be treated by a Walk-in Centre or Pharmacy. It will be easy for me to book an appointment, and I will be able to do this either on the internet, on the telephone, or by visiting the surgery. The receptionist that I speak to will be friendly and we will work together to get access to the help that I need within one contact – I won’t be asked to call back. However, I may receive a call from a nurse the same day so that it can be decided what kind of appointment would be best for me, and if there is another service that would be better for me to use.

The nurse may actually be able to help me over the telephone, without needing to come to the surgery at all.

The staff at my GP Practice will be skilled to advise on and treat a wider range of healthcare problems than ever before. It is likely that my GP Practice will be working with those locally to make sure that these skills are shared, and that even if my own practice cannot offer a particular service, I will be able to access it locally.

So, if I am suffering from a minor skin complaint, my GP may either have had special training to deal with this him or herself, or will ask me to attend a local surgery where there are staff that have this expertise. This will mean that hospital services are able to see those with the most complex and serious of problems, and will mean that I can have an appointment quickly, and in my community.

If I do need to see a specialist, I will be offered choice, and will be given information about
anything unexpected from happening to my health. My care will be proactive rather than kicking in once I have suffered a crisis or a setback.

My care will be personalised to me, taking into account as far as possible any particular needs that I may have. I will have a personalised care plan that is available to all the people looking after me: I will be treated as a whole person, rather than just for the condition that I have.

If I am over 75 and have a long term health condition, I will know the name of a senior clinician – either a doctor or senior nurse – who will take the responsibility for organising my care.

Whatever my age, I won’t be left on my own to navigate my journey, or the journey of a loved one, through the health and social care system. I will know who to contact to find out at any stage what is happening with my treatment or care; this will be made as easy as possible for me, as I will be able to contact the surgery by

waiting times and location so that this will be an informed choice.

There may be new services at my GP Practice that I do not recognise, such as physiotherapy, and counselling. For many services, I will be able to choose between a range of providers, so I can choose the one that best meets my needs. If this is not at my own GP Practice, it will be within my own community.

If I have a long term health condition, I will be given lots of information so that I understand what my body is going through, the effect this will have on my health, and what I can do to make this condition more manageable. Those caring for me will work together and will share essential information about me, so that I do not have to have the same tests done twice, and that I do not have to wait too long for the right care. I may be offered access to technology to use in my own home to help me to monitor and take control of my health. Any readings will be shared with those looking after me, so that they can work together to identify and prevent
I will understand how to provide feedback on any care or treatment that I have received, and will be able to talk through any concerns with my GP Practice in the first instance.

I will be confident that my friends and family will all receive the same standard of care and treatment as I do, and that particular effort will be made to ensure that those that are vulnerable or from a minority group can access healthcare in an equal way.

e-mail, and receive information relating to my care via SMS.

My mental health will be considered alongside my physical health at all times; for instance, if I have a long term health condition such as diabetes, those involved in my care will consider how this is affecting my mental health, and I will be offered support if it is needed.

I will know how to get involved in the planning of healthcare services locally and will be given the opportunity to be part of a patient group – both for my general practice, and for those that are responsible community and hospital healthcare services. I will be given the choice to attend meetings to share my views, or, if I provide my e-mail address, will be sent regular information about health and social care locally, and be given the opportunity to share my views.

I will be treated with dignity, respect, care and compassion at all times. The buildings that I visit to see a healthcare professional will be fit for purpose, clean, safe, and accessible.
Wider primary care, provided at scale

Our vision is one of primary care communities, where the majority of healthcare – whether that is routine or unplanned care, is delivered outside of hospital and specialist settings, close to people’s homes. Communities will be built around GP Practices and will see healthcare and social care professionals working together to prevent ill health, provide fast and responsive access to advice and treatment for medical conditions, and supporting those with long term conditions and complex needs to manage their condition and have greater independence.

Primary Care teams will play a key role in navigating and co-ordinating the journey of patients through the system, working alongside community staff such as nurses and therapists, and specialists such as consultants, along with mental health practitioners and social workers, and other organisations such as pharmacies, opticians, and the voluntary sector, to provide care and support that is tailored to the individual, and not to the organisations that provide it. By working together we will keep people healthy and happy in their own homes and communities for as long as possible, so that going to hospital or being admitted to a care home is something that is the exception and not the norm.

If we are to deliver the transformational change of ‘wider primary care, delivered at scale’, with GP Practices placed at the heart of this primary care system, then we will need to facilitate an environment where there is much greater co-operation between services, with general practices working together and alongside a range of other health, social care and voluntary sector organisations to jointly own and deliver these outcomes.
Integration of care

A modern model of integrated care will be achieved by systematically integrating both services and pathways, horizontally and vertically across organisational boundaries, providing tailored care for patients.

For horizontal integration this will mean a single team approach to care across health and social services so that duplication is reduced and care is coordinated in a more effective fashion.

For vertical integration this will mean primary, community and hospital services working together to ensure patient journeys are seamless across organisational boundaries.

Access to the highest quality of urgent and emergency care

By integrating care vertically this will ensure that the full spectrum of primary and secondary care services are mapped so that patients access appropriate unplanned care at the right time in the right environment.

For example by creating a variety of primary care and community centres to deal with lower end conditions this should ensure adequate capacity for major conditions that are required to be seen in a hospital setting.

For such services to work effectively all members of the health community need to ensure that users of the services are aware of the services that are available and the need to promote self-care.
Step change in the productivity of elective care

To ensure people are seen by the right person at the right time, by the right clinician in the most appropriate setting with appropriate referral. This will be supported using robust referral pathways which include triage/advice and minimises need for face to face consultation. It will also include access to specialist services only when appropriate and within the community where possible.

There will be a drive to reduce duplication and maximise efficiency by developing referral protocols and guidelines. We will seek to move all appropriate activity from a hospital setting into community hubs across Wirral.

Pathways will support education and up skilling and support the delivery of procedures and treatment interventions previously carried out by specialists in a secondary care setting.

Specialised services concentrated in centres of excellence

The CCG will work closely with commissioners of specialised services and neighbouring CCGs where there maybe potential for commissioning at scale; this might be in areas where there is low volume of activity in tandem with high cost per procedure and high degree of clinical specialism.

This will need to be in line with NICE Improving Outcomes guidance, sensitive to local need and citizen engagement.
Empowering patients and citizens

The CCG upholds the NHS 2012 white paper “No decision about me without me”. The CCG has recently produced a refreshed Experience, Engagement and Communication strategy which includes 7 objectives of how the CCG intends to engage with its local population. This includes a combination of specific engagement events with clinicians and residents as well as routine engagement via established patient groups.

In addition the CCG is developing its presence on social media to enable members of the public to interact and comment more rapidly on CCG business.

The CCG will be engaging with the public and local workforce throughout the development of Vision 2018 to ensure that the strategy is built upon the needs of our population.

A significant number of people with long term conditions want to remain as independent as possible and live as healthily as they can.

Their feedback suggested that they need more information, online and face-to-face. “PUFELL” is a free, Internet-based portal which allows people to create a Personal Health Account and to track goals and engage with services where appropriate. This links with Wirral Well.org to direct people to existing services as they seek to self-support.

For those people not online VCAW offer a face to face and printable option. At every opportunity people are empowered to self-care and make responsible decisions regarding their lifestyle choices.
**The plan**

**Where we will focus our effort**

**Introduction**

This section provides an overview of the key strategic challenges that we will seek to tackle. It describes the major components of the plan over the next 5 years.

1. An overall timing plan is provided as illustration.

2. The key outcomes we are planning to improve is described including
   - The 7 outcome ambitions; reducing health inequalities; parity of esteem
   - Improving health through prevention and self management

3. An overview of how the strategy seeks to tackle financial sustainability
High level programme plan

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve the programme in its totality.

Further detail on individual programmes is provided later in the Key Programmes of Change section.
Quality and Outcomes: 7 outcome ambitions

The 7 ambitions for improving outcomes

The National Outcomes Framework describes the five main categories of better outcomes to be delivered. These outcomes have been translated into seven specific, measurable ambitions, or critical indicators of success, against which the CCG will be measured over the 5 year planned period and year one and two as measures as progress:

1. Securing additional years of life for people with treatable mental and physical health conditions

   **PYLL (per 100,000 population)**

   From 2237 (14/15) to 1931 (18/19)

   This is a priority for the CCG, to drive improvement and reduce from baseline the potential for years of life lost from causes that can be supported by healthcare for all adults, children and young people.

   A clear focus will be on self-care and empowering people to take more control.

2. Improving health related quality of life for people with Long Term Conditions, including Mental Health

   **Average EQ-5D score for people reporting to have one or more LTC**

   From 70.58 (14/15) to 74.90 (18/19)

   This is a priority for the CCG, to improve health related quality of life for people with long term conditions and deliver
personalised and responsive care for all. This will be achieved by understanding patient participation in healthcare and responding to the needs of the individuals and the Wirral community.

Working with all stakeholders to create health and social care services that are both integrated and aligned to the community hubs, with a focus on individual need and care delivered at home or closer to home.

The care coordination model and single gateway for health and social care referrals will support a greater number of people managed within the community setting and reduce the need for non-elective admissions and care home placements where appropriate.

3. Reducing the amount of time people spend in hospital by having more integrated care in the community

E.A.4 Emergency admissions composite indicator

From 2588.7 (14/15) to 2316.2 (18/19)

This is again a priority for the CCG to ensure patients can share in the decision-making process about themselves and their care and support.

The interactions between community, residential and hospital services will be improved, with care delivered through integrated services 7 days a week that are joined up around the needs of patients.

This integrated care will be provided across the community, bringing specialised care and treatment (when appropriate) into community settings near patients’ homes, to enable the right care to be provided at the right time and the right place, with
Quality and Outcomes: 7 outcome ambitions

patients supported to self-care as appropriate. Health and social care professionals will work together, involving people in planning their own care and looking after their own wellbeing. People will have one key contact, who co-ordinates their GP, hospital, community and social care. More services will be available in the community ensuring shorter patient stays. The model of care will be co-developed with public and staff, to ensure it meets the needs of the Wirral population, with the right capacity and balance across the community, residential and hospital.

4. Increasing proportion of older people living at home independently following discharge from hospital

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

From 87.0 (14/15) to 87.0 (18/19)

Wirral’s current performance against this indicator is well above the average (80% in the North West) and this may be because services to support older people to live independently (for example reablement, intermediate care) have previously been fragmented across health and social care, therefore what could be monitored was limited in terms of which services were included in the analysis.

In addition because we are intending to move more care at discharge into step down care we expect that more complex patients will be included in the analysis which will also contribute to a slight reduction. However a performance of 87% is still well above the average for the North West of England and maintaining performance at this level would be a significant achievement
5. Increasing the number of people with physical and Mental Health conditions who have a positive experience of hospital care

E.A.5 The proportion of people reporting poor patient experience of inpatient care
From 122.5 (14/15) to 112.5 (18/19)

Data demonstrates that scores have improved by 22% since the first report in April 2013. This broadly reflects good general levels of satisfaction by patients using acute inpatient experience care and A&E services as measured by the Friends and Family Test. However national measures to evidence patient/service user experience are currently under development for this area, with details due to be announced when available by NHS England.

We will use our quality systems to respond to complaints, and to react systemically to common themes / apply lessons learned.

6. Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community

The proportion of people reporting poor experience of General Practice and Out-of-Hours Services
From 4.0 (14/15) to 3.2 (18/19)

The CCG is performing well against this particular outcome measure and trajectories for the next 5 years reflect that holding the line will be a significant achievement given the significant challenges ahead.

The CCG will strive to achieve improvements based on the following improvements -

Relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes.

The opportunity for the patient to see the
same clinician should be available, if the patient chooses to do so. Younger fitter patients generally have less need of relationship continuity whereas older and more vulnerable patients need it more and they should be helped to achieve it.

- CCG will explore options for capturing routine data on patients’ pattern of contact with professionals
- CCG will develop a practice toolkit that supports practices in methods of assessing and promoting relationship continuity
- CCG will consider incentives for practices to embed robust processes for maintaining relationship continuity

7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

By looking at contributory factors such as rates of Clostridium Difficile (C-Diff) and MRSA: C-Diff still affects patients, plus new HCAI, e.g. norovirus and CPE (which are infections facing us in future years). Improvement plans are in place and our strategic commissioning will focus on eliminating this risk for our patients.

We will also focus attention upon medication errors into avoidable deaths and the need to record near misses and serious incidents

Through this, we will also seek assurance around the dissemination of learning and implementation of quality improvement plans.
Quality and outcomes: Health improvement and self care

Context

We have deliberately focused the attention of this vital work-stream on meeting chronic needs in different ways, but also recognise the value of the approach in responding proactively to episodic needs.

Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years (Department of Health 2011c).

People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days.

Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budgets in England (Department of Health 2011).

Around 70-80 per cent of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).

At the heart of chronic disease/needs management is an informed patient who is empowered with access information and supported by local networks of treatment and care.

Approach

Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011).

We will work across the economy with Public Health and social care to align efforts across the spectrum from health treatment to wellness and prevention of ill health via the Prevention and Self Care Work stream of the Vision 2018 Programme. The scope of the CCGs efforts will focus largely upon enabling patients to
Health care enabling elements -

- Targeted risk stratification for over 60’s
- Use of technology including telehealth / telecare; assistive equipment
- Providing patients with access to their own records
- Patient and carer education programmes to advise on the best way to navigate towards support required
- Medicines advice and support in partnership with local pharmacy
- Progress work to develop community team resilience and capacity across health and social care
- Improved access to advice and support about lifestyle issues including diet and exercise; smoking and alcohol
- Low level psychological interventions such as counselling and coaching
- Access to advice and networks of support- eg pain management diabetes, info from charities etc
Quality and outcomes: Health improvement and self care

Existing schemes to build upon

Wirral already have many schemes in various stages of development and maturity. We will review these in the round and focus investment into the priorities which will yield the greatest potential improvement in outcomes.

Jointly commissioned current schemes include:

‘PUFFELL’
- Focused upon enabling people to find ways to improve their health, wellbeing and happiness by identifying goals and tracking progress

‘Breeze’ pilot
- Focused upon group based advice networks to provide information on diet, first aid, mental health awareness

Streaming and triage enhancements
- Focused upon helping staff consistently guide patients to the most appropriate setting of care for their needs

Promotion of advocacy and self advocacy;
- Focussed on equipping people with the resources to cope, and the resilience to deal with the future, and a better understanding of their well being, through services such as Bounce Back

Expanding the scope of GP kiosks/ into A&E
- Focused upon providing intelligent health information tailored to the individual

Wirral Well’
- focussed on working with partners to develop an online one stop shop information hub for wellbeing, health and social care services.

‘Closer working with local voluntary/ support networks
- Focussed on engaging with local communities in supporting their own local residents to manage their own care through working with community groups such as Heswall Together, Lairdside Communities Together, North Birkenhead Development Trust

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- Focused upon providing intelligent health information tailored to the individual
Promotion of peer support;

- Focussed on empowering people to manage their conditions with the support of people who have similar experiences and are managing their own care, through services such as the Breeze patient peer mentoring programme

Promotion of volunteering;

- Focussed on befriending and helping people with everyday tasks when they are struggling to cope through services such as POPIN, Home from Hospital, and Age UK

Choose Well;

- Focused upon providing the help and advice needed to inform people’s choices

Provision of assistive technologies and equipment.

- Focused upon widening the use of assistive technologies and equipment to assist with self care that enables people to maintain their independence for as long as possible.

Health Trainers

- Focused upon providing one to one support, advice and guidance to people who want to improve their own health and wellbeing

‘Pharmacy First’

- Focused upon directing people to local pharmacies for appropriate health and treatment advice
Quality and outcomes: Health improvement and self care

Goals

The goals of this work-stream are focused upon enabling people within Wirral to live longer, healthier lives by being encouraged and enabled to take responsibility and make different choices in managing their own care needs.

Some of the key quality benefits we are seeking from investing in health improvement and self care include:

- Reducing health inequalities, eg those related to gender
- Improvement in patient experience through improved knowledge and responsibility
- Improve the quality of life of people living with health issues
- Improve the life years lost from disability

Target aspirations

In addition to quality improvements we plan to focus efforts on achieving contributions towards improved operational performance.

The precise targets will be developed by the Prevention and Self Care programme, with the following as a basis for scoping further:

1. Contribution to reducing inappropriate attendances and clinically inappropriate admissions to A&E

   (Evidence nationally suggests that up to 30% of attendances and 25% of admissions to A&E could be dealt with in a lower clinical setting)

2. Reducing inappropriate GP appointments which could be managed in a different setting (e.g. pharmacy)

   (A recent survey of GPs in Wirral indicated that a third of respondents felt that 30% of appointments could have been managed better in a more appropriate setting)
The programmes of change and improvement described in the following section will be developed further and refined to align with the 2018 programme structure outlined in the Commitment and Ownership section towards the end of this document.

The underlying logic underpinning our strategy is that of first managing and/or avoiding demand; appropriate demand needs to be then co-ordinated to the right clinical and cost setting; and those settings need to be as efficient as possible.

Approach to balancing system finances

The overall financial challenge was set out in the financial section of the case for change earlier in the document. The conclusions were that the CCG could face a gap up to £140m in 18/19 in its funding to keep up with cost and activity growth.

The CCG will work to align its own planning with that of the wider system Vision 2018 programme to ensure that efforts are consolidated into a single plan.

Plan for financial sustainability

Examples of What other systems are basing their strategies upon

Managing Demand

- Prevention
- Integrated Care
- Referral Management

Right care – right setting

- Right setting
- LoS

Efficiency

- Improved pathway
- Workforce flexibility

Avoid c 10% episodic demand

Prevent x% LTC demand via self care

Transfer 20-40% of planned care to community

15% of episodic demand differently

Improve pathway efficiency by 15-20%
Impact of Better Care Fund

In 2015-16 financial year, circa £25m will be transferred from existing CCG allocations into a pooled budget arrangement for the Wirral Health & Social Care Economy enabled through the Better Care Fund.

The £25m will consist of a number of current CCG / NHS England budgets with the balancing fund to be made up of savings across existing health expenditure (in the form of a reduction of emergency activity / admissions into secondary care).

Current assessment of existing budgets to transfer into the pool is as follows:

- Reablement: £2.116m
- Carers: £0.7m
- Joint Working: £8.252m

(currently £6.4m and held by NHS England)

Total: £11.068m

The current assessment of resulting required reduction in CCG expenditure is circa £13.9m.

We are working with public health colleagues to retain a focus on early intervention and prevention and to ensure that a range of requirements are delivered through existing investments, for example supporting self-care, alcohol services and falls prevention.

We will continue work with health and social care partners as well greater involvement of the community and voluntary sectors to realise opportunities to impact on demand management, reduce duplication and improve outcomes for people needing care.

This plan has been supported by the evidence base from the JSNA and will link in with both CCG and Council commissioning plans for 2014/15 and 2015/16.
**Introduction**

NHS England has identified that any high quality, sustainable health and care system in England will be built upon six key characteristics which locally will be directly influenced by the CCG’s commissioning strategy over the next 5 years.

Wirral’s 5 Year Strategic Plan will be built upon the following approach and will include improvement in the following outcome indicators –

These work-streams are supported by the additional two characteristics of a high quality, care, and the CCG’s operational plan will be built around ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
Key programme: Modern integrated care

Introduction

Our overall strategy is centred on the development of Integrated Care to better meet the ongoing care needs of the people of Wirral. This section describes our plan for a person centred health and care system which will enable people to self care, to keep themselves well for longer and to reduce the level of unplanned care they receive.

This is different both in the nature of the care people receive and how the system is organised to deliver it. A whole systems approach means health and social care provider organisations forming new integrated care teams around the person - with co-ordinated team work to deliver care. This care will be directed by the people receiving it, where they define the outcomes they want and are empowered to achieve them. General practice will be at the centre of co-ordinating these teams which will make innovative preventative interventions, often social care based, to prevent unnecessary deterioration of people’s health and admission to hospital. Local authorities, CCGs and NHS England will pool budgets such that providers have collective responsibility for outcomes and for the budgets to deliver them. This collective responsibility will incentivise the integrated working of staff for the benefit of people, so they receive a seamless and efficient service. This new way of working will require major changes in cultures, behaviours and system structures to achieve change.

Goals

Over the next 5 years we are aiming to deliver a transformed service, focusing upon moving care from hospital to community based resources and supporting people in their own homes. Key goals include:

- Reducing the need for unplanned admissions to hospital for the over 75s
- Reducing the time spent in hospital to complete their care needs
- Reducing the need for long and short term residential care placements
Key programme: Modern integrated care

Approach

We have developed a number of scenarios using different peoples needs to describe how we see integrated care working in practice – eg

**Wirral Caring together for Mrs Smith**

**Who is Mrs Smith**

Mrs Smith is 80 years old. She lives on the Wirral, her family live down south. She is getting frailler and she has Diabetes and COPD; she is a lifelong smoker. Her neighbours help when they can, but she is fearful she will lose her independence.

**Her Current Journey**

- She falls and is taken to A&E.
- She is then admitted to A&U.
- She is transferred to DME ward; although medically fit OT assessment indicates package of care.
- Package not available for 1 and a half weeks.
- A rapid access bed is arranged.
- Mrs Smith’s condition exacerbates – she is now on insulin, her COPD requires further treatment.
- She is at risk of falling again.
- Mrs Smith moves to short term residential care. Her family like the care home.
- Mrs Smith stays at the care home.

**Future Journey**

- Integrated teams available in the community
- Core team of health and social care professionals
- Single Assessment
- Key worker
- Responsive service
- Hospital admission avoided

**Self Care**

- Social networking
- Lifestyle choices
- Goal setting
- Online/community offline
- Connects to support services

**Risk Stratification**

- Identify those at risk of hospital or care home admission
- Identify complexity of need
- Care plan in place
- Stream to Integrated teams where needed

On Wirral, we will work to make this vision a reality by bringing together all of the public agencies that provide health and social care support, especially for older people, to better co-ordinate services such as health, social care and housing, to maximise individuals’ access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting - we will deliver this through developing integrated care coordination teams’.
Key programme: Modern integrated care

Delivery

Through movement of care to the community and supporting self-care, signposting and early intervention we will reduce demand on downstream services such as acute care and long term social care. We will also use risk stratification to target integrated support for patients who are potential high users of health and social care services.

We believe this transformation will require a different way of working across our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities. This will be through providing:

- Seamless and timely response from integrated teams and other appropriate services
- Single gateway and streamlined pathways which are easier for people to navigate
- Encouraging self-care and self help

- Health and social care having joint responsibility for the patient pathway by pooling budgets to reduce duplication
- Implementation of shared electronic record to improve communication
- Coordinated care plans with patient led goal setting

We will continue to develop and improve the following schemes as examples:

- Self-care, self-help, information advice and support
- Early intervention and prevention (falls community equipment, early assessment)
- Integrated discharge team redesign and development of Integrated Care Coordination teams (ICCTs)
- Risk stratification and a more central role for primary care services
- Whole system model of care for adults with Learning Disabilities
- Mental health outreach and an integrated approach to dementia care e.g. improving access to psychological therapies
Key programme: Modern integrated care

Integration and Children’s services

In line with the Department of Health’s document on reducing hospitalisation for children and contributing to the future outcomes of integrated children’s services, NHS at Home, 2011, it is the intention of Wirral CCG to commission children’s services differently by developing a Community Nursing Service for the population of Wirral.

There are currently very few local Community Children’s Nursing (CCN) services able to meet the needs of all ill and disabled children and young people, the following are the group that have been identified as needing services:

- Children with acute and short-term conditions
- Children with long term conditions
- Children with disabilities and complex conditions, including those requiring continuing care and neonates
- Children/young adults transitioning into adult care

Integration and Mental Health services

We will do all that we can to meet the Government’s mandate to put mental health on a par with physical health, and to close the gap in life expectancy between those with mental health problem and the wider population.

We will seek to address this through:

- Promotion of equal access to physical healthcare including prevention services
- Ensuring rapid response to crisis services
- Supporting partnering providers to take a multi disciplinary approach to mental illness at in patient/out patient
- Improving case management of people who’s mental health is affecting physical health and vice versa by sharing case workers
Key programme: Modern integrated care

High level plan for Integrated Care

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.
Key programme: Modern integrated care

Measurement

We will measure the agreed outcomes (both BCF and locally agreed) through a jointly developed performance reporting system which feeds into a monthly strategic joint commissioning group. This will cover the key overarching aim of reducing unplanned care admissions by 15% and elective care admissions by 20%, key BCF measures and other locally agreed measures. The key BCF measures are:

- **Avoidable emergency admissions** (composite measure)
- **Percentage of care packages commenced within 24 hours of initial contact with agency**

- **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population**
- **Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**
- **Delayed transfers of care from hospital per 100,000 population (average per month)**
Key programme: Wider Primary Care

Introduction

The future model for Primary Care will be increasingly patient-centred, with GPs at the centre of organising and co-ordinating people’s care.

Primary Care has a unique role in enabling Wirral’s vision of future care delivery, through providing capacity to meet the demand for out of hospital care; and helping to drive integration by navigating and educating patients towards different sources of care – including increasing self management.

Goals

Over the next 5 years we are aiming to deliver a transformed Primary Care which is different in terms of: its role within managing urgent care demand; working in multi disciplinary teams; offering greater access; guiding patients to different choices. Key goals include:

- Reducing the demand on emergency admissions by 15%, and patients accessing A&E
- Reducing admissions to care homes by 10%
- Improve clinical outcomes for people who have one or more long term condition
- Improve recovery rates for Primary Care mental health.
- Increasing the uptake of NHS Health Checks and other prevention measures

Approach

We will achieve our vision through the implementation of a wide variety of initiatives intended to grow the contribution of Primary Care within the overall system.

These include but are not limited to:

- Developing wider primary healthcare teams, working cohesively across groups of practices to deliver services such as community nursing, smoking cessation and flu vaccination clinics;
- Developing the roles of other primary care sources of capacity including pharmacists, opticians and dentists.
Key programme: Wider Primary Care

- Implementing integrated teams of physical health, mental health, and social care to work together to manage those people at most risk of a hospital admission.

- Ensuring that patients, particularly frail older people and those with long term conditions receive continuity of care from an appropriate team of health and social care professionals, with care delivered in an integrated and co-ordinated way, and with everybody aged over 75 having their care co-ordinated by an accountable clinician.

- Managing demand for services, ensuring that referrals to specialists are only made where appropriate, to make the best use of our resources.

- Using technology to enable our clinicians to work more closely together, undertaking diagnostic tests more quickly and easily, and in supporting patients to look after their own health.

- Facilitating the opportunity for GP practices to work together to share skills and expertise and to realise efficiencies in the delivery of core general practice care.

- Working with NHS England to ensure that the GP Practice estate is fit for purpose to deliver this vision and is future-proofed for the next generation of patient care.
High level plan for wider primary care at scale

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.
Key programme: High quality urgent care

Introduction

Over the next 5 years there will be a large scale movement of care from the hospital setting to the community setting. Currently the ambulance service, A&E and acute care are the default settings for urgent care. It has been identified that there is growth in the number of patients being conveyed to hospital by 999 ambulance and in inappropriate 0 day length of stay admissions. These are the areas that we will target for movement of care activity to more appropriate settings – regarding inappropriate A&E use as failure of the overall system.

Goals

Over the next 5 years we are aiming to deliver a transformed urgent care response which is joined up and manages demand for treatment in a more manageable and sustainable way. Key goals include:

• Reducing the demand on emergency admissions by 15%
• Reducing unnecessary ambulance conveyance
• Significant reduction in patients being re-admitted to hospital within 30 days
• Improved management of frequent attenders of A&E and people who are frequently admitted to hospital

Approach

We will achieve significant improvements for patients in urgent care by connecting urgent and emergency care services into a cohesive network so the overall system is more than just the sum of its parts.

A new model of care will be developed that centres around primary care (in the broadest sense) ensuring that patients in need of medical assessment can receive that assessment in their own home or in a community setting (for example in a community based hub).

These medical assessment services will need to include a range of medical interventions
(such as IV fluids and antibiotics), diagnostic tests and access to specialist opinion (without the need for hospital admission or attendance) for example from a community geriatrician or an acute physician in the community hub.

We will continue to commission services that will support people with an acute exacerbation of their mental illness to receive fast and responsive care in the community, to ensure that inpatient beds are only ever used appropriately: this will include the use of home treatment teams for adults and older people. Where it is not possible to care for people safely within their own homes, we will continue to commission a small number of mental health crisis beds, but will seek to reduce the number of beds used year-on-year.

The history of systemic abuse at Winterbourne View has told us that too many people with a learning disability are placed in inpatient beds and out of area, and that more must be done within the community to prevent crisis and use of acute care facilities. As such, we will be working with our Local Authority partners to meet the requirements of the Winterbourne View Concordat, further reducing our use of learning disability and inpatient crisis beds, but ensuring that when somebody does require admission, that a multi-disciplinary team works with the patient and their carer immediately upon admission to plan for a safe discharge into the community, with steps put into place to prevent future crisis.

Emergency patients will be treated in the most appropriate centre with the expertise and facilities in order to maximise their chances of survival and a good recovery - only patients with acute healthcare needs are admitted to an acute hospital.

There will be a true Single Point of Access for health professionals, providing 24/7 access to physical, social and mental health services.

Patients are able to easily navigate the urgent and emergency care system to get the right advice in the right place, first time. Care plans for known patients will be managed and kept up to date and available at all urgent
and emergency care access points so that a patient’s information is always available to those treating them.

**Implementation**

We will make a number of key changes to enable the shift in outcomes desired happen, these include:

- The development and implementation of ambulance pathfinder and community care plans to ensure that the patient is treated in the right place.

- The implementation of step up/step down system will ensure that patients have access to care that is appropriate to their needs.

- The development and bedding in of a range of admission prevention services and pathways which will promote self-care

- Redesign of urgent mental health assessment pathway to ensure that needs are assessed and met without unnecessary delays.

- Redesign discharge pathways to ensure that patients are discharged safely and reduce the need for readmissions.

- Redesign of children’s pathways in urgent care and the community to prevent unnecessary hospital attendances.
The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.

**Wirral CCG: creating the Unplanned Care Community**

**Needs and drivers for change**
- Increase in long term conditions
- Increase in over 65s
- High prevalence of mental illness and substance misuse
- Increase in emergency admissions
- Reduced capacity in primary care
- Not enough joint-working between services
- Not enough emphasis on patient education and self-care
- Poor performance against the A&E 4 hour target

**Priority plans for primary care**
- Single front door for urgent care on the APH site, including streaming patients back to primary care
- Ambulance pathfinder and community care plans
- Ensure successful transition and implementation of step up/step down system
- Implement a new model of urgent care hubs in the community, including medical assessment
- Develop a range of admission prevention services and pathways
- Implement NHS 111 and new GP out of hours service
- Redesign of urgent mental health assessment pathway
- Redesign discharge pathways
- Redesign of children’s pathways in urgent care and the community

**System reconfiguration**
- Acute care
  - Emergency, critical and specialist care that can only be delivered in an acute setting
- Integrated community and primary care
  - GP practices working together, supported by primary care teams, to give advice, diagnose, treat, and support patients to look after themselves.
  - Integrated care teams supporting the most complex, with rapid response to those at risk of hospital admission

**Enablers**
- Service specification, procurement, joint commissioning

**Outcomes for unplanned care**
- Reduced non elective admissions (long and short stay)
- Reduction in length of stay and therefore hospital beds
- Increased community capacity for urgent care services
- Reduced conveyance to hospital by ambulance
- Reduced emergency readmissions
- Ensure consistent high quality, safe and effective care

### 2014/15  2015/16  2016/17  2017/18

**Key programme: High quality urgent care**

**High level plan for high quality urgent care**
Key programme: Elective care productivity

Introduction

The way elective (planned) care is currently organised has potential to improve in terms of productivity and outcomes for patients. There is variation in referral rates for outpatient consultations, and not every contact adds value to the patients treatment and recovery.

Elective services are largely delivered within the boundaries of acute hospitals, delivered by a traditional secondary care staffing model. Procedures can have longer lengths of stay than necessary.

A ‘traditional’ outpatient model of multiple face-to-face visits for diagnostics and consultations with no access to GP records is currently a barrier to more joined up care.

Goals

This programme of work has a number of important and quantifiable goals which we are seeking to achieve in the next 5 years, these include:

- A 20% improvement in the productivity of elective care
- An improvement in Patient Reported Outcome Measures across a range of conditions
- A greater proportion of elective treatment to be provided in community settings

Approach

Clinical resources across community / secondary would be utilised across traditional organisational boundaries through the community hubs to support improvements in patient outcomes by supporting self-care, prioritisation of resources and

Secondary care providers would therefore be responsible for the delivery of appropriate
services including those patients who require procedures and investigations that can only be in a hospital setting.

A future model would be for the majority of appropriate outpatient activity to be delivered in the constituency community hubs across a number of specialties including respiratory, cardiology, dermatology, diabetes and endocrinology, Ear Nose and Throat (ENT), elderly medicine, haematology, therapies, gastroenterology, ophthalmology, rheumatology, orthopaedics, urology, vascular, general surgery etc.

Implementation

There are a number of key changes to the organisation and flow of elective care required. These include:

- Establishment of agreed referral protocols based on best practice to reduce unwarranted variation
- GPs supported to make the correct clinical judgement during consultations and use audit and feedback to reduce referrals that could have been managed in a different way
- An elective care system that is more ‘fluid’ encouraging consultants to discharge sooner, which would be supported by GPs as barriers to referring back are removed
- Safe, clean and modern facilities for elective care with services not confined to the traditional acute hospital setting i.e. outpatient appointments, diagnostics and minor elective procedures provided out of community ‘hubs’ by a flexible workforce and linked with integrated care teams.
- Enhanced recovery programmes linked into community teams resulting in reductions in overall LoS.
- Alternative types of outpatient clinic including technological solutions and one-stop shops with full access to GPs record.
Key programme: Elective care productivity

High level plan for step change in productivity of elective care

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.

Wirral CCG: creating the Planned Care Community

Needs and drivers for change

- Increase in long term conditions
- Increase in over 65s
- Right place right time right clinician
- Increase in planned elective care
- Develop community and primary care
- Not enough joint-working between services
- Not enough emphasis on patient education and self-care
- 18 week target

Priority plans for planned care

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System reconfiguration

Enablers

Outcomes for planned care

- Planned care
  - Appropriately delivered hospital services.
  - Grow community care

- Integrated community and primary care
  - GP practices working together, supported by primary care teams, to give advice, diagnose, treat, and support patients to look after themselves.
  - Integrated care teams supporting the most complex, with rapid response to those at risk of hospital admission

- Service specification, procurement, joint commissioning

- Reduced elective admissions (excess bed days)
- Reduction in length of stay and therefore hospital beds
- Increased community capacity for planned care services
- Increase number of people managed in integrated service
- Protocols and managed referrals
- Ensure consistent high quality, safe and effective care
Enabling programmes

Introduction

As part of the refresh of Vision 2018 it has been recognised that to enable the key programmes of change to be successful, there are a number of important projects required to underpin the plan as a whole.

These are previewed as part of the Vision programme shown in the section later dealing with governance. For further detail please refer to Vision programme documentation.

This section provides a brief overview of the key enablers identified in the CCG’s planning, signalling that these will be aligned with Vision programmes as part of the process to bring these together.

Information Management Technology (IM&T)

The current disconnected nature of health and care information management systems is a significant barrier to achieving a new model of delivery which has integrated care at its heart, in order to achieve the required scale and pace of change the existing IM&T infrastructure will need to be addressed.

The CCG IM&T strategy sets out how we will utilise information and technology to support the our vision to improve health and reduce disease by working with patients, public and partners, tackling health inequalities and enable people take care of themselves.

Education and training

The delivery of significant change across Wirral will require a fundamental rethink about the size and shape of the future workforce – it will require a system wide workforce model underpinned by agreed principles for how the workforce will be redeployed as part of initiatives that look to drive changes in settings of care.

We will also help staff to adapt to new roles and ways of working through a joined up programme of skills development to support them through the changes.
Enabling programmes

Estates

Delivering a model of patient centred integrated care provides a real opportunity to radically transform the way the estate has historically been used in the Wirral. Central to this will be the idea that from a patient perspective there they are accessing NHS care without organisational boundaries.

Our strategy aims to review the use of estate right across the system to take advantage of existing scale and opportunities to join up care around the needs of patients.

Contracting and funding

In order to initiate service transformation, the CCG are looking at alternative contracting models which will overcome existing barriers to change. The CCG are looking to explore different contracting models eg Prime Provider/commissioner and alliance contractor as a way of improving the patient pathway.
Commitment and ownership

Working together to make it happen

Introduction

It is appreciated that there is significant change ahead and that organising and managing this will be a complex task. Recent work to bring leadership from across the system to strengthen the system Vision programme has highlighted the collective commitment that exists to work together and overcome obstacles.

We are committed to using this opportunity to bring stakeholders including organisations, clinicians and patients together to help shape and redesign how care is organised, located and delivered. We have therefore invested considerable effort in using their insights to direct this strategy, and will continue to do so as we develop the detail of proposed programmes.

As a CCG we recognise the importance of leadership and creating the right environment across the system where ideas and innovation can flourish, whilst at the same time being disciplined about delivery and collectively staying on track.
Clinical engagement

In developing this strategy, NHS Wirral CCG has engaged with its Member Practices through its consortia structure and through wider stakeholder engagement undertaken as part of Wirral CCG’s statutory obligations as outlined in the 2012 Health and Social Care Act and NHS England guidance: ‘A Call To Action,’ Everyone Counts Planning 2014/14 to 2018/19’ and ‘Transforming Participation in Health and Care 2013’. The Consortia continue to engage with their Member Practices on the development and implementation of the Vision programme, particularly in relation to the transformation of primary care.

The CCG has established a number of teams that comprise clinical and managerial representation from the CCG and a range of local providers, to drive the commissioning agenda in specific clinical areas. Feedback from clinicians, patients and Member Practices, as well as national and local evidence, drives the work of these QIPP (Quality Innovation Productivity Prevention) teams, and key themes and ideas emerging from these groups have supported the development of the CCG strategy.

There has been a wide number of staff and clinical engagement events including presentations at key meetings such as LMCs, Health and Wellbeing Boards, Families and Wellbeing Board, Staff Forums, Clinical Members Forums, Public Service Boards and Lectures.

An executive summary of the Vision 2018 programme and a survey has been sent to all staff across partner organisations in health and social care on Wirral. Staff were also given opportunity to input ideas in breakout development sessions at a workshop attend by 100 and Q&A sessions at the workshop and a separate lecture attended by 100 clinical staff. The qualitative and quantitative feedback and ideas captured from all this engagement will be analysed and used in workshops and work-streams when developing plans.
Citizen engagement

In the development of its 5 year plan, NHS Wirral CCG has employed a number of methods of engagement in order to encourage participation of local citizens. These have included public events, where, for example, local citizens attended a ‘Vision’ event to hear about, discuss and inform the CCG’s long term plans and the development of the Better Care Fund.

As well as taking part in active discussions, citizens and stakeholders were encouraged to record their thoughts and comments on the day and there is also a questionnaire available on the CCG website so people can continue to express their thoughts and opinions which will, in turn, inform the planning process. The insights gathered from the engagement events are recorded and provided in a ‘you said we did’ format on the CCG website to provide transparency.

Each of the commissioning Consortia has an active Patient Council that brings together representatives from Practice Patient Participation Groups and the wider population, who have driven the development of services that now play a key part in future CCG strategy. Each of the Consortia has also developed virtual means of engaging with its population, for instance via websites and virtual e-mail groups. The Consortia engagement structure will continue to play a significant role in the implementation of the strategy and Vision 2018 programme.

Wirral CCG has invested in an experience led commissioning programme to support our patient engagement processes. The process ensures patients, carers and staff are consulted at the earliest opportunity to allow patient feedback, thoughts and perspectives to be central to all service redesign projects. We have recently completed a Stroke Prevention project with an open question of how do we improve people’s experience of stroke
Stakeholder involvement

Prevention in Wirral. There were no expectations as to what patients would tell us or what we would implement as a result of the project. This is an approach we are keen to continue to ensure patients are truly at the heart of the decision making.

In addition to this project, we use the principles of the process to run numerous focus group sessions for specific project areas (Cancer Survivorship, Anticoagulation, Vision 2018): this is an approach we plan to continue throughout coming years to ensure all our projects are patient centred. Our focus groups also include discussions around supporting patients to manage their conditions and self-care to ensure that we are including the support mechanisms within our service redesign to empower patients manage their own care as and when appropriate.

In addition to focus groups we also conduct numerous patient surveys and questionnaires and our projects are presented to our CCG patient groups for their feedback and input.

In Wirral we are committed to expanding our attendance for focus groups to all patients to ensure authentic citizen participation. When designing and implementing CCG communication and engagement activities, the diversity of the population served, the need for equality and the potential barriers to communication and involvement some people face will be taken into account.

We advertise events through numerous mechanisms; these include CCG patient groups, GP Practice Patient Participation Groups, VCAW (Voluntary & Community Action Wirral), Health watch Wirral, GP practice TV screens, Wirral Multicultural society and subject specific voluntary organisations. For example, we recruited some patients for our stroke prevention project via the Stroke Association and AF Association and similarly recruited patients for an Ophthalmology event via Macular Disease Society.

For topics where focus group attendance may be difficult we have made a conscious effort to
Stakeholder involvement

The CCG works collaboratively with the Cheshire and Merseyside Clinical Network as part of a partnership working approach to plan and use best evidence for quality care and outcomes for patients. The learning and teaching from the Network informs the local operational delivery plan.

Communication and engagement for integration is key to driving greater transparency by working collaboratively with key stakeholders including provider organisations, Health watch and Community Action Wirral to deliver the desired outcomes. This engagement has been a key principle for the integration work stream here on Wirral.

Friends and Family Test (FFT) data and complaints information are regularly discussed and monitored at the CCG’s Quality and Performance Committee. For FFT in particular, there is a regular Quality and Clinical Risk Meeting with the local acute provider where themes and issues are discussed and resolved. Any areas where there is a recurrent issue would inform both the contracting and planning processes.

Our aim is to consult with patients throughout a specific project ensuring patients are involved in the planning processes but also as projects progress it is important to keep patient views and priorities central to every project.

The CCG works collaboratively with the Cheshire and Merseyside Clinical Network as part of a partnership working approach to plan and use best evidence for quality care and outcomes for patients. The learning and teaching from the Network informs the local operational delivery plan.

Communication and engagement for integration is key to driving greater transparency by working collaboratively with key stakeholders including provider organisations, Health watch and Community Action Wirral to deliver the desired outcomes. This engagement has been a key principle for the integration work stream here on Wirral.

A number of workshops have been held with both staff and public and regular meetings of the ‘Engagement with people’ sub group and their contribution has been used to shape the design of the Integrated Care Co-ordination Teams and the broader Vision 2018 programme.

travel to the patients we need to speak to. For example, during a project on children’s A&E, because our target audience was parents with young children, we attended Children’s A&E, playgroups, nurseries, and women’s groups including domestic violence groups and breastfeeding groups.

Friends and Family Test (FFT) data and complaints information are regularly discussed and monitored at the CCG’s Quality and Performance Committee. For FFT in particular, there is a regular Quality and Clinical Risk Meeting with the local acute provider where themes and issues are discussed and resolved. Any areas where there is a recurrent issue would inform both the contracting and planning processes.
Stakeholder involvement

(ICCTs). This ensures that their valuable contribution has supported real decision making regarding the care coordinator model and the one number to contact that has been recommended by those engaging.

In addition the integration work stream encourages clinicians and professionals from the provider organisations to participate in design via the systems design group which combines service re-design and IT infrastructure to develop a shared record and care planning. This supports the overall aim to bring about transformation from a ‘bottom-up’, practical approach that reflects the views of all those involved in as transparent a way as possible to deliver our integration programme.

The CCG is using social media such as Facebook and Twitter to continue to encourage participation and an ongoing series of events is planned throughout the coming year around the broader strategic vision alongside Local Authority colleagues and local providers. This is alongside utilising communication and engagement channels such as Patient Councils, Patient Participation Groups to share messages and encourage feedback.

Finally, when undertaking service redesign initiatives, the CCG will continue to involve patients in the shaping of local services and ensure that, where appropriate, a formal consultation process is undertaken. This ensures that such developments are transparent in their development and embrace both citizen and clinical perspectives.

Staff engagement

The CCG also seeks to actively involve and inform its staff, alongside colleagues in partner organisations, in the ongoing development of the vision for Wirral.
Alignment of programmes with Vision 2018

Prior to submission of this strategy the CCG and its partners across health and social care have begun a process designed to strengthen planning and delivery of the Vision 2018 system plan by streamlining the structure of programmes and establishing tighter governance protocols. A key outcome from this approach is to harmonise the two strategies to arrive at a single plan for system sustainability.

Strategic leaders have agreed to focus improvement effort into three key thrusts –

- Planned (Elective)Care
- Unplanned (Non-Elective) Care
- Long Term Conditions and complex needs

These are underpinned by a range of enabling programmes as illustrated in the diagram to the right.

Development of Vision/ CCG strategy and programmes

Strategic leaders have agreed a process and timeline to develop the system plan and associated programmes for sign off in November. The pivotal outcome required is for the system to identify and agree the finance and activity trajectory for the next 5 years.
Governance

Governance arrangements have recently been refined as part of the refresh of the Vision programme.

A Strategic Leaders Group has been established to act as the forum for organisational leaders to define and agree the high level strategic direction required to achieve a sustainable system. This group reports to the Health and Wellbeing Board.

To organise and manage programme delivery an revised Implementation Group has been established which will be supported by a central Programme Office which will report on progress and help identify and manage interdependencies between initiatives.

Commitment and behaviours

Strategic leaders understand the need to create the right environment where they can meet the challenges ahead as a collective.

A set of principle and behaviours have been jointly agreed which leaders will observe, model and hold each other account to.
Contents

How the strategy was developed

Evaluation and research support

Ensuring quality and safety
How the strategy was developed

Approach

NHS planning has in the past been successful in supporting the delivery of annual incremental improvement. However due to the unprecedented challenges facing the NHS and Social Care, a longer term view of the planning of services to reflect the transformational change required is necessary.

NHS Wirral Clinical Commissioning Group’s strategy and plans have developed taking into account this level of challenge, together with a number of strands of work including:

Legacy Strategies

The NHS Wirral Clinical Commissioning Group
2013-2016 Strategic Plan

Currently available guidance and documents

- The NHS Constitution
NHS Wirral CCG’s commissioning approach is based upon the below methodology and in line with the 5 key steps

1. Analyse key health problems. The CCG evaluates and utilises local JSNA data and local intelligence combined with analysis and supported by benchmarking exercises

2. Understand and prioritise and set common goals. This is an integral part of the Strategic Plan focusing on the top health problems for Wirral and particularly those that cross cut across all provider pathways such as Long Term Conditions, elderly frail and this includes early detection particularly in primary care, through screening and enhanced services.

3. Identify high impact programmes. The CCG jointly commissions primary and secondary care initiatives with the Department of Adult Social Services, neighbouring CCGs as part of Better Care Fund initiatives and

Integration Programme

4. Plan resources. The CCG focuses on innovative use of resource and investment such as tele-health, tele-dermatology to support reduction in acute capacity

5. Measure and experiment. The CCG utilises expertise from John Moores University to evaluate and measure outcomes, such as the Integration Programme Evaluation

Outcome Based Commissioning

The CCG supports the shared purpose of all staff to deliver high quality compassionate care to achieve health and wellbeing outcomes for all. The focus is on 6 key action areas below. A key example is our Integration programme, which has a focus to deliver all action areas as we work collaboratively for better outcomes for all, to treat people as a whole person in a seamless way.

Action area one:
Helping people to stay independent, maximise well-being and improving health outcomes
How the strategy was developed

well-being and improving health outcomes

Action area two:
Working with people to provide a positive experience of care

Action area three:
Delivering high quality care and measuring the impact

Action area four:
Building and strengthening leadership

Action area five:
Ensuring we have the right staff, with the right skills, in the right place

Action area six:
Supporting positive staff experience

Experience Led Commissioning

ELC is an innovative new commissioning operating model that puts people and participative co-design at the centre of commissioning process. ELC is a commissioning approach that has been independently evaluated and is helping Wirral CCG to achieve patient centric service design. This approach has been used to develop a stroke prevention strategy for Wirral.

It is a new way to undertake evidence based commissioning that transforms the process into a series of facilitated 'conversations' between people who use services, commissioners, and the front line caregivers and professionals who deliver them. These conversations employ co-design principles and build on evidence drawn from experience research. They are facilitated by accredited ELC Practitioners and underpinned by robust experience research that benchmarks local people’s experiences.

The process delivers both clinical and community engagement and ensures that clinical commissioners have a rigorous evidence base on which to base their decisions. ELC management processes are also evidence-based, which makes ELC is a unique, deeply evidence-based, person-centred commissioning management approach.
Evaluation and research support

Liverpool John Moore’s University Evaluation

The evaluation of the Integration Programme includes a review of the literature, evaluation of staff and patient perceptions, pre- and post-integrated care, using relevant research questions. A mixed methods approach of case studies, surveys, interviews, focus groups is utilised to gain insights and deliver conclusions. This also includes quantitative and economic assessment and appraisal and will collectively be invaluable to show the step change integration is delivering across Wirral.

Research & Innovation

The CCG has a robust commissioning and service design team who ensure that any planned changes are supported by latest evidence and research. In some cases, specific research and evaluation is commissioned by the CCG from academic institutions, such as the work commissioned from Liverpool John Moores University on the Integration Programme.

This included a review of the literature, evaluation of staff and patient perceptions pre and post integrated care using relevant research questions. In addition, a mixed methods approach of case studies, surveys, interviews, focus groups was utilised to gain insights and deliver conclusions. The CCG also works closely with academia on specific initiatives and approaches. This has included Experience Led Commissioning approach described above.

In addition, the CCG supports a bursary scheme which can include research projects as part of academic study.

The CCG also utilises knowledge from the National Institute of Clinical Excellence (NICE), Clinical Networks and other sources to both utilise latest evidence and benchmark best practice.

Also, membership of organisations such as AQUA ensure access to innovative approaches to improving quality in service developments.
The CCG has a responsibility to ensure that services that they commission consistently provide safe high quality and effective care for all- now and for future generations. There have been a number of reports into events within the NHS that have made it clear that a fundamental cultural change is needed to ensure that patients’ needs are paramount in the delivery of care. These principles have been embedded into the CCG’s commissioning activities.

Francis Report

The report on events at Mid Staffordshire Foundation Trust identified a series of systemic failings into patient care. The CCG has responded to this report by:

- Incorporating the recommendations from the Francis report into Provider contracts.
- Establishing a robust reporting mechanism within the CCG.

Berwick Report

This has enhanced the Francis report by ensuring that the NHS hears the voice of patients and staff. The CCG is using this challenge to providers to enhance their data capture in regard to patient experience. With the data capture systems that are in place, themes and trends can be analysed to identify areas of concern.

Keogh report

This highlighted the importance of sharing intelligence on a larger scale between CCG’s and regulators. This has led to the establishment of Quality Surveillance Groups within Area Teams. Wirral CCG has played a full and active role in these meetings, and has identified areas of concerns that have been acted on by other CCGs and the AT.

Ensuring quality and safety

• Incentivising providers to perform optimally against these standards (through CQUINs scheme)
• Holding providers to account with regard to quality.
Ensuring quality and safety

Winterbourne View

In response to the Winterbourne View report (December 2012), Wirral CCG is working in partnership with the Local Authority to develop a local model of integrated care for patients with a Learning Disability and one that favours a Multi-Disciplinary Approach with a team around the patient. There will be less reliance on inpatient beds for this client group as per the national guidance and more on community support and early intervention, as well as discharge planning involving the patient and their families and carers. The model will also include a step up and step down approach for people in the right place at the right time.

We are committed to maintaining/improving the experiences that patients and families have when accessing a CCG commissioned service. To this end we are promoting the use of the family and friends test in all settings including primary care in order to gain the views of our population in relation to the quality of care that is delivered locally.

Through our established patient and public feedback mechanisms, the CCG is aware of patient concerns in relation to safety and infection rates. The CCG plans to reduce the amount of C-difficile infections by the required 20% over the next year and will continue to secure through commissioning, best practice in responsible effective prescribing and reviewed practice at hospital clinical ward level to identify any areas for further training.

The CCG will ensure the local hospital continues to undertake mandatory reporting of Methicillin Resistant Staphylococcus aureus (MRSA) and Escherichia coli (Ecoli) cases.

We will work with the local hospital and other CCG’s to continually explore innovative solutions that help towards further reducing MRSA cases, for example;

- The role of the Consultant antimicrobial pharmacist.
- A campaign to support effective management of patients requiring
antibiotic treatment. Consideration of a smart phone application to enable doctors to effectively and safely prescribe antimicrobials.

- Developing innovative practices for controlling and preventing healthcare acquired infections by collaborative working with the National Centre for Infection Prevention Management

The safety and welfare of children and vulnerable adults is of paramount importance to Wirral CCG. We work diligently to ensure that all of the services we commission ensure high quality safe effective care.

The following measures ensure that safeguarding and promoting the welfare of children and vulnerable adults is given priority and is discharged effectively across the whole local health community through commissioning arrangements:

- Executive level CCG membership of the Local Safeguarding Children Boards which ensures that safeguarding is at the forefront of service planning
- Senior CCG membership on the Health and Wellbeing Board
- Close collaboration with the Local Authority to assess and ensure the provision of coordinated integrated services to meet the needs of the local population, including specialist services for vulnerable groups
- Ensuring that safeguarding children and adult strategies and associated policies are in place
- Ensuring that providers of services are held to account through regular review of safeguarding arrangements through quality scrutiny processes
- Designated Nurses and Doctors in post to offer professional expertise and advice regarding safeguarding matters.
Ensuring quality and safety

For children and young people the CCG is required to have regard to the need to safeguard and promote the welfare of children; ensure robust governance arrangements are in place and to be active members of the Wirral Safeguarding Children’s Board. The draft Care and Support Bill sets out comparable requirements with respect to safeguarding vulnerable adults, including membership of Safeguarding Adults Boards.

The CCG has responsibilities to provide Looked After Children with healthcare assessments, on placement and annually/bi-annually review thereafter and provide for identified health care.

The systems that have been developed by the CCG are tested through a quarterly review process by the AT, to ensure that there are improvements in the quality of the services that they commission.