Healthy Wirral Vanguard New Care Model
Value Proposition 2016-17

8th February 2016
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and Strategic context</td>
<td>Page 3</td>
</tr>
<tr>
<td>High level Programme Overview</td>
<td>Page 4</td>
</tr>
<tr>
<td>Enablers: Cross Functional Workstreams</td>
<td>Page 4</td>
</tr>
<tr>
<td>Pump Priming Requirement</td>
<td>Page 5</td>
</tr>
<tr>
<td>Healthy Wirral New Model of Care</td>
<td>Page 6</td>
</tr>
<tr>
<td>Prevention, Early Help &amp; Self Care Programme</td>
<td>Page 6</td>
</tr>
<tr>
<td>Enhancing Integration Programme</td>
<td>Pages 7 - 10</td>
</tr>
<tr>
<td>Technology &amp; Informatics Programme</td>
<td>Page 11</td>
</tr>
<tr>
<td>Transformation of Diabetes Care &amp; Respiratory Care</td>
<td>Pages 12 - 13</td>
</tr>
<tr>
<td>Strategic Alignment: Moving Towards an Accountable Care System</td>
<td>Pages 14-15</td>
</tr>
<tr>
<td>Alignment with Delivering the Forward View</td>
<td>Pages 16-17</td>
</tr>
<tr>
<td>Programme Delivery and Structure</td>
<td>Pages 18-19</td>
</tr>
<tr>
<td>Commissioning for outcomes and whole-population Budget</td>
<td>Pages 20-21</td>
</tr>
<tr>
<td>Enabling Cross Functional Workstreams – Further detail</td>
<td>Pages 22-23</td>
</tr>
<tr>
<td>Replicability</td>
<td>Page 24</td>
</tr>
</tbody>
</table>
**Introduction and Strategic context**

It is with great pleasure that we, the Healthy Wirral Partners submit our revised Value Proposition for 2016/17, which seeks to build upon the progress made during 2015/16. This reflects learning from our experience gained to date, conversations with our community, evidence obtained via best practice and national research, and learning from other vanguard sites. We continue to balance the need to deliver transformation at pace, running in parallel with an evidenced-based methodology to realise improvements in quality, outcomes and value for money.

The Healthy Wirral Value Proposition submitted in June 2015 stated the Wirral Partners intention to

- Develop a model of integrated care supported by an informatics enabled Population Health Management technology solution
- Integrate the commissioning functions of the CCG and the Local Authority, and explore and test new contract models
- Take the first step toward a more accountable care system whereby all partners are held and hold each other to account for delivery, and will explore new models of commissioning, contracting and service provision as an enabler to transformational system change.

Our model continues to reflect the different approaches required to meet the needs of the whole population which is demonstrated in the triangle of need below

---

**Figure 1**

- **High-Risk Patients**: 5% of patients; usually with complex disease(s), comorbidities
- **Rising-Risk Patients**: 15-35% of patients; may have conditions not under control
- **Low-Risk Patients**: 60-80% of patients; any minor conditions are easily managed

This value proposition continues to reflect the strategic outcomes set by the Wirral Partners in 2015 which were aligned to the “triple aim”. We have developed a logic model to describe our new care model (Appendix 1).

This demonstrates how the programmes, projects and work-streams in the Healthy Wirral Vanguard Portfolio align to our strategic outcomes and the triple aim.

Furthermore, our value generation hypothesis tree (Appendix 1) maps the Wirral Partners’ drivers towards the “triple aim”, describing the evidence our new care model is based upon, and the metrics we will gather to measure the impact of our new models upon clinical outcomes, patient experience and efficiency in Wirral.
**High level Programme Overview**

The graphic below in Figure 2 demonstrates how the portfolio is organised, the key programmes of work and enabling work streams:

**Figure 2**

The Programmes of work highlighted below identify some of the key areas which drive the development of our new care model:

- **Enhanced integration** which includes Integrated Community Care Teams, Single Front Door, Rapid community response service, Single Integrated Gateway, Dementia liaison nurses, Voluntary sector initiatives, Community Geriatricians and the alignment of primary care services with the Integrated Community Care Hubs (ICCHs).

- **Transformation of Diabetes** care including end-to-end service redesign, operational delivery supported by our new population health management tool, and a new commissioning and contracting model.

- **Transformation of Respiratory** care including end-to-end service redesign, operational delivery supported by our new population health management tool, and a new commissioning and contracting model.

- **Prevention and Early Help/self-care** – The identification and mapping of community based assets and provision of effective access for the population to information, advice and guidance.

**Enablers: Cross Functional Workstream:**

All of the programmes are enabled by cross functional work streams, as demonstrated within Figure 2 and our logic model in Appendix 1:

- People and Organisational Development – Developing an integrated, flexible workforce aligned to a Wirral wide accountable care system which has capability and capacity aligned to local need.

- Communications, Insight and Engagement – Understanding what matters to local people and creating opportunities to shape future delivery, providing effective communications to all stakeholders.

- Information and Technology – The implementation of the new Wirral care record and registries to support the management of care pathways and population health analysis.
• Redesign of funding and contracting models to support a system-wide approach to outcomes-based commissioning.

**Pump Priming Requirement**

Implementation of these new care models and other actions can deliver significant efficiency gains by removing duplication, optimising clinical care and addressing existing alignment of the cost base within the health and social care system. However, there remains an additional funding requirement for upfront, pump-priming investment in order to support scale and pace of transformation changes whilst existing form and function is in place as there is a need to manage systems of care not just individual organisations.

Details of the pump priming requirement are provided within the Value Proposition in order to accelerate the implementation of the Wirral Health & Wellbeing model and the respective balance between recurrent cost base between acute and primary/ community services as appropriate to the transformation change programme as displayed in the diagrams below.

Please see **Appendix 12** for the full Finance and Evaluation Breakdown.
Healthy Wirral New Model of Care

The Healthy Wirral new model of care is based on a model where care is delivered in an integrated way across primary, community, social and acute sectors with connections into the voluntary sector to reduce the risk of hospital admission and increase the availability of care in a local community based setting and where possible in people’s homes.

The focus of our Health and Wellbeing model is person centred and considers self-care and independence as a foundation to wellbeing, enabling timely access to information, advice and guidance as appropriate and access to public sector services only when necessary. Our model promotes a care navigation approach to accessing layers of provision as appropriate to individual need, which supports people to live healthier for longer, but with less emphasis on institutional care and more on empowered self, familial and community based models.

The following illustration shows the Wider Health and Wellbeing Model with the Healthy Wirral Vanguard initiatives highlighted in red.

Figure 3

Prevention, Early Help & Self Care Programme

The diagram above shows the creation of the Wirral digital marketplace (part of the Prevention and Early Help/Self-care Programme) at the centre of the model which will enable people to look after themselves and their family. Appendix 6 (Neighbourhood connectivity model) illustrates the routes through which professionals and the public will be able to access this repository of community assets which was funded through the Vanguard programme in 2015-16. It should be noted that we have secured £1.1m funding from Wirral CCG and Wirral Council to support the implementation, evaluation and sustainability of the programme.

In 2016-17 we will expand the Puffell tool, an online portal for self-management of lifestyle and health conditions to specifically deliver an application for people with type 2 diabetes, known as the “Diabetes Deck”. The deck will include:

- a risk assessment tool for people who are at risk of type 2 diabetes
- a tool to manage medication and goal setting
- educational information
- advice in relation to managing diabetes
- access to local service information and Diabetes UK.

**Enhancing Integration Programme**

We seek vanguard funding in 2016-17 to commission Community Connectors through our local voluntary sector that will be based in the four local integrated care hubs and support people to stay in their own home. In addition we plan to establish an exciting initiative with Age UK and the existing Home from Hospital service who will run the Discharge Lounge at the acute hospital taking an innovative approach to engaging people at the point of discharge to identify support they require to sustain them to live well and independently in the community. They will also expand their existing offer to the inpatient wards from a 5-day service to a 7-day service and expand to cover Accident & Emergency and the Walk-in Centre at Arrowe Park Hospital providing alternative pathways to admission for some patients. Furthermore we have requested funding to support a Wirral wide co-ordinated approach to the training of frontline Health and Social care staff to “Making every contact count”.

This will be enhanced by two further work streams in 2016-17.

- Learning from models of care initiated in care homes based in Airedale (Vanguard site) and Sefton, Healthy Wirral believes it will be able to progress towards the triple aim through the introduction of teletriage to care homes. Local evidence shows (appendix 7) shows that the levels of ambulance conveyances, A&E presentations and hospital admissions are significant among people residing in care homes in Wirral. We therefore propose to conduct a pilot in 30 local care homes (there are a total of 100+ care homes in Wirral) to reduce the need for ambulance call outs and conveyances by 20%, and non-elective hospital admissions by 10% from people within these homes.
- Efficiency will be improved through the further development of the Integrated Gateway for Health and Social Care services in Wirral in 2016-17. The first step of this project is for the teams to be co-located (relocation to new premises in February 2016), and then integrating the offer by blending staff roles, redesigning processes to streamline and remove duplication, and obtain optimised efficiency enabled by ICT. In 2016-17 the initiative will be expanded to include the single point of access for Mental Health and Learning Disability services with on-going redesign activity to streamline and simplify the referral pathways, seeking opportunities to increase efficiency and improved experience for professionals such as GPs and Social Workers, and the local people that access the services.

It is recognised that effective communication, engagement and insight to support these programmes of work are essential, and this will be enabled via a significant communications and engagement campaign to support the prevention, early help/self-care programme self-care in 2016-17. This will be entirely insight-led and delivered with flair and energy.

The Healthy Wirral new model of care also enables quick and effective access to specialist advice and guidance when required (right care, right time and right place). In 2015-16 the rapid community response service and the Single Front Door initiative at the acute hospital went live. The community based rapid response team are able to implement safe alternatives to admission to hospital or care homes for people who are in crisis, whilst the single front door is diverting circa 15% of adults self-presenting at A&E to more appropriate alternatives.

Whilst these projects have begun to prevent unnecessary hospital attendance or admission, we want to continue and expand these in 2016-17 so that together with the wider development of integrated care (including Community geriatricians, GPs, dementia services, voluntary sector), supported by the new Wirral care record they drive a significant change in pathways that will deliver efficiency savings (i.e.
reach a tipping point to enable bed closures). In 2016-17 we will extend the single front door initiative to children, expand the remit and functionality of the service and in the longer term we will develop a capital business case to redesign the front door to present the public with self-care and primary & community based services as their first port of call. With support of vanguard funding, the Rapid community response service will extend its offer in three ways:

- Support reduction of length of stay for people who are older and/or have complex needs by offering a follow up visit within 2 hours of discharge to ensure individuals are safe and enabled in their home environment
- Provide rapid community response physiotherapy and occupational therapy services at the weekend
- Linking to the tele-triage initiative for care homes, and working with local GPs to provide rapid response community services to care homes

Our delivery model for integrated care is based on a geographic locality structure aligned to the four parliamentary constituencies. As our vanguard programme commenced, Integrated Care Co-ordination Teams (ICCTs) were in an embryonic state with a core of community nursing, therapy and social care staff.

During 2015-16 four Integrated Care Co-ordination Hubs (ICCHs) hubs were established in autumn 2015 which operate from Monday to Friday 8am to 5pm. The functions undertaken within the hubs already include Mental Health and will be extended to include End of Life and Tissue Viability specialist nurses. In parallel, a transformation programme for community nursing services has been conducted by Wirral Community Trust to determine its capacity and skill mix to develop a predictive workforce model that will be aligned to the four ICCHs. During 2016-17 we intend to align additional services of Mental Health, Learning Disabilities and Child and Adolescent Services to the ICCHs. This provides an opportunity for the co-location of one of the ICCTs within its current estate. In addition, the legal structure of the team is being explored (Section 75 agreement) to transfer the LA staff to the Community Trust.

In 2016-17 the ICCTs will further explore how they work with the Integrated Discharge Team based at the acute hospital to pull patients from their locality out of hospital as soon as they are medically optimised, reducing length of stay and the risk to patients of institutionalisation, falls and infections.

From this base in 2016-17, we are excited to further expand the services available within or aligned to the ICCHs

- **Expansion of Community Geriatrician services**

The Healthy Wirral Value Proposition submitted in June 2015 described the five pathways being implemented to ensure older people receive specialist care in the most appropriate setting. These services have been established but recognise that the capacity to bring comprehensive change is limited by only having two community geriatricians in post.

In 2016-17 we propose to expand the Community Geriatrician workforce to 4 Whole Time Equivalent to create additional older people’s rapid access clinics (for GPs to access to prevent referral to medical assessment unit), and provide greater input to care homes and intermediate care beds so that frail older people receive timely comprehensive geriatric review and each have an advanced care plan (ACP) so that no person with an ACP will be admitted to hospital over their last 6 months of life when they have stated they wish to die in their own home. The community geriatricians will establish working relationships with General Practices and Pharmacy services within their hub locality and agree clear roles and responsibilities for GPs and Community Geriatricians to prevent duplication. Community Geriatricians will work closely with the ICCH based health care, social care and voluntary sector staff to agree join care plans to maintain the health and wellbeing of individual people.
The ability to do this will be enhanced by access to the new Wirral care record, and vanguard-led communication and engagement initiatives will be proactive in raising public and professional awareness of this new approach to care. We are in the process of evidencing the need to build a registry as part of the Wirral care record to support the care pathway for frail older people.

Our hypothesis is that consultant-led community based services combined with a partnership approach with GPs will reduce hospital admission and length of stay enabling a reduction of inpatient bed base and associated workforce.

- **Expansion of Dementia liaison nurse services and establish Alzheimer’s Society volunteer connector service**

  In 2015-16 Dementia specialist nurse input to three acute hospital wards has demonstrated a reduction in readmissions of this cohort of patients from 35% to 10%. Healthy Wirral recognises the need to expand specialist dementia nursing support to A&E, admission areas and community and primary care to reduce hospital admission, readmission and improve the experience of patients and their carers so they feel more confident in caring for them at home. These nurses will also deliver more extensive training to staff across the health and social care economy to increase knowledge, skills and confidence of staff in managing people with dementia.

  In addition we will partner with the Alzheimer’s Society to enable people affected by dementia to access the right services to meet their needs and help them remain in their community and homes for as long as possible. A specific Dementia Key Worker (DKW) will provide guidance and support to Dementia Specialist Nurses, local GPs, community and social service staff, people with dementia, their carers and families, to help facilitate improvements to local Dementia support and ensure access to the right services at the right time. The DKW will develop a tailored service and support to meet Healthy Wirral’s outcomes, helping to:

  - support the provision of integrated services for people affected by dementia in their local community setting
  - ensure consistent levels of care
  - act as a driver to empower and improve person-centred care
  - encouraging a holistic approach to health care
  - facilitate the sharing of best practice

- **Alignment of Primary Care services to ICCHs**

  This will include ensuring the consistent use of referral pathways to ICCTs following risk stratification by primary care of patients with complex needs who are at risk of unplanned hospital admission. Commissioners will explore how locally-enhanced schemes can drive the consistent use of these pathways.

Following establishment of the enhanced services within the ICCHs, our hubs will provide a more extensive offer to support people in their local area to remain as independent and well as possible. The diagram below illustrates our locality-based integrated care model (“the flower model”) with the expanded range of voluntary and statutory services offered in each.
We are supporting our integrated model of care by overlaying the existing local, well advanced digital patient record with a population health management approach. The new Wirral Care Record will ensure that all health and social care staff are able to view system wide information to support patient care and provide care planning and decision support tools that promote the delivery of evidenced based care pathways across organisational care boundaries.

A King’s Fund paper on the Leeds interface geriatrician service (October 2014) reported that a barrier existed because there was no single portal whereby health and social care information could be accessed. It identified that a shared record was needed to combat this barrier. The Wirral Partners new care model is unique in developing a **new single care record** for the local population.
Technology & Informatics Programme

Through the implementation of a new longitudinal care record (Wirral Care Record) we are able to take a targeted approach to the health of the local population. In 2015-16 clinical teams have worked in partnership with informatics leads to co-design five “registries” for Respiratory and Diabetes care which are predicated upon the best national, international and local care standards to drive a consistent delivery of high quality care to the local population. These registries which go live in summer 2016 have been designed for children and adult cohorts and will be replicable to other sites within England. We have commenced development on the next phase of registries including depression and social wellness (children). The registries will provide analytics which, when used proactively will drive improved clinical outcomes, patient experience and efficiencies. We recognise the importance of working in partnership with Primary Care teams to optimise the use of this tool and in 2016-17 we seek to use vanguard funding to appoint an individual who will work closely with practices to optimisation the benefits of our new registries.

The longitudinal care record also goes live in summer 2016 when data streams from Primary and Acute Care, quickly followed by Community Care, will flow into the new record enabling care staff from across the whole economy to view a single version of an individual’s care record. Data streams from mental health and social care services will flow into the longitudinal record by year end enabling a whole system view of the care record. This phase of work creates the infrastructure and content so that we will be able to use our single record to provide analytics that enable a targeted approach to care planning and outcomes based commissioning across the triangle of need.

The implementation of the Wirral Care Record will enable the system to:

- Support and enable targeted intervention and prevention and contribute to reducing inequalities and gaps in care, both at an individual Patient/Service User level, and on a broader Population Health basis.
- Enable staff across all organisations to view patients and service users holistically, and have an informed history and relevant information to identify the most appropriate treatment, care and support.
- Improve patient experience by enabling information to be shared, to prevent patients having to tell their story and provide information more than once.
- Streamline processes for front-line staff by reducing and removing the administration burden.
- Enable culture change and true integration, by sharing information and working together across existing boundaries.
- Provide Insight and analytics to inform commissioning and resource management for the whole population.
- Inform the changes of the funding and contracting model and future landscape of services
- Reduce duplication and waste, enable and drive end-to-end service redesign to maximise efficiency and reduce costs. For example, domiciliary carers access to the record will enable them to see if their clients have been admitted to hospital and will prevent them from carrying out an unnecessary visit. Instead they can contact the hospital to inform discharge planning.

It should be noted that we will take a joint approach to the programme management of this extensive initiative with our commercial partners, Cerner UK.
Transformation of Diabetes Care & Respiratory Care

New Model Pilot – Diabetes Care

During 2015-16 the development of a Community Diabetes Service Pilot (“hub and spoke” model) has been established. The first spoke went live in November 2015 and the second is scheduled for 23rd February. This model works whereby GPs with Special Interest (GPwSI) clinics and Diabetes Specialist Nurse support are available in the local community. In addition they also visit patients with diabetes in care homes to support planned management of their condition. The new model is being run as a Pilot, with a clear method for capturing the impact and effectiveness of this. Learning will be captured as part of the process, with controlled variations to the model as appropriate. The pilot will result in patients with type 2 diabetes, who have been receiving their follow up care in the secondary care setting will begin to receive this in a community based setting.

For those patients already receiving their care in a community based setting, we aim to optimise their treatment, reduce variation and improve control/self-management of their diabetes. This will be enabled by the Wirral Care Record and the Puffell deck. The programme will also identify patients with pre-diabetes and review education and advice programmes for patients with diabetes or at risk of diabetes. An up-skilling programme for wider primary and community staff will be established to improve non-specialist care of diabetes in the community. Whilst we have identified the in-year benefits and returns of introducing the new model of diabetes care, it is apparent that more significant benefits will be realised in the medium-to-longer term as a consequence of end-to-end redesign of the service.

New Model Pilot – Respiratory Care

The development of an Integrated Respiratory Service Pilot has been established and GPwSIs appointed to support delivery. The Respiratory care pathway programme is also delivering the following elements which provide intense community support:

- Early supported discharge, enabling people to return to their home more quickly following hospital admission.
- Community based pulmonary rehabilitation to support people with COPD to stay well at home and prevent unplanned hospital admission
- Urgent appointments in community based hot clinics to provide access to specialist expertise and avoid admission

In 2016-17 this programme will extend COPD early supported discharge to 7 days per week, reducing hospital length of stay and expand and evaluate the pulmonary rehabilitation programme. From September 2016 a community based, specialist nurse acute respiratory response service will take a proactive approach to maintain people with respiratory conditions in the community.

Healthy Wirral is seeking funding to continue to embed the Diabetes and Respiratory care models in 2016-17 which it believes will change patterns of care delivery from hospital based outpatient and inpatient delivered care to one focussed on community based care for all but the sickest of patients. In parallel, commissioners will explore and implement new approaches to funding and contracting models which will further facilitate a move towards capitated budgets and outcome based commissioning.
End to End Redesign: Diabetes & Respiratory

There are two significant programmes of work to transform Diabetes and Respiratory care pathways. These are being developed in a phased approach with new models being piloted in parallel to complex end to end service redesign. The first step is to develop and pilot a Community Based Diabetes service and Integrated Respiratory Service.

Alongside this work an evidenced based end to end redesign will be implemented in the following areas:

- Emergency Department Flow
- Approaches to Reduced Length of Stay
- Discharge Processes
- Prevention Avoidance
- Primary Care Transformation (Adoption and use of Registries, changes to pathways)
- Assessing Gaps in care and establishing solutions where appropriate

All of the redesign described above will be undertaken using Lean Six Sigma methodology and an evidence based approach which is enabled by the insight, analysis and information we can obtain via the implementation of the Wirral Care Record. The transformation and redesign projects will be undertaken in line with the development of all condition-specific registries, with the first two areas being for Diabetes and Respiratory, with an additional 6 registries and consequently transformation projects being established by 2018/19.

The delivery of these transformation programmes will drive quick access to specialist advice via a community based model (see Figure 3 Health and Wellbeing model)
Strategic Alignment: Moving Towards an Accountable Care System

We have made important first steps towards the integration of local organisations to support Population Health Management through an accountable care system. Through the Healthy Wirral Partners Board a Memorandum of Understanding and risk sharing agreement (appendix 2) has been developed and approved by partner organisations' boards to support such an approach.

Crucially, the Healthy Wirral Programme Board has identified a five year pathway towards integration of organisations into an Accountable Care System. The following diagram illustrates a year by year progression towards this organisational model.

Figure 5

Towards an Accountable Care System...

In 2016/17, Wirral Partners will take indicative steps ‘towards an accountable care system’ approach with discussions currently taking place as to how a joined up approach that spans the traditional commissioner / provider divide can be developed and in accordance with the principles of the Sustainability and Transformation Plan and 5 year Forward View.

Wirral Partners are actively driving a different discussion for future financial years, one that it based upon the principles of an open book approach and comparing the total resources available to the costs of provision within the system rather than traditional activity based contracting (in a ‘Payment By Results’ environment) and the traditional ‘push / pull’ between the organisations within the process.

As part of this process and in specific relation to the 2016-17 Healthy Wirral Vanguard Value Proposition the pump priming measures identified are targeted towards the required and appropriate shift in the models of care as aligned to the PACS status of the Healthy Wirral Programme.

Activity and ‘PbR’ impact assessments have been developed and will help support the ‘shift left’ in activity terms as part of the transformation process. New Models of Care with a wider focus on prevention, avoiding unplanned escalation and removing associated secondary care costs form part of the system wide rationale for pump priming integrated care and ‘hub and spoke models’ for Diabetes and Respiratory as two particular examples.
All partners recognise the need to move towards a new approach given the scale of the challenge overall and on an individual organisational level. We are committed to working collaboratively across the partnership to reach an agreed outcome and Wirral Partners have already began sourcing external support (AQUA / Renuma) to help negotiate a mutually favourable approach.

The programmes of work will make positive steps towards the basis of an Accountable Care System such as the redesign and the formation of an Alliance Contract (further detail is included within the Commissioning for Outcomes section); however it is acknowledged that a detailed business case will need to be developed to explore the various options and potential legal frameworks (i.e. Joint Venture/Accountable Care System etc.) that are most suited which will be informed by the evidence base captured.

The Wirral Partners are keen to support a more unified way of working from regulatory bodies so that our organisations are scrutinised as a whole system which has shared accountability for the whole care needs of the local population.
Alignment with Delivering the Forward View

The partnership is mindful of the publication of the 2016/17 – 2020/21 Planning Guidance “Delivering the Forward View” and the need to be able to describe the key deliverables of this at a local level and at a more strategic level with the development of sustainability and transformational plans.

The Wirral Partners are accountable for the whole health and care needs of the local population (330,000 people) which is reflected in our care model for population health and wellbeing.

Due to the geography and patient flows of Wirral residents, we believe that the greatest opportunity for transformation is at a local level with lives being transformed through our neighbourhoods, social, primary and community care. (Locality Level one)

We will also seek to collaborate with our neighbouring CCGs in West Cheshire and Cheshire on a sector basis so as to sustain services in respect of outcomes, access, workforce, estates and value for money. (Sector Level two)

For services provided from a single access point that require a larger catchment population we will seek to develop a single Sustainability and Transformational Plan (STP) in conjunction with commissioners and providers. (Level three)

In so doing, this places Healthy Wirral transformation into context within the wider sustainability collaborative approaches.

The Wirral Partners envisage that its Value Proposition for Vanguard will play a role in the development of the local STP. Given the resource available to support the Healthy Wirral Vanguard initiative we recognise that the existing programme cannot fully meet the forecast gap that the economy faces in a “do nothing ”scenario. However, the Healthy Wirral Programme is leading the way across the local health and social care economy to deliver a new care model which will contribute closing the three gaps identified in the Five Year Forward View (Care and quality, health and wellbeing, finance and efficiency).
The Healthy Wirral Programme has considered its alignment to NHS England’s objectives for 2016-17

<table>
<thead>
<tr>
<th>Objective</th>
<th>Area of focus</th>
<th>Healthy Wirral alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>To help create the safest, highest quality health and care service</td>
<td>Seven day services</td>
<td>Enhanced integration (Single front door, Integrated rapid community service, Integrated gateway).</td>
</tr>
<tr>
<td>Patient experience</td>
<td></td>
<td>Prevention and self-care, Integration, Diabetes care model, Respiratory Care model, Dementia Liaison nurses, older peoples community based services. Communications and Engagement work stream- What Matters to me?</td>
</tr>
<tr>
<td>To balance the NHS budget and improve efficiency and productivity</td>
<td>Balancing the NHS budget</td>
<td>Healthy Wirral programme aligned to the triple aim to create a sustainable health and social care economy.</td>
</tr>
<tr>
<td>To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives</td>
<td>Obesity and diabetes</td>
<td>Behaviour change project improving access to information and advice services. Diabetes care pathway including diabetes registry. Diabetes prevention programme. Wellbeing registry adults and children</td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td>Expansion of Dementia liaison nurse service to community services (Primary care, integrated care teams) and assessment units in acute care.</td>
</tr>
<tr>
<td>To maintain and improve performance against key standards</td>
<td>A&amp;E, ambulances and RTT</td>
<td>Integrated rapid community service Single front door Integrated gateway</td>
</tr>
<tr>
<td>To improve out of hospital care</td>
<td>New models of care and general practice</td>
<td>Risk stratification tool and referral to Integrated care teams Development of Wirral care record New care pathways (diabetes/respiratory) include GP delivered services. Integrated gateway</td>
</tr>
<tr>
<td>Health and Social care integration</td>
<td></td>
<td>Wirral care record Enhanced integrated community care teams Integrated gateway Integrated rapid community service Integrated discharge team Integrated commissioning hub</td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td>Development of depression registry in Wirral care record</td>
</tr>
<tr>
<td>To support research, innovation and growth</td>
<td>Technology</td>
<td>Neighbourhood connectivity programme Wirral care record</td>
</tr>
<tr>
<td>Health and Work</td>
<td></td>
<td>Wirral Partner organisation standard measures for staff to be healthy.</td>
</tr>
</tbody>
</table>
**Programme Delivery and Structure**

In order to achieve the transformation set out within this Value Proposition, a robust and proportionate change management approach is required, this structure is designed to support and enable effective delivery at pace, whilst ensuring robust and effective governance for decision making.

The diagram below demonstrates the portfolio structure to enable the delivery of successful and sustainable change.

*Figure 7*

---

**Programme Methodology and Approach**

The team adopt a toolkit approach which is designed on best practice for the management of change such as MSP, Prince 2 and Lean Six Sigma principles. The methodologies detailed within Appendix 3 and Appendix 4 demonstrates the structure and approach taken, both in terms of Service Redesign and Programme Management.

This methodology is designed to be proportionate to the scale, complexity and risk at an individual project level as appropriate, and sets out the minimum expectations in terms of evidence base and delivery through gateways.

The approach to deliver change will be collaborative and will involve patients, clinicians and practitioners to inform and deliver the changes on the ground. The Healthy Wirral Team will have an active role in supporting this and will align resources of change managers to enable the delivery and pace and provide rigor. This will involve the team being responsible for the delivery of key activities and acting as a facilitator, drawing in expertise from across the partner organisations as applicable to ensure effective change is achieved.
Programme Governance and Reporting

The diagram below demonstrates the Governance Structure and Reporting that will be undertaken for the Programme. The monthly reporting schedule is attached in appendix 5.

*Figure 8*

## Portfolio Governance

![Portfolio Governance Diagram]

Enabling Cross Functional Work-streams

As demonstrated within Figure 7, the Portfolio has in place cross functional work streams that underpin and enable the delivery. This includes specific areas such as Communication, Insight and Engagement, Information Governance etc (further detail is provided later on within this document).

In addition there is acknowledgement that further work-streams may be required for future phases as detailed below:

### Assets & Estates

This group will consist of representatives from all partners’ organisations and will be tasked with developing a strategic asset rationalisation plan that will be developed that will align to the delivery of the redesign across the wider landscape as part of the Sustainability and Transformation Plan (STP).

### Specialist Support

It is acknowledged that during the delivery of transformation there may be requirements to pull in specific specialist support within the Programme Delivery. The support will be provided from colleagues and technical experts from the Wirral Partner organisations and will include areas such as Commissioning, Contract Management, and Legal and Procurement as required.

In addition, Wirral Partners have engaged with a range of regional and national organisations to draw upon their expertise and experience to enhance the development of our new care model. For example the Information Commissioners Office (Information governance), Health Education England (workforce modelling) and AQuA (leadership development and change management). Healthy Wirral has established networks with other vanguard sites to share best practice.
Commissioning for outcomes and whole-population budget

Vision for 2020

Whilst the Sustainability and Transformation Plan is yet to be developed, it is agreed that the future way of commissioning services in Wirral will change with the aim of services being commissioned jointly with the Local Authority and commissioned to meet agreed outcomes. By 2020 there will be an Accountable Care System in Wirral which will enable the whole health and care system to act as one economy with an aim of delivering health and social care at the right place at the right time and to the right person.

We remain committed to commissioning services which reward positive outcomes for the people using them and services will be expected to demonstrate improved outcomes for patients and improved patient experience whilst also ensuring the efficient use of resource. This consistent approach to ongoing outcome improvement will in turn will reduce variation to improve the health inequality profile of Wirral.

Progress to date

The ‘programme board' approach, and the learning from it, is now influencing the development of a much more ambitious and far-reaching alliance model for the commissioning and contracting of urgent and unplanned care services across Wirral. This alliance model is the first phase of moving towards the development of the whole accountable care system. The alliance model will facilitate a new way for the organisations to work together in delivering the outcomes agreed. This will also continue the development of positive relationships between the organisations that will enable the roll out of the alliance approach to the wider health and social care system. The Wirral health and social care system are signed up to the development of the alliance and work is on going to ensure its implementation in 2016/17.

In terms of progress to date, we have now developed and implemented a Rapid Community Service aimed at avoiding unnecessary hospital admission and facilitating timely discharge. The basis for the development of this service was through the adoption of a ‘programme board' approach to ensure that all stakeholders were involved in development of the specification and its associated outcomes – the service is now fully implemented and will be evaluated as part of the local Better Care Fund review.

Implementation of an outcomes-based community service for diabetes care is also in development. A phased approach has been adopted with the community based service being piloted, with Stage 1 implemented (GP with Special Interest (GPwSI)-led spoke service at constituency level) and Stage 2 planned during 2016/17. Associated outcomes for this service will be closely monitored. However, some of the anticipated impact will be longer term, for example, reduction in amputation rates. A similar approach has been adopted for the community respiratory service. The Healthy Wirral pilot work for diabetes and respiratory is embedded into contracts through the Service Development and Improvement Plans of appropriate host pilot sites, with plans to explore and implement new approaches to funding and contracting models which will further facilitate a move towards capitated budgets and outcome based commissioning.

2016/17 plans

It is the intention of Wirral CCG to embed the approach of commissioning for outcomes during 2016/17. To this end there are a number of work projects planned, with some key projects highlighted below. The CCG is also adopting the Right Care methodology in ensuring value is optimised from health services. This will enable the CCG to prioritise additional work plans that will deliver changes to increase the value, both in terms of outcomes for patients and efficiency.
It is anticipated that the first phase of the alliance model for urgent care will be implemented in April 2016 with subsequent phases coming online in October 2016 and April 2017. The population of Wirral are being asked what is important to them and this feedback will be used together with nationally recognised quality outcomes to develop outcomes expected from the alliance. Within the first phase of the alliance contract will be Wirral CCG, Wirral University Teaching Hospital, Wirral Community Trust and Cheshire and Wirral Partnership (Mental health provider). Work will progress during the year to increase the scope of the alliance contract to include the Local Authority and other providers such as primary care.

In terms of commissioning for outcomes, agreement has been reached to develop and shadow some key outcomes for specific mental health services with Cheshire and Wirral Partnership. The outcomes will be agreed in Quarter 1 2016-17 and shadow monitoring will commence from Quarter 2 onwards.

The development of local registries and the Wirral Care Record will have significant further impact on our ability to commission for outcomes. This platform will provide a wealth of information to enable us to fully understand, for the first time in ‘real’ time, the needs and variation in outcomes and care provision for our population. This information will allow us in future years to target our commissioning more appropriately to reduce inequality and will provide invaluable data to develop more sophisticated and targeted outcome measures. Registry development and Wirral Care Record deployment are on target for the 2016/2017 financial year.

**Moving towards whole-population budgets**

A whole-population budget is the proposed solution for vanguard sites that have not yet developed a locally determined capitation approach, or for any site that may choose to follow in the near future.

NHS England’s expectation is that all multispecialty community providers (MCPs) and primary acute care systems (PACS) vanguard sites will develop a whole-population budget spanning several years for implementation in April 2017, unless they are already developing a locally determined capitation approach.

Wirral Partners have begun to explore a range of new commissioning/contracting models that are appropriate to the accountable care system that it is trying to develop as a different way of working and with an increased focused upon outcomes based commissioning rather than traditional activity based planning assumptions.

Wirral partners have agreed to review its system wide approach to whole-population budgets and pilot new ‘capitated’ budget approaches in the ‘vanguard’ areas such as diabetes and respiratory within 2016/17 financial year.

The Programme Management support will begin to design an appropriate form using the structured methodology as recommended by NHS England New Models of Care team and begin to shadow an approach during quarter one of 2016/17 as part of its wider system modelling and financial planning support.

The aspiration of the Healthy Wirral approach will be to develop a robust multi-year payment mechanism for the total population covering all in-scope services based on current cost with an agreed apportionment of risk appropriately between the relative provider and commissioner based upon the available data.
Enabling Cross Functional Workstream

People and Organisational Development

The Wirral partners recognise that this enabling work stream is essential to ensure a sustainable and transformational approach to our programme. Using Vanguard funding, in 2016-17 we plan to take an innovative approach by working in partnership with a neighbouring MCP Vanguard site, Western Cheshire to appoint a joint People and OD work stream lead and OD practitioner. This approach will support replicability, providing an opportunity for Healthy Wirral to learn from what has already been piloted and/or achieved in West Cheshire e.g. relational proximity work. This does not mean our solutions need to be the same, but rather that learning is shared, ideas built upon and common principles are established which will assist with the wider aims of Vanguard.

We also recognise that cultural change amongst our workforce is vital to ensure all our staff actively promotes our new care model of integrated care delivery supported by population health management to improve local health and wellbeing outcomes, people’s experience and efficiency. This change needs to take place across the workforce including clinical leaders, organisational leads and front line staff. Following work with AQuA in 2015-16 to understand the cultural change required to support our workforce, we have requested Vanguard funding to support a range of relational proximity initiatives in 2016-17.

Our intention is to work with our partner’s ICE Creates, we want to approach the values, beliefs and behaviours of our Integrated Community Care Teams by tearing up the rule book of traditional staff engagement. We believe that the best examples of those delivering genuinely person-centred, values-led care and support are to be found in the countless community connectors and local champions in our community. Totally unencumbered by organisational boundaries, job remits, and budgets (and often performing their roles with little or no financial incentive), these are the people that, through sheer force of personality and commitment are filling the gaps of service provision and bringing real value to their neighbourhoods. These are precisely the values and beliefs we want to embed within our integrated teams.

Our approach will be based on bringing a cohort of the many community connectors and volunteers that we have met together to understand what beliefs they hold, that drive their behaviours. Working with local company, ICE Creates we intend to put a programme of modelling, learning and engagement together to ensure that our Integrated Teams learn from these connectors – to ensure we can bring these beliefs, and deliver these behaviours into the formal care setting. This is an innovative, unique, and genuinely grass roots-led approach to ensuring our teams represent the very best of our diverse community. See Appendix 14 the proposal from ICE Creates for Aligning Culture and embedding new ways of working.

We are also working with Renuma Consulting to design a tailored approach to create an effective leadership environment. Effective collaboration between the five represented organisations will require good working relationships at every level of delivery. A first step is to ensure there is strong relationship at senior leadership level. Establishing this foundation will facilitate the growth of effective relationship at other levels within each organisation by:

- Providing ‘top cover’ for collaboration and joint decision-making
- Introducing a commonly accessible language and framework of collaborative relationship into the system
- Identifying significant cultural and organisational barriers to collaboration that can be proactively addressed through the work of the Senior Leadership Group.

The Renuma Relational Proximity® framework allows the bi-lateral measurement of tangible components of relationship that are both easily understood and can be intentionally adjusted. With such
specific insight, inter-organisational relationships can be improved more quickly and across a whole system. The progress made in improving relationships can also be tracked and evaluated in a consistent way. The approach has been used in various sectors to clear a backlog of stalled delivery projects, enable senior leaders to voice and address poor history and help programme directors collaborate where trust had broken down.

In 2016-17 we will also pilot exiting initiatives with voluntary sector partners where their people will deliver support and advice to our local population to promote a sustainable model of self and community based care. This will include Age UK representatives working in the hospital discharge lounge and Alzheimer’s Society connectors working within Integrated Community Care Hubs.

**Communications, Insight and Engagement**

As an enabling work stream, Communications, Insight and Engagement works across all projects, highlighting and addressing the “human factors” of each initiative and intervention. The specific behavioural insight function within the Healthy Wirral team will contribute a predominantly qualitative perspective on each project; this will inform communications or potentially service interventions, (or “nudges”).

Where communications interventions are required to deliver the outcomes of projects, they will be entirely insight-led and delivered with flair and energy. This approach will ensure that all project-based communications are effective, and cost-efficient – as they will be based on addressing the particular needs of our target groups, and thoroughly tested prior to implementation. Subject to vanguard funding in 2016-17, the Communications, Insight and Engagement team will lead a comprehensive campaign to support the successful roll out of the prevention, self-help/self-care work-stream across Wirral.

In this respect, the approach of Communications, Insight and Engagement cuts through the entire portfolio and contributes to achieving a wide range of specified outcomes attributed to the Healthy Wirral team.

For example:

**“We will reduce health inequalities so that all Wirral’s residents can expect and receive the same health and wellbeing opportunities”**

A key aspiration of the “What Matters to Wirral?” initiative, undertaken during January 2016, was to reach seldom-heard or previously excluded members of the Wirral community to ensure their views were taken into consideration in developing the Healthy Wirral communications and engagement strategy. Through this we have developed excellent relationships with representatives of our LGBT community, our migrant and BME community, and members of our most deprived neighbourhoods. As a result of this, we already have a much more engaged community and a much clearer sense of how to support citizens to reduce health inequalities in Wirral.

This is the beginning of leading to a community with true parity of esteem across our entire community in 2020.
Replicability

Healthy Wirral recognises the responsibility vanguard sites have in ensuring its new care model is replicable to other sites across England.

During 2015-16 our programme has reviewed its learning and recorded examples of practice that would be replicable across other sites. For example, Wirral Partners MoU, and Wirral care record Information Sharing Agreement.

The development of the informatics enabled population health management tool to support the new Wirral Care record and disease and wellness registries is first of type in England. The need for replicability has been a part of contract negotiations with Cerner UK. Whilst the technical infrastructure will remain a proprietary Cerner product, as part of the programme delivery, the process to obtain the changes and metrics will be replicable. In terms of delivery of change, lessons learnt is built into our methodology so that we can ensure that we adopt any learning as part of the development process and in addition we are able to share our findings and approach with others.

The clinical development of the optimum care pathways has been created using national metrics such as NICE & QOF measures. Early stage content is available to share and we are working with AQuA with the explicit intention to proactively make this content available for use by their partner organisations and others. The work by Wirral Partners to negotiate information governance agreements to support the necessary data sharing, as well as their work with EMIS, Millennium, System One, Liquid Logic and Care Notes to develop interoperability solutions will be available to the New Care Models programme.

Where we are developing new models of care in relation to prevention and early help/self-care, teletriage and enhanced integration (including community geriatricians, voluntary services and dementia liaison nurses) we will work with colleagues in our Public Health team and use the NCM additional evaluation funding to appraise each project and capture learning to model an approach that can be replicated on a national level. In addition where we are working with external partners (e.g. ICE creates and Alzheimer’s Society) we have likewise asked them to build evaluation into the project to establish learning to model an approach that can be replicated.