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WIRRAL

Health and Wellbeing Board

Date:	**Wednesday, 15 April 2015**
Time:	**3.00 pm**
Venue:	Cabinet Briefing Room - Wallasey Town Hall

Contact Officer: Pat Phillips
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AGENDA

1. DECLARATIONS OF INTEREST

Members of the Board are asked whether they have any personal or prejudicial interests in connection with any application on the agenda and, if so, to declare them and state the nature of the interest.

2. APOLOGIES

3. MINUTES (Pages 1 - 10)

To approve the accuracy of the Minutes of the meeting of the Health and Wellbeing Formal Board held on 12 November, 2014.

4. PEER REVIEW FEEDBACK, NEXT STEPS AND KEY THEMES FOR THE HEALTH AND WELLBEING STRATEGY (Pages 11 - 30)

5. VANGUARD PROPOSAL (Pages 31 - 44)

6. BETTER CARE FUND - QUARTERLY UPDATE (Pages 45 - 54)

7. QUARTERLY ACCOUNTABILITY REPORT FROM NHS ENGLAND (Pages 55 - 62)

8. LEARNING DISABILITIES - SELF ASSESSMENT FRAMEWORK ASSESSMENT

Verbal report – Jayne Marshall, Department of Adult Social Services (DASS).

9. FOR NOTING (Pages 63 - 66)

- Pharmaceutical needs assessment

10. DATE OF NEXT FORMAL BOARD MEETING

The date of the next formal Board meeting is Wednesday 8 July, 2015 at 4:00pm in Committee Room 1, Town Hall, Wallasey.

HEALTH AND WELLBEING BOARD

Wednesday, 12 November 2014

Present ;

Cllr P Davies	(Chair)
Cllr C Jones	Portfolio Holder for Adult Social Care
Cllr P Gilchrist	Leader of the Liberal Democrat Group
Ms F Johnstone	Director of Public Health
Mr G Hodkinson	Director of Adult Social Services
Dr P Naylor	Wirral CCG
Ms J Hassall	Director of Children's Services
Ms S Cumiskey	Cheshire and Wirral NHS Partnership Trust
Mr S Gilby	CEO Wirral NHS Community Trust
Cllr T Smith	Cabinet Member Children and Family Services
Mr P Davies	Chair, Healthwatch Wirral
Ms J Evans	Head of Transformation, Adult Social Services
Ms C Fish	Strategic Director Families & Wellbeing
Mr P Murphy	Mersey Fire and Rescue
Chief Superintendent John Martin	Merseyside Police
Ms J Webster	Head of Public Health
Karen Livesay	Community Action, Wirral
Richard Freeman	NHS England

62 **DECLARATIONS OF INTEREST**

Councillor C Jones declared a personal interest by virtue of her employment with the Cheshire and Wirral Partnership NHS Foundation Trust.

Councillor Phil Gilchrist declared a personal interest in general by virtue of being Cheshire and Wirral NHS Partnership Trust Appointed Governor.

Councillor Phil Davies declared a personal interest in Item 7, Wirral's Pharmaceutical Needs Assessment (PNA): Update on Progress and Timescales by virtue of his wife being a Pharmacist.

63 **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor J Green, Jon Develing, Wirral CCG, Val McGee, Cheshire and Wirral Partnership NHS Trust, Andrew Cannell, CEO, Clatterbridge Cancer Centre, David Allison, CEO, Wirral University Hospital Trust, Annette Roberts, Voluntary and Community Action Wirral, Andrew Crawshaw, NHS England, Deborah Veevers, Department for Work and Pensions, Anthony Hassall, Director of Strategic and Organisational Development NHS Foundation Trust.

64 **MINUTES**

Resolved – That subject to the amendment that Councillor Chris Jones declared a personal interest by virtue of her employment with the Cheshire and Wirral Partnership NHS Foundation Trust not as a Governor as stated, the

accuracy of the Minutes of the Health and Wellbeing Formal Board held on 17 September, 2014 be approved as a correct record.

65 **ORDER OF BUSINESS**

The Chair agreed to vary the order of business.

66 **UPDATE ON RESPONSE TO BETTER CARE FUND SUBMISSION**

Ms Jacqui Evans, Department of Adult Social Services attended the meeting and provided members with an update on the Better Care Fund's Re-submission. Confirmation had been received that the re-submission had been "Approved with Support" and the Local team had been given full responsibility for its BCF budget. Ms Evans outlined the overall findings which included the comment "Strong plan which was ambitious & well structured. Wirral has the highest emergency admission rate in the country and we thought this was reflected in their stretch ambition which goes beyond the 3.5% required." The report also showed Wirral's position within the National position and set out the next steps. Appendix 1 to the report – the performance baseline and current performance 2014/15 was circulated at the meeting.

Members commented on the report and Jacqui Evans responded to members questions. Dr Pete Naylor, Wirral CCG noted that Wirral's submission was only one of five in the country that had been approved and this was a significant achievement. Richard Freeman commented that he looked forward to its implementation. Councillor Phil Davies observed that the Health & Wellbeing Board clearly needed data's and asked for future reports to include information on how outcomes were improving. Councillor Phil Davies thanked Ms Evans for the update and she advised the Board that she would be happy to spend time with individual members of the Board if there were any details of the report that needed clarification.

Resolved – That;

1. **the draft Better Care Fund submission be approved.**
2. **the performance baseline and dashboard be noted.**

67 **NHS ENGLAND UPDATE ON WINTER PLANNING AND FLU PLAN.**

Richard Freeman, NHS England, attended the meeting and gave members an update on winter planning and flu plan. It was reported that a resilience group had been set up, data flows were being tested and there had been a recent improvement in performance. His report gave details of Pandemic Flu Planning and the Seasonal Flu Campaign. The focus was on improving the flu vaccine uptake for vulnerable groups through GP groups including vaccines to women during pregnancy. Figures for October were currently awaited.

Resolved – That the report be noted.

68 **UPDATE ON CHILD SEX EXPLOITATION IN WIRRAL**

Simon Garner, Corporate Safeguarding Manager, attended the meeting and presented a report that provided the Board with an update on Child Sex Exploitation in Wirral.

The report was written following the enquiry into Rotherham Metropolitan Borough Council by Professor Alexis Jay, published in August 2014. It was an outline of the issues arising from the Rotherham Enquiry. It provided details of work that was already taking place to address Child Sexual Exploitation (CSE) in Wirral, and planned future work. It included a proposal with regard to how the Local Safeguarding Boards and the Health and Wellbeing Board worked together.

The Board considered the report and the proposed protocol that concerned how the Local Safeguarding Boards and the Health and Wellbeing Board worked together in relation to safeguarding issues, such as CSE.

It was reported that Child sexual exploitation was tackled effectively when there was clear and committed leadership and where safeguarding professionals cooperated together. In Wirral direction was provided through the Local Safeguarding Children Board and a regional approach to strategic partnership working. The report set out a plan of action, delivered with key partner agencies, to identify and support young people at risk of CSE. It also explained the range of responses and services that were provided and how greater engagement of the community would support early identification of the risks.

The report by Professor Alexis Jay estimated that 1,400 children had been sexually exploited in Rotherham between 1997 and 2013. Professor Jay's report had described the level of abuse as 'appalling' and said it included the rape of girls as young as 11 by large numbers of male perpetrators.

In response to the report Alan Wood, the president of the Association of Director's of Children's Services, had stated that:

"The publication of the Independent Inquiry into Child Sexual Exploitation in Rotherham this week must serve as a call to action for all safeguarding partners to ensure that that the voices of children, young people and their families raising similar concerns in the future are both heard, believed and acted upon and that the necessary help and support is provided when they need it most".

Professor Jay's report had made 15 recommendations and members were informed that the full recommendations could be found in her report and all of which had been considered in developing an action plan for Wirral.

Within Professor Jay's Report, reference was made to the former Director of Public Prosecutions, Keir Starmer, who had revised the Crown Prosecution Services guidance on child sexual exploitation in October 2013. The guidance had been revised to include a list of stereotypical assumptions previously thought to undermine the credibility of young victims.

Members gave consideration to Key Strategic Partnerships, the current position within Wirral Council and the actions developed in response to the Recommendations from the Rotherham Enquiry. The Protocol for the relationship between the Wirral Health and Wellbeing Board (HWB), the Wirral Safeguarding

Children Board (WSCB) and the Wirral Safeguarding Adults Partnership Board (SAPB) was attached as an appendix to the report.

Members of the Board thanked Clare Fish and Simon Goacher for the report and it was;

Resolved – That;

1. the progress to date be noted.

2. the proposed protocol concerning how the Local Safeguarding Boards and the Health & Wellbeing Board work together in relation to safeguarding issues, such as CSE, be agreed and signed on behalf of the Health & Wellbeing Board by the Chair, Councillor Phil Davies, and be reviewed on an annual basis.

69 **WIRRAL'S PHARMACEUTICAL NEEDS ASSESSMENT (PNA): UPDATE ON PROGRESS AND TIMESCALES.**

The Board considered a report that summarised the progress to date towards the publication of Wirral's Pharmaceutical Needs Assessment (PNA) and proposed a timescale for the statutory consultation period.

Fiona Johnstone, Director of Public Health presented the report and gave an outline of Pharmaceutical Needs Assessments (PNAs) that were carried out to assess the pharmacy needs of the local population. The PNA presented an overview of local pharmaceutical service provision; reviewing access, range and adequacy of service provision and choice of provider to build on the sectors capacity and capability to help address health inequalities and support self-care in areas of greatest need.

It was reported that NHS England would rely on the PNA when making decisions on applications to open new pharmacies. The Board were informed that each Health and Wellbeing Board must publish its first pharmaceutical needs assessment by 1st April 2015. Wirral's current PNA could be accessed at www.info.wirral.nhs.uk/pna.

Fiona Johnstone gave the Board a progress update and informed members that a draft PNA had been developed under the direction of Wirral's PNA Development Group (including members from Public Health, Local Pharmaceutical Committee and NHS England). This group had reported directly to Wirral's JSNA Executive Group. Information sources for the PNA had included Wirral's JSNA, NHS England, Census data, Health & Social Care Information Centre (HSCIC), service user and community pharmacy questionnaires. A total of 1,192 responses had been received from the public survey. From Wirral's 94 community pharmacies, 89 had responded to the pharmacy survey.

The Board was reminded that it was obliged to ensure a minimum 60 day pre-publication consultation period. Groups to be consulted would include community and hospital providers, local pharmacies, Clinical Commissioning Group, Local Medical Committee, Local Pharmaceutical Committee, local Healthwatch, NHS Trusts and Foundation Trusts, other professional bodies, voluntary and community groups, patients and the public. It was proposed that the consultation for Wirral's PNA be commenced on the 3rd November 2014 through to 12th January 2015. Following this

period, the revised PNA would be brought back to the Health and Wellbeing Board in March 2015 for final sign off prior to publication by 1st April 2015.

Resolved - That;

1. the progress to date be noted.

2. the proposed timescales for consultation be approved.

70 **UPDATE ON CHILDREN & FAMILIES ACT**

Julia Hassall, Director of Children's Services, presented an update on the Children and Families Act 2014. She focussed on 4 key elements; Part 1: Adoption and contact, Part 2: Family Justice, Part 3: Children with SEN or Disabilities and Part 5: Welfare of Children and how these relate to Wirral. In relation to Adoption and Contact, the Board were informed about the details of legislation that had been put in place from 25 July, 2014 that focussed on Fostering for Adoption, helped to reduce delay and on earlier decision making and identifying a likely match for a child. It also identified the small number of children with specific adopters being considered.

The Board was also informed that the key points of the legislation were that the permission of the Court was required before expert evidence could be given. There was now a 26-week time limit re Care Proceedings and when considering a child's care plan and it was reported that in Wirral 26 weeks had been achieved in October – an improvement from 32 weeks. The Court only considered matters essential for permanence provisions, i.e. whether the child was to live with a parent, a member or friend of the child's family, or whether the child was to be adopted or placed in other long term care. Other local responses to the legislation included the LAAM process being strengthened (Legal Advice and Action Meeting) and new Legal Issues Meetings- which tracked and addressed issues as they arose, the duties relating to the support of SEN pupils and also that former looked after children would be able to "stay put" with their foster carer until they were 21 years old.

Regarding changes to SEND legislation it was reported that the Act introduced far reaching changes to how local authorities and partners respond to children and young people with special educational needs and / or disabilities. The Act placed a stronger emphasis upon children and young people's wishes and feelings, meeting their aspirations and set out how children and young people must be at the centre of all planning for them. From 1st September Council's were required to publish their Local Offer, a directory of services available, implement new Education, Health and Care (EHC) assessments and plans (replacing Statements of Special Educational Needs) and have a process in place for converting existing Statements into the new EHC plans. There were other provisions regarding personal budgets and the implementation of new mediation processes. There were new duties to promote integration between Health and Social Care where this would promote wellbeing and the legislation set out the Health duties between local authorities and clinical commissioning groups.

There was now also a requirement to have a "virtual school head" and it was reported that in Wirral there were two "virtual school heads".

Resolved – That Julia Hassall, Director of Children's Services, be thanked for the presentation.

71 **CARE ACT IMPLICATIONS - UPDATE ON PROGRESS AND EMERGING PLANS**

The Board considered a report of Graham Hodkinson, Director of Adult Social Services that highlighted the key changes that would have a significant impact on Wirral Council from April 2015. It built upon the earlier Cabinet report and previous papers to CESG that set out the key legislative changes that the Act brought by setting out emerging plans based on capacity requirements to meet the increased demand anticipated as a result of these changes.

The Director of Adult Social Services also shared a short animation presentation with the Board http://www.skillsforcare.org.uk/Standards/Care-Act/Care-Act.aspx that linked with the report and gave a summary of the key elements of the implementation of the Care Act.

It was reported that on 14 May 2014, the Care Bill had received Royal Assent and become the Care Act 2014 ("Care Act"). This would come into effect on 1 April 2015 apart from the funding reform elements, which were scheduled to come into effect on 1 April 2016. Implementation depended heavily upon regulations and guidance for detail. The 2015 regulations and guidance had now been published along with cost estimates from the new burdens associated with the Care Act. These needed to be understood and provision needed to be put in place to meet the new demands. Consultation on the 2016 regulations and guidance was scheduled to take place at a later stage.

The Care Act legislated to provide social care protection and support to the people who needed it most, and took forward elements of the government's initial response to the Francis Inquiry, to give people peace of mind that they would be treated with compassion when in hospital, care homes or their own home. The Care Act brought together existing care and support legislation into a new, modern set of laws which would build the system around people's outcomes and wellbeing.

The Care Act aimed to reform the care and support system into one that:

- Focused on people's wellbeing and support to help them remain independent for as long as possible.
- Introduced greater national consistency in access to care and support.
- Provided better information to help people make choices about their care.
- Would give people more control over their care.
- Improved support for carers.
- Improved the quality of care and support.
- Improved the integration of different services.

The Care Act aimed to establish a new legal framework for Adult Social Care, putting the wellbeing of individuals at the heart of care and support service. The Government believed that the Care Act marked the biggest transformation to care and support law in over 60 years. It was intended to replace over a dozen separate pieces of legislation relating to Adult Social Care with a single modern law. It aimed

to put people more in control of their own lives and to reform the funding of care and support to ensure that:

· Everyone would receive the care they needed and that more support would go to those in the greatest need.
· The unfairness and fear caused by unlimited care costs would be ended.
· People were protected from having to sell their home in 'their lifetime' to pay for care.

Given these changes, it was reported that the Care Act outlined the most significant change in Adult Social Care in decades with changes to underpinning legislation, eligibility criteria, funding, changes to the status of Adult Safeguarding and a host of other associated areas.

The report also set out the implications for Wirral regarding capacity. The Director reported that the Council would need to consider the implications of the changes arising from the new legislation. Some of the key issues that the Council would need to address were set out as:

· Understanding the implications for the Council of a national eligibility framework.
· The implications for assessment and care management staff with a move to proportionate assessments with an 'asset based' approach i.e. enabling people to determine the best way in which their needs can be met utilising their own resources, with any additional support being provided via the Local Authority.
· The need for clear information about self-funders; not just in care homes but also those with eligible needs who were purchasing community based support services, who would be entitled to an assessment of need, support plan and annual review.
· Increased demand for assessment relating to full fee payers could lead to some delays in placement depending upon frequency of that demand.
· Gaining an understanding of the new processes that will need to be put in place for the provision of 'care accounts' including:
- Financial assessments of self-funders
- The monitoring of self-funders' eligible care costs, based on what the Local Authority would pay for the care i.e. 'reasonable cost', not on the amount the self-funder was paying
- Production and provision of 'care account' statements for self-funders
· Assessing the financial implications of the cap on care costs and of an increase in the upper threshold for financial support from the Local Authority.
· Awareness of those people, including carers, who had unmet needs who would be eligible for social care services.
· An understanding of the numbers of carers who would be entitled to an assessment, to support planning where relevant.
· The financial implications of extended carers' support services – which will be non-chargeable.
· The implications arising from the responsibility of ensuring there were sufficient preventative services which delay people's need for long term care and support.

· The development of processes to recover costs for meeting a person's eligible needs where funding responsibility lay with another Local Authority.
· The resource implications of extended responsibilities in relation to transitions from children to adult services.
· The implication of extended responsibilities to provide written information and advice to people with non-eligible needs on what could be done to prevent or delay the need for care and support.

The Director of Adult Social Services commented that the emphasis would be on people finding out for themselves and the Council would therefore need to find new ways of reaching out to people.

There was also an expectation set out in the Care Act that adult social care wouldl increasingly integrate services with local health partners. This had been considered alongside the Better Care Fund (BCF). There was a requirement for this to be fully reflected in the Section 75 Pooled Budget with the Clinical Commissioning Group (CCG) for 2015/16.

The report also outlined resource implications for the Council and an appendix to the report set out Wirral Council Funding allocations for the Care Act and a further appendix set out the initial Care Act Programme board profile.

Resolved – That;

1. the appointment of a programme lead using the implementation grant be supported.
2. the principle of using new responsibilities funding in the manner outlined in the report be noted and supported.
3. the level-off risk to the Council be noted and the programme governance framework as suggested in the report be supported.
4. the Director of Adult Social Services be thanked for the report.

72 QUARTERLY SUMMARY OF HEALTH WATCH

Mr P Davies, Chair, Healthwatch Wirral, gave an update to the Board and responded to Members questions. The report outlined the services covered by Healthwatch, its main functions and achievements. It was reported that volunteers had identified that not everyone was aware who Healthwatch was and the report referred to its Outreach programme, including One Stop Shops, presence in GP surgeries and the proposed desk at Arrowe Park and Tesco Community. The report also contained recommendations for the Health and Wellbeing Board recommending that agendas should be set with future plans in mind and Healthwatch's concern for future funding and consistency for local Healthwatch's.

Resolved – That the report be noted and Phil Davies be thanked for the update.

73 FOR INFORMATION

The Board gave consideration to items that had been included in the agenda for information;

- NHS Five Year Forward View
- Public Health England From evidence into action; opportunities to protect and improve the nation's health.

Resolved – That the items be noted and returned to in future meetings of the Health and Wellbeing Board.

74 **KEVIN CARBERY**

Councillor Phil Davies,Chair, referred to the impending departure of Kevin Carbery, Business Manager, Public Health who was leaving on Friday 14 , November, 2014. The Chair acknowledged the great help and support he had been to the Health and Wellbeing Board and on behalf of the Board offered him sincere thanks and very best wishes for the future.

75 **DATE OF NEXT FORMAL BOARD MEETING**

The next meeting of the Formal Board was to be held on Wednesday 1 March, 2015 at 4:00 pm, Committee Room, Town Hall, Wallasey.

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WIRRAL COUNCIL

WIRRAL HEALTH & WELLBEING BOARD

15 APRIL 2015

SUBJECT:	***HEALTH & WELLBEING PEER CHALLENGE***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***DIRECTOR OF PUBLIC HEALTH***

1.0 EXECUTIVE SUMMARY

1.1 Wirral Health & Wellbeing Board took part in a Peer Challenge process during 26th-29th January 2015. The Peer Challenge is the Local Government Association's health and wellbeing system improvement programme, co-created with a number of national organisations (e.g. Department of Health, NHS Confederation, Public Health England).

1.2 During the four days of the visit the Peer Challenge team ran 42 sessions and met with 84 people to support their understanding of five headline questions. The membership of the Peer Challenge team, and the key questions are provided in Appendix 1. While feedback was given through a presentation shortly after the visit, Wirral Health & Wellbeing Board has received the letter in Appendix 1, which details the main findings from the review, and the key recommendations. The Board is now required to receive this letter and consider its next steps in response to the recommendations made.

2.0 BACKGROUND AND KEY ISSUES

2.1 Wirral Health & Wellbeing Board has already recognised the need to review the way it works and its areas of focus, together with the need to refresh the Joint Health & Wellbeing Strategy. A development session in mid-January determined the willingness of all partners to re-frame the Strategy and to identify priorities for action.

2.2 Key recommendations from the report identified a need for a clear vision, with a narrative for Wirral, together with effective programme management and communication with wider stakeholders as critically important. In addition, the Peer Challengers recommended that the partnership structure on Wirral is reviewed and the place of the Health & Wellbeing Board is clarified along with other partnerships and working groups that exist. This is particularly important with the fact that the Local Strategic Partnership no longer meets.

2.3 An additional recommendation identified the importance of determining the relationship between Healthwatch, the Families and Wellbeing Policy & Performance Committee and the Health & Wellbeing Board.

2.4 A significant component of the peer review feedback focussed on the need for a clear narrative and strategic direction for the board. This paper proposes a single vision statement and draft set of strategic aims for the board. The option suggested is that the board adopts the following vision statement (taken from Wirral Council's Corporate Plan 2014-16) as a starter for the strategic narrative as this is generally perceived to incorporate all of the major partner aspirations:

"Wirral will be a place where the vulnerable are safe and protected, where employers want to invest and local businesses thrive, and where good health and an excellent quality of life is within the reach of everyone who lives here."

2.5 A piece of work has recently been undertaken to identify the key themes within the vision statements of key partner organisations. These were pulled together under common headings. From this work, a number of draft strategic aims have been listed below which could accompany the overarching vision statement.

1. *We want to make Wirral a place where people are not disadvantaged by where they live, who they are or the circumstances they were born into.*
2. *We do not want any child in Wirral to live in poverty.*
3. *We will support Wirral residents to do as much as possible to keep themselves healthy, manage their own health basic health conditions and live long, fulfilling lives.*
4. *We will provide high quality care that is safe, effective and good value for money. This will include making the most of new technology wherever possible.*
5. *We want people to receive the right support at the right time at a place convenient to them. This will include providing more care in community venues rather than in hospital.*
6. *We will continue to make sure that hospital and specialist care (for those that need it) is appropriate, safe and effective.*

2.6 As previously discussed, all of the above would be underpinned by a set of principles that the HWB would also sign up to. Principles would include conducting appropriate engagement and consultation, basing decisions wherever possible upon sound evidence.

2.7 Once agreed, the strategic aims would then lead into a discussion about objectives for the board. In setting its objectives, the board would need to refer to the preferred way forward that was agreed during its recent development sessions (e.g. limiting the number of objectives, focussing on making a difference and on the added value of the HWBB).

For example, under the strategic aims 3,1and 4, the board might decide that for 2015-16 it will ensure delivery of the 'Know Your Numbers' hypertension campaign in order to drive down high blood pressure (a major risk factor for serious illness and death). Such a programme could provide a platform for practical joint action across all partners.

Another potential objective for the board (which is strongly linked particularly to strategic aims 6, 5 and 3) would be to deliver the integrated primary and acute care system (PACS) as set out in the newly-awarded 'Vanguard' proposal.

3.0 RELEVANT RISKS

3.1 Without an agreed single vision, the board will be unable to perform its statutory function and will be unable to act upon the recommendations of the peer review.

4.0 OTHER OPTIONS CONSIDERED

4.1 The proposals in this paper represent a 'starter for ten' and as such, can be adapted to suit the board's purpose.

5.0 CONSULTATION

5.1 The proposals within this paper have resulted from January's peer review which involved a large amount of consultation and engagement with key partners. Once a single vision, strategic aims and associated objectives have been agreed by the board, this would form the basis for further engagement with the local community.

6.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 Voluntary, community and faith groups will play a crucial role in the delivery of the board's aims and objectives.

7.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

7.1 These would need to be discussed following agreement of strategic direction and associated objectives

8.0 LEGAL IMPLICATIONS

8.1 None at this stage

9.0 EQUALITIES IMPLICATIONS

9.1 Has the potential impact of your proposal(s) been reviewed with regard to equality?

(c) No because of another reason which is:

Equality impact will need to be conducted once action plans are in place.

10.0 CARBON REDUCTION IMPLICATIONS

10.1 None at this stage

11.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 None at this stage

3.0 RECOMMENDATION/S

3.1 *The Board is asked to note the feedback letter from the Peer Challenge Team, and to agree the next steps for action against the recommendations.*

3.2 *The Board is asked to consider, comment on, and approve the vision and strategic aims for Health & Wellbeing in Wirral.*

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APPENDICES

Appendix 1: Letter from Peer Challenge Team
Appendix 2: Next steps for recommendations

Local Government Association

Councillor Phil Davies, Leader of the Council & Chair of the Health and Wellbeing Board
Wirral Council
Wallasey Town Hall
Brighton Street
Wallasey
Wirral CH44 8ED

7th February 2015

Dear Councillor Davies

Health and Wellbeing Peer Challenge 26th – 29th January 2015

On behalf of the peer team, I would like to say what a pleasure and privilege it was to be invited into Wirral Council to deliver the health and wellbeing peer challenge as part of the LGA's Health and Wellbeing System Improvement Programme.

This programme is based on the principles of sector led improvement that:

- Councils are responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people in their area
- Councils are primarily accountable to local communities (not government or the inspectorates) and stronger accountability through increased transparency helps local people drive further improvement
- Councils have a collective responsibility for the performance of the sector as a whole (evidenced by sharing best practice, offering member and officer peers, etc).

Challenge from one's peers is a proven tool for sector led improvement. Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Wirral Borough Council were:

- Rob Walsh, Chief Executive, North East Lincolnshire Council
- Cllr Iain Malcolm, Leader, South Tyneside Council
- Dr Graham Jackson, Clinical Chair, Aylesbury Vale Clinical Commissioning Group, Vice Chair Buckinghamshire Health and Wellbeing Board

- Ben Barr, Senior Clinical Lecturer in Applied Public Health Research, Department of Public Health and Policy; Institute of Psychology, Health and Society; University of Liverpool
- Phillip Woodward, Chair - Local Government Reference Group, NICE Trustee - Royal Society for Public Health,
- John Tench, Adviser (Healthwatch), Local Government Association
- Kay Burkett, Programme Manager, Local Government Association

Scope and focus of the peer challenge

The purpose of the health and wellbeing peer challenge is to support councils in implementing their new statutory responsibilities in health from 1st April 2013, by way of a systematic challenge through sector peers in order to improve local practice. It also supports health and wellbeing boards become more confident in their system wide strategic leadership role; have the capability to deliver transformational change; through the development of effective strategies to drive the successful commissioning and provision of services; and to create improvements in the health and wellbeing of the local community.

Our framework for the challenge was five headline questions:

1. Is there a clear, appropriate and achievable approach to improving the health and wellbeing of local residents?
2. Is the Health and Wellbeing Board (HWB) at the heart of an effective governance system? Does leadership work well across the local system?
3. Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?
4. Are there effective arrangements for evaluating impacts of the health and wellbeing strategy?
5. Are there effective arrangements for ensuring accountability to the public?

You also asked us to comment on the following:

- Is there a clear, appropriate and achievable approach to improving the health and wellbeing of local residents and tackling health inequalities?
- Is the work of the Board leading to improved outcomes for local residents?
- Has the Board got the balance right between a focus on action to tackle the wider determinants of health and the reform of the health and social care system?
- Is the Board adding value to local work? Is it focussed on the major issues to improve health and wellbeing for local residents and has it got a grip on the actions required?
- Are the relationships between the Board, Vision 2018, Better Care Fund, Constituency Committees plus other partnership groups clear and understood?

- Are we maximising opportunities to promote prevention and self-care and deliver a shift in demand for high cost services?
- How should the Board develop its relationship and profile with local communities?

Responses to these questions have been woven into the five methodology questions with a separate focus on health inequalities.

It is important to stress that this was not an inspection. Peer challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material they read.

This letter provides a summary of the peer team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the peer challenge team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress Wirral Council and its Health and Wellbeing Board (HWB) have made whilst stimulating debate and thinking about future challenges.

Headline Messages

Wirral is emerging from a difficult set of challenges. You are determined to improve the quality of life and experiences of residents, that is abundantly clear. You are not alone. The challenges you face across the health economy present an ideal opportunity to galvanise the collective and positive intent, foster key relationships and work together to focus on better health and wellbeing outcomes for your residents and communities. Your Health and Wellbeing Board could be placed at the heart of this. Willingness by partners to work together is a springboard for going further and faster towards achieving the Wirral ambition

We have seen and been told about a host of good things happening on the ground, across the health and wellbeing system. There is good work happening for 'Place' and good work for 'People' but they need to be more connected. In addition, for this good work to have long term, sustainable impact, you require a more strategically coherent approach to tackling health inequality in Wirral. With both the Council and the Clinical Commissioning Group (CCG) emerging from periods of turbulence, this presents an ideal opportunity to recalibrate this key strategic relationship and work more cohesively with partners in the public, private and voluntary sectors.

The peer challenge team met with a lot of highly motivated and caring people from across the health and wellbeing system in Wirral. People across the piece were passionate about their work and wanted to make a difference in reducing the inequalities that exist. We found there to be strong desire and commitment to improving health and wellbeing outcomes for your communities.

The Council's challenges are the area's challenges. The area's opportunities are the Council's opportunities. This should provide a strong foundation to agree, with partners, a compelling narrative that describes the Wirral of the future to provide a clear direction and to harness your capacity. To achieve this be clear about how the health and wellbeing system can move from where it is now to where it needs to be, and use this to further engage staff, providers, partners and the community. If Wirral is to move forward then collective focus, prioritisation, courage and bravery will be essential. Seize this opportunity.

1. **Is there a clear, appropriate and achievable approach to improving the health and wellbeing of local residents?**

There was evidence of good community engagement in the development of the Joint Strategic Needs Assessment JSNA and the Joint Health and Wellbeing Strategy (JHWS). The 'Spotlight On' sessions have helped to raise awareness of some of the key challenges relating to the wider determinants of health and together they provide a good picture of Wirral and the health and wellbeing needs of the local population. However, in order to understand whether what the refreshed JHWS is saying is actually having the impact the system wants, there is an absolute need to have a single and integrated performance management framework to inform and serve the HWB, scrutiny committee and other partners.

Vision 2018 has clear strategic outcomes with a strong case for change for the health and social care economy e.g. stretch ambition within the BCF to reduce emergency admission rate. The focus on a number of projects e.g. Tackling Health Related Worklessness, with strong commitment from partners, and the investment approach by Public Health on place based alcohol issues and healthy eating has emerged from the Vision 2018 work. This multi organisational approach can be built upon in the refreshed JHWS to tackle the wider determinants of health, including housing, transport and regeneration to accelerate your ambitions to reduce health inequalities and focus on the causes of preventative conditions and early intervention.

The HWB works well through the Children's Trust and has established it as workstream under the board. Clear outcomes for children have been agreed to inform the Early Years Strategy and work on child poverty, for example, through the School Hubs initiative.

There is a growing awareness of the importance of harnessing the strengths of local people, organisations and services to support people so that they are able to look after themselves where this is appropriate and to prevent escalation of health issues. There is recognition of the need to build greater community resilience to meet needs in a sustainable way, within the context of reduced public resources. Better use of your vibrant, engaged and skilled voluntary and community sector will help accelerate tangible outcomes by building on the successes of existing projects e.g. Youth Fishing volunteers, The Quays peer led recovery service and outreach support for homeless people.

A focus on key challenges, like the higher than national average number of overweight children living in Wirral's most deprived social economic wards, has resulted in important developments e.g. the Takeaway for a Change project developed and delivered by Environmental Health Practitioners. This innovative healthy eating programme aimed at educating and guiding consumers and business owners, with over 200 families participating and nutritional analysis provides an excellent model in evaluating what works in tackling health inequalities and to inform what could be scaled up.

There are varying degrees to how partners currently make use of the JSNA and their view of it. The voluntary and community sector use the JSNA to align priorities and help with access to the Innovation Fund. Revitalising the JSNA to inform the refresh of the JHWS and other strategies will help ensure it is being used by all partners to agree the right focus between short and longer term priorities. The JSNA Executive Group could oversee this as part of a widen remit of communication and engagement of the JHWS and the work of the board, building on the successful methods already in place e.g. JSNA website and bulletins.

The HWB has learnt from its first two years and is using this to consider the focus of the JHWS going forward and the importance of getting greater ownership of its implementation. As well as giving high-level strategic direction the board needs to ensure there is a sense of responsibility for outcomes and for the resilience of the system. Build upon the programme and project management approach within Vision 2018 to help achieve this.

2. Is there a clear approach to tackling health inequalities?

There is high-level recognition of health inequalities as a major issue for the borough. The current JHWS clearly outlines the strong contrast between the older, highly urbanised areas of Birkenhead and Wallasey, which contain some of the poorest communities in England and the wealthier commuter settlements in the west of Wirral. Everyone we met was clear that the priority of the HWB is to address the variations of 12.4 years in life expectancy for men and 10 years for women between the most deprived neighbourhood and the most affluent, less than six miles away.

The Leader and Cabinet are strong champions for action on health inequalities. They recognise the importance of utilising the whole range of energies, ideas, talents and expertise the system has to offer in order to tackle underlying causes of complex social and clinical challenges. Rethinking services to put the user at the centre of integrating services to improve quality and value for money will require system leadership beyond traditional joint working. It is essential that the strong commitment from the CCG and other key stakeholders is maximised to address the structural, material and relational barriers to individuals and communities achieving their potential and significantly contribute towards tackling health inequalities.

The neighbourhood delivery of services around the four Constituency Committees is starting to enable better targeting and adaption of resources to

address local needs. The Committees are developing 3 – 5 year plans based on the Council's Corporate Plan and Vision 2018 which could provide a very strong platform for tackling health inequalities. Each Constituency has a dedicated Manager and Engagement Officer to co-ordinate services, they work closely with community and voluntary organisations and resources have been devolved to support local initiatives.
The JHWS emphasises the importance of bringing people together to find the right solutions to the issues and challenges in their communities. This approach is starting to help identify the assets in Wirral that have the greatest potential to promote health and wellbeing. However, in going forward it will be important to align use of these assets with the intentions of partners, e.g. the CCG Strategic Plan, in order to better co-ordinate future models of delivery and neighbourhood working e.g. children's services and outpatient activity, as part of a whole system approach to prevention and reducing health inequalities.

Innovative work with the Fire Service has enabled an impressive system for identifying vulnerable households for targeted activity. Linked data across MFRS WBC's Revenue & Benefits department, the Department of Adult Social Services (DASS) and Magenta Living have been used to create a 'Vulnerable Person's Index'.

Many partners, particularly the third sectors, feel well engaged with the JSNA, both feeding information in about clients' needs and using data to inform their priorities. Optimising the JSNA process, local intelligence and expanding best practice on data sharing will support early identification of people at risk and target prevention. Developing a plan for data sharing across the partnership that can feed into the JSNA would support timely and relevant analysis for all partners to help decision-making and guide commissioning across health and local government.

Action on health inequalities is not yet embedded to be everyone's business, both across Council departments and the wider partnership. Health inequalities is in the main seen as being the job of the public health team and health inequalities is not a major feature in the language of partner organisations. More could be done to enable the engagement and influence of public health across the Council to address the wider determinants of health, such as housing, planning, regeneration, environment, leisure. This is progressing but remains largely on a project-by-project basis.

Find the capacity to support the strengthening of relationship at all levels between the Council and the CCG, not just with public health.. The compelling narrative describing the vision for Wirral must be meshed in strategic plans and form the basis for closer working to make an impact on the life-expectancy variations across the Borough.

The Public Health innovation fund could be built upon to drive public health action across other sectors. Rather than investing in individual projects part of the public health grant could be used across Council directorates to influence core activity on the social determinants of health. This needs to include a systematic health impact assessment process to ensure all relevant policies decisions and investments contribute to health improvement and agreements that commit each directorate to delivery against the Public Health Outcomes Framework (PHOF). The goal should be to influence core spend across each sector and not just performance monitoring of the additional investment from the public health grant.

It is not clear how investment and disinvestment is occurring over the life course. Good progress has been made on the integration of support for the elderly, some progress is now being made for children, however, there appears to be limited overview of how resources and support are connected across the life course. There is a need for a strategic lead to the coordinating and integration across the life course and managing the shift of resources to the early years that is necessary to help address health inequalities in the long-term. Use public health expertise to ensure investment across the life course reflects the evidence for action on health inequalities and clarify the roles and responsibilities of the HWB and the Children Trust to provide strategic direction.

There is a risk under the current financial constraints that resources are concentrated on support for the highest risk groups to the detriment to targeted prevention. The efficiency and effectiveness of targeted prevention services could be improved by integrating these across the health and wellbeing system. At present there are a number of separate targeted prevention services, from smoking cessation to welfare advice, with some good models of integrated support in schools. The HWB can mobilise the partnership, supported by public health expertise, to develop integrated targeted prevention across the key determinants of health (employment, financial security, health behaviours), with clear links to integrated support for higher risk groups.

3. Is the HWB at the heart of an effective governance system? Does leadership work well across the local system?

The HWB has created the opportunity for conversations between partners by being clear that its remit was to be over and above a commissioning role. Having Wirral University Hospitals Trust, Wirral Community Trust, Cheshire & Wirral Partnerships Trust and Clatterbridge Cancer Centre as members of the board from the start provides a good basis for the integration agenda to progress at pace. The board has enabled the voice of the voluntary sector to be represented by inviting Community Action Wirral to be a member alongside Healthwatch. Recent extension of the membership to include police, Merseyside Fire & Rescue and housing will help the board to tackle the wider social determinants.

The Tackling Health Related Worklessness project is a good example of a borough wide commitment to one of your key challenges. Organisational

commitment has been secured and partners are scoping out the level of detailed support that they can give to the project including Cheshire & Wirral Partnership Trust as key sponsor and DWP/Jobcentre Plus committing a 0.2 FTE staff member attachment to the Council to drive forward their engagement in the development phase of the project. Evaluating the impact of the project will be important in understanding whether this approach could be scaled up.

There is a desire by all key partners to work together to deliver improved health for local people. People are very positive and signed up to the health and wellbeing agenda but the role of the HWB is not clear. This could be addressed by developing a clear and inclusive action plan which focuses on things that only the board can do. Such a plan will enable decisions and actions on the big ticket issues of financial constraints and breaking down organisational barriers. In doing this the HWB will be better placed to deliver and monitor the outcomes the board has recognised for itself as needing to be developed or improved for the refreshed JHWS – prevention and reducing demand on services.

There is a lack of clarity about what is expected of board members, particularly those with a lead responsibility. In moving forward, we think it is important for the HWB to ensure that it can consistently hold all partners to account and not just partners external to the council. Using a programme management approach that includes outcome based action plans, lead officers, risk analysis and clear resourcing the board can receive regular project updates to monitor progress and take action when needed.

The partnership landscape is crowded with some bodies and boards competing for the same space, exemplified by the Public Service Board and the HWB, and this is impeding progress. The business of strategic 'Place' leadership needs to be coordinated from one source. You have already recognised the need to review the wider partnership arrangements. It is important to accelerate this planned review and try and streamline and clarify the relationships of the partnership landscape so that it can better support key priorities and recognise the new ways of working that are being developed through this work. The board also needs to be clear about how and where commissioning and decommissioning decisions will be made.

It is also important to find creative ways for all partners, statutory and non-statutory, to remain fully engaged and be part of the strategic debate and discussion on health and wellbeing matters. Within this create a higher profile for housing to help tackle areas of high deprivation within the Borough to create healthier communities. The opportunity also exists to position the HWB Board as the entity that is THE partnership forum that takes Wirral forward over a 3, 5, 10, 15 year journey.

Appropriate and focused statistical information is not being provided to the HWB to enable it to provide robust challenge and for monitoring of progress towards the vision. The HWB needs to ensure that the whole system is working to progress the priorities in the JHWS but also that the board itself is playing its part. An action plan derived from the JHWS which sets out the agreed role of

different constituent organisations, including the board itself, will be instrumental in keeping on track. Consideration could be given to a range of tools such as dashboards and traffic light systems to give an overview of progress and highlight problem areas which require concerted action by board members. Snapshots of performance may be broken down into individual organisations such as providers, or into themes, for example mental health.

As you move to the next level of your development you need a range of communication approaches to keep the HWB up to date on activities and progress outside of board meetings. This could be incorporated into a wider integrated communication and engagement strategy so the work of the HWB is more visible and projects and programmes on the ground can be easily aligned with the priorities of the HWB. There is recognition of the importance and usefulness of deploying a range of communication approaches, including social media, to get key messages to the public at a neighbourhood level. You will need to consider a multitude of engagement channels and systematically start linking all the community engagement that is going on across Wirral for clarity for the public and efficiency of your processes.

The HWB development sessions have been helpful for partners to explore and discuss priorities outside of formal public meetings. In order to move forward with focus and pace it is time to develop the board as a system leadership team and have some wide ranging debates about the shared single vision for Wirral and how it will be achieved. A key question for the HWB is how it can operate in a way that gives flexibility to respond to rapidly changing circumstances in achieving the vision, including; future pressures in the system, maximising opportunities for tackling inequalities from the Wirral Waters regeneration for the Birkenhead and Wallasey Docklands, and 'keep ahead of the curve'.

4. Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?

Wirral has passionate, caring and committed people at every level who demonstrate their desire to make a positive difference to the health and wellbeing of the community. We were impressed with the commitment shown to delivering the highest quality public services and improving the quality of life of local people. Developing a compelling narrative of the vision for Wirral with a refreshed JHWS will help to embed priorities in partner organisations and harness a strong sense of purpose and direction. With proactive communication and engagement about transformation and system change these collective energies can be focused on delivering the outcomes required.

The Public Health Team is beginning to influence the wider agenda and making progress in embedding into the whole business of the Council. There are many examples of public health joining and initiating projects. One of these is The Better Food Wirral project which has been successful in bidding for Systems Leadership support to tackle rising levels of food poverty by ensuring everyone can access and afford fresh and healthy food. The Health Walks and Fitness Buddy schemes is making good use of Wirral's parks to increase the

uptake of physical activity of hard to reach groups in the most deprived communities.

The Wirral Alcohol Strategy has strong 'buy-in' from partners as a result of being one of three areas of focus agreed by the HWB and is informed by people who use services. The strategy is enabling a pulling together of existing preventative resources to provide better information, advice and guidance, promotion of the Wirral Alcohol website and campaigns such as the Alcohol Awareness Week. This approach provides a good foundation for a more joined up effort in relation to preventable conditions and people being able to manage their conditions and make informed choices about their own health.

There are significant financial challenges across the system and you need to work together to address them. One of the notable anomalies we observed was that, whilst everyone was aware of the impending financial challenges, no one was really discussing it with any sense of urgency. We would therefore strongly urge you to give priority and create a safe space to have a fundamental debate about the financial situation. As the leaders of the system you need to start thinking about what you will do when you have to make severe reductions in your budget. As part of your development programme you need a safe space to discuss the reality and impact and develop your options to deal with it.

There is potential for wider data sharing arrangements building on existing arrangements e.g. the Vulnerable Persons database currently enabling prevention work across the partnership. As part of this consider how to further develop BME data to understand where there are increased health needs.

Opportunities are being missed to capitalise on a joint approach to pooling assets and resources across the system. Joint commissioning needs to be accelerated and aligned with current financial planning and strategic partnership development to secure maximum impact for resources in the context of continued austerity. Leadership needs to ensure that assets and resources beyond the Better Care Fund are considered in terms of the whole system and placed at the heart of implementing the refreshed JHWS.

5. Are there effective arrangements for evaluating impacts of the health and wellbeing strategy?

Effective scrutiny is well understood by stakeholders and the focused information sessions have helped members gain a wider understanding of key issues within the JSNA. Performance outputs are routinely reported at departmental management team meetings across the Council and quarterly performance reports (RAG rated) are presented to the Families and Wellbeing Policy and Performance (Scrutiny) Committee. However, there is evidence that the current arrangements do not provide an effective means of measuring whether the HWB is achieving the objectives is has defined in the JHWS. The HWB should adopt a clear performance framework (ideally in a form consistent with the Council's) which identifies the key objectives it is seeking to address,

timescales for implementing actions to deliver the objectives, the allocation of responsibility for delivery of actions and the accountable body which will take the lead role in monitoring progress.

You now need to consider putting in place a dashboard and delivery plan to help the HWB to manage performance against the JHWS. As part of this you need to develop comprehensive and shared metrics and consider using trends, trajectories and economic impacts. This should make it easier for everyone to understand what you are trying achieve; what you are measuring; what people need to look for in the data and understand; and what needs to develop and change as a result of it.

Individual initiatives are evaluated for reach and impact, such as drug and alcohol treatment programmes, integration approaches to hospital discharges and local initiatives delivered through the Constituency teams. However, this appears to be undertaken on an ad hoc basis without
a consistent approach in place to evaluating the impact of the health and wellbeing spend in the community. A coordinated approach to evaluation will be important when considering the scaling-up of successful projects or when investment / disinvestment decisions are required.

In the short time we were in Wirral, we could not find strong enough evidence on how you involve citizens in evaluating the effectiveness of your services and strategies. Clearly you have the base structures in place through the four Constituency Committees and Elected Members are bringing community issues to the fore and enabling the local population to engage effectively. You should use these to reach out to your diverse communities and feed the information back into the system.

Giving more attention to qualitative evidence such as personal stories of service users, patients, carers and community voices will 'bring to life' the implementation of the JHWS. This would be helped by a focus on outcomes in the JHWS that are person-centred to increase the relevance for partners and local communities

5. Are there effective arrangements for ensuring accountability to the public?

The health and wellbeing system in Wirral uses a variety of tools to engage with the public such as bulletins, questionnaires sent to homes, and holding HWB meetings in public. A consultation process was undertaken to explore the relevance and resonance of the key health and wellbeing issues as highlighted in Wirral's JSNA with almost 600 local people contributing to surveys. There is a large network of voluntary and community organisations with large memberships such as Community Action Wirral and Healthwatch Wirral that support engagement through their networks.

Operational staff are committed to public engagement to inform service delivery and consultations for service changes and commissioning were

engaged in well by the public and partner organisations. Healthwatch are invaluable in supporting the distribution and uptake of the consultations.

Consider how the HWB can create a more public friendly environment and products to support engagement and visibility. It is uncertain about what the HWB would like to engage the public for and, as a result, the format of the meetings (held only in the Town Hall) and the documents produced (large agendas and board minutes) are not conducive to easy engagement from a member of the public.

Local Healthwatch is well respected amongst peers and stakeholders within the system and is welcomed as a partner at the HWB. They have made efforts to engage seldom heard members of the community, through providing BSL translators to engage with deaf residents, and they engage well with partners in the system to raise issues. However, there is confusion from the public and partners around Healthwatch's distinct role in the system and how it differs from other organisations with similar roles.

There is a lack of clarify about the relationship between the HWB, Policy and Performance Committee (Scrutiny) and Healthwatch as well as a lack of clear understanding of what Healthwatch is expected to provide both in the system and at health and wellbeing board level. The system would benefit from a greater understanding of its role, remit, structure and organisational accountability. Developing a protocol or memorandum of understanding between the HWB, Policy and Performance Committee and Healthwatch about the respective roles of each and how they relate to each other would be beneficial.

Continue to support Healthwatch to participate in the collective responsibility of the HWB in its system leadership role as well as its role in challenging and holding the board to account in a constructive way.

6. Moving forward

In moving forward our key recommendations for the Health and Wellbeing Board are:

a. Set aside time to develop the HWB as a team and have some wide ranging debates about the added value of its purpose, the future agenda and vision
b. Develop a clear vision, with a narrative for Wirral, that encapsulates change to which the public and key stakeholders in the health and wellbeing system can relate
c. Develop a clearer forward plan for the HWB which focuses on things that only the board can do and ensure the right partners are around the table to achieve the vision
d. Further strengthen programme management by using a consistent system for data sharing, action plans, risk analysis and resourcing with project updates to the HWB

e. Develop your communication approaches which will keep the HWB, wider stakeholders and public up to date on activities and progress outside of the board meetings, ensuring a two way flow
f. Consider how the wider partnership structure functions and connects together
g. Support Healthwatch to participate in the collective responsibility of the HWB as well as its role in challenging and holding the board to account e.g. memorandum of understanding between HWB, Families and Wellbeing Policy and Performance (Scrutiny) Committee and Healthwatch
h. Scale up seamless services by bringing together frontline staff and managers to harness their creativity to roll out and upscale successful projects
i. Consider how cross sector community assets, like GP surgeries and school hubs could be used to best effect to share key messages and promote the wider wellbeing agenda

7. Next steps

The council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how the council wishes to take things forward. As part of the peer challenge process, there is an offer of continued activity to support this. If you wish to take this up then I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Gill Taylor, Principal Adviser for North West, is the main contact between your authority and the Local Government Association. Gill can be contacted at gill.taylor@local.gov.uk (or tel. 07789 512173) and can provide access to our resources and any further support.

In the meantime, all of us connected with the peer challenge would like to wish the council every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely,

Kay Burkett

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Programme Manager
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On behalf of the peer challenge team

Appendix 2: Recommendations & Next Steps

Recommendation	Next Step	Action owner(s)
a. Set aside time to develop the HWB as a team and have some wide ranging debates about the added value of its purpose, the future agenda and vision	The Health & Wellbeing Board has development sessions identified during the year which will be used for this purpose.	HWB Members Director of Public Health
b. Develop a clear vision, with a narrative for Wirral, that encapsulates change to which the public and key stakeholders in the health and wellbeing system can relate	A proposed vision is included in this paper.	H&W Board
c. Develop a clearer forward plan for the HWB which focuses on things that only the board can do and ensure the right partners are around the table to achieve the vision	The Forward Plan will be developed through identifying priorities for action under the strategy. An agenda setting group will be established to manage this.	DPH
d. Further strengthen programme management by using a consistent system for data sharing, action plans, risk analysis and resourcing with project updates to the HWB	We will seek to secure appropriate programme management support.	Decision for HWB regarding programme support structures.
e. Develop your communication approaches which will keep the HWB, wider stakeholders and public up to date on activities and progress outside of the board meetings, ensuring a two way flow	We have agreed to a half-time Communication & Engagement officer to support the Health & Wellbeing Board and the public health directorate. They will have a role in developing an appropriate action plan in response to this recommendations	DPH/ Senior Manager: Marketing & Communications Wirral Council
f. Consider how the wider partnership structure functions and connects together	A Partnership Review is underway, lead by the Policy Team at Wirral Council. Recommendations will be brought forward for consideration.	Policy and Strategy Manager, Wirral Council
g. Support Healthwatch to participate in the collective responsibility of the HWB as well as its role in challenging and holding the board to	An initial meeting to develop a protocol for effective working took place on 5th	Families & Wellbeing Scrutiny Support Officer

account e.g. memorandum of understanding between HWB, Families and Wellbeing Policy and Performance (Scrutiny) Committee and Healthwatch	December 2014. It was agreed that a further session would be arranged, but that the Health & Wellbeing Board needed to be clear about its purpose to enable the discussion to be more fruitful. A review of protocols that exist elsewhere has provided a suggested framework for a protocol for Wirral	
h. Scale up seamless services by bringing together frontline staff and managers to harness their creativity to roll out and upscale successful projects	This is an ambition of the Better Care Fund projects, and our approach to integrated Commissioning. It will be critical to effective delivery of a new Vanguard model for Wirral.	All partners
i. Consider how cross sector community assets, like GP surgeries and school hubs could be used to best effect to share key messages and promote the wider wellbeing agenda	This will be picked up as part of the Communications work identified earlier	Communications & Engagement Leads.

WIRRAL HEALTH & WELLBEING BOARD

15 APRIL 2015

SUBJECT	**Five Year Forward View – Wirral Vanguard Application**
AUTHOR(S)	**Wirral Partners[1]**

1.1 Wirral has recently been successful in bidding to be a Vanguard site for the national Five Year Forward View programme developed by NHS England. The intention of the programme is to test the models of care described in the NHSE December planning guidance The Forward View into Action.

1.2 Initially, NHSE have invited interest in four models:

- multi-specialty community providers (MCPs);
- integrated primary and acute care systems (PACS);
- additional approaches to creating smaller viable hospitals; and
- models of enhanced health in care homes.

1.3 The December guidance said that successful applicants will already have in place:

- an ambitious vision of what change local areas want to achieve to the model of care, in order to meet the needs and preferences of their local population;
- a record of already having made tangible progress towards new ways of working;
- a credible plan to make move at serious pace and make rapid change in 2015;
- funded local investment in transformation that is already agreed;
- effective managerial and clinical leadership, and the capacity and capability to succeed;
- strong, diverse and active delivery partners, such as voluntary and community sector organisations;
- positive local relationships, for example the support of local commissioners and communities; and that they will also need to show:
- appetite to engage intensively with other sites across the country, and with national bodies, in a co-designed and structured programme of support aimed at (a) identifying, prioritising and tackling national barriers experienced locally; (b) developing common rather than unique local solutions that can easily be replicated by subsequent sites; and (c) assessing progress, through a staged development process;

[1] Wirral Health Partners includes NHS Wirral CCG, Wirral University Teaching Hospitals NHS Trust, Wirral NHS Community Trust, Cheshire & Wirral Partnership Trust, and Wirral Council

- a commitment to richer, standardised data to enable real-time monitoring and evaluation of health and care quality outcomes, the costs of change, and the benefits that accrue.

1.4 The Wirral bid was submitted in partnership with three other organisations: Cerner UK Ltd (cornerstone partner in the delivery of informatics solutions and promotion population health management), Advocate Physician Partners ACO, (USA)(cornerstone partner in the delivery of modelled Accountable Care Organisation deployment and learning) and the King's Fund (cornerstone partner in the delivery of research, learning, evaluation and dissemination). A copy of the submitted application is attached to this report.

1.5 Wirral Health and Wellbeing Board partners have committed to developing a Vision for future health and social care services on Wirral since 2014. A significant amount of activity has been taking place to develop programmes and work-streams that will deliver positive services for our local population, while at the same time promoting prevention, and enabling effective demand management. The Vanguard programme provided an opportunity to integrate the ideas outlined in the Five Year Forward View with the existing approaches being developed through Vision 2018. The bid that was submitted is attached as Appendix 1.

2.0 **RECOMMENDATIONS**

2.1 The Board is requested to note the successful outcome of Wirral's application to be a Vanguard site for the Five Year Forward View, and to receive regular feedback on progress with this initiative.

APPENDIX 1: Vanguard Registration of Interest

Q1. **Who is making the application?**

(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)

This application submitted for and on behalf of the Wirral Health and Social Care Economy, in partnership with a leading international technology firm, with strong experience of delivering population health, together with an established Accountable Care Organisation operating in the United States and a leading research and evaluation organisation. Wirral University Teaching Hospital NHS Foundation Trust led this collaborative initiative.

Key participating health and social care local organisations involved include –

- Wirral University Hospital NHS Foundation Trust (cornerstone partner in the delivery of home facing specialist acute care)
- Cheshire and Wirral Partnership NHS Foundation Trust (cornerstone partner in the delivery of integrated mental health services)
- Wirral Community NHS Trust (cornerstone partner in the delivery of integrated community services)
- Wirral Clinical Commissioning Group (cornerstone partner in the delivery of reformed commissioning, contracting and payment models and GP member lead organisation)
- GPs on the Wirral are currently represented through a set of collaborative consortia. In the development of this bid a number of GPs have been engaged and have expressed strong commitment to advance their current work in integrated care by developing and implementing this plan.
- Wirral Metropolitan Borough Council (cornerstone partner in the delivery of integrated social care services and reformed commissioning, contracting and payment models)

All of these organisations already share a set of collaborative principles as part of our 'Vision 2018 programme' which aims to;

- minimise the need for hospital admission through promoting health and wellbeing and proactively managing those most at risk
- Promote integration of care to avoid duplication and fragmentation of care
- Improve health outcomes and optimise the patient experience
- Increase efficiency delivering more for less.

Key Partner Organisations to this application include –

- Cerner UK Ltd (cornerstone partner in the delivery of informatics solutions and promotion population health management)
- Advocate Physician Partners ACO, (USA)(cornerstone partner in the delivery of modelled Accountable Care Organisation deployment and learning)
- King's Fund (cornerstone partner in the delivery of research, learning, evaluation and dissemination)

Key contact for the application is David Allison, Chief Executive, Wirral University Hospital NHS Foundation Trust - David.Allison1@nhs.net or 0151 604 7002

Co-sponsor of this application is Dr Pete Naylor, Chair, Wirral Clinical Commissioning Group – Peter.Naylor1@nhs.net or 0151 651 0011

Q2. What are you trying to do?

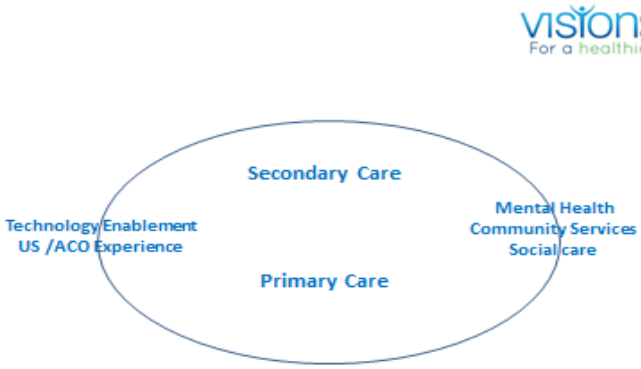
(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

Our model will catalyse a new model of integrated care on that is already being piloted through our 'Vision 2018' health economy collaboration programme, supported by a technology enabled

population health model. It will entail testing of a capitated budget approach for target population segments across primary and acute care, but with support from mental health and community providers. This will have the dual focus of reducing health inequalities while achieving costs savings through and reduced inefficiency and duplication.

We call this the *Wirral Health Partners* model, shown in figure 1 below, the innovative model is founded upon;

- The engagement of world class delivery partners.
- Integrated care shaped via learning from a US ACO
- Sophisticated integrated world class IT systems and advanced predictive analytics
- Effectively aligned integrated organisational structures
- Patient and citizen engagement and activation
- Aligned incentives



Wirral Health Partners

WIRRAL | Wirral Clinical Commissioning Group | NHS | In partnership with: Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Trust, Wirral University Teaching Hospital NHS Foundation Trust

This new model of care will reveal how – infused with leading edge information technology from Cerner and the proven experience of existing and successful ACO Advocate Physician Health partners – new ways of working and better organisational design will better fulfil the health needs of the Wirral peninsula's population. The proposal builds upon our strengths, including the highly advanced level of digitalisation, in both primary and secondary care and the tight geographical boundaries of the peninsula. We aim to test, evidence and disseminate the opportunities to be gained from an integrated approach with aligned incentives to manage improved outcomes for patients.

The Wirral peninsula, a population of 330,000 has many of the challenges seen in other areas of England with the added challenge that Wirral has the largest gap in Disability Free Life Expectancy (Marmot indicators 2012) for males and females for any authority in England (20 years for men, 17 years for women). It has a relatively high older population and relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole and the population over 85 is projected to increase by 29.9% by 2021. 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). In this regard, the Wirral provides ***an ideal test bed for the whole NHS*** for the development of new models of care, as indicated by our highly diverse range of health needs and opportunities, but with a high degree of co-terminosity of health and social care boundaries and care provision.

Recognising that existing commissioning models do not always incentivise primary and secondary care clinicians to work together to achieve efficiency or the best outcomes, Wirral clinicians are enthusiastic to test a new models which would offer the flexibility for delivery of the right care by the right person. Benefiting from the experience of Advocate Physician Partners, we propose a pluralistic

approach to the engagement with primary care. In essence this would allow interested clinicians to either work directly for the partnership on salaried basis, or to continue to act as independent contractors. We know this approach has proven successful for Advocate and one which would be attractive to a proportion of our potential GP partners. We will work with primary care partners to develop options for GP practices to engage with the integrated care partnership.

Primary care on the Wirral is already well developed and accustomed to testing new and innovative models of care. Three groups of GP consortia currently act cohesively in their approach to primary care provision and have fostered strong examples of out of hospital provision. Many are already actively involved in the current model of integrated care and are enthusiastic about the opportunities this application invites.

We understand that the supported Lead Cohorts will also need to develop and test the operational machinery required to deliver new care models. Attending the NHS England – King's Fund conference on New Care Models it was clear that there are a number of important selecting outcomes to track. Two of the most important - and not unrelated - are workforce and informatics implications. Wirral University Hospital NHS Foundation Trust is already a leader in employee engagement, evidenced through our 2014 HSJ Award. We offer that our Lead Cohort will focus on studying workforce and informatics implications to establish a framework and toolkit as we go to support the next wave of cohorts developing new care models. We will form and lead a working group across other selected Lead Cohorts to maximise learning, particularly in relation to workforce. Our partners have key strengths to contribute from an ACO with ten years' experience of workforce impact of operating a clinically integrated network.

There are strong and improving working relationships in place between health and social care partners, solidified in recent years through our Vision 2018 programme. The application offers an opportunity to strengthen these relationships even further.

The 'Vision 2018' model has developed four Integrated Care co-ordination teams in community settings, aswell as a hospital based Integrated discharge team. These provide coterminous and co-located health and social care services across the full spectrum of NHS primary, community, mental health, acute care and social care. These teams are now expediting discharge of admitted patients into home/community based settings, delivered on a locality (constituency) model and providing a local response to patients with complex needs. Our proposals will further catalyse these developments aimed at delivering a de-hospitalised model of care, reducing health inequalities and reducing costs.

Delivery partners

Fundamental to this application are the key principals of learning from international best practice, leveraging our best in class IT, and strong evaluation. The application is co-sponsored by globally-renowned delivery partners: Cerner, Advocate Physician Partners ACO, and the King's Fund.

Cerner, a global health IT leader supporting Accountable Care Organisations (ACOs) in the USA, will co-sponsor to understand the role that informatics has to play in moving to new care models and managing the health of the population against new payment models. Cerner UK have worked in partnership with the NHS for more than 25 years. During this time, Cerner UK has delivered *Cerner Millennium*® across 22 Trusts including WUTH, supporting NHS providers in the delivery of high quality care to patients, safely and cost effectively. More than 66,700 active clinicians and staff within the NHS use *Cerner Millennium* solutions to help achieve key healthcare imperatives. Trusts such as WUTH are now highly automated up to Level 6 (out of 7) on the respected HIMMS scale. Choosing a global partner that is providing local solutions enables us to mobilise learning from the International market but also will enable us to demonstrate how we can contribute to shared learning to be repeatable and scalable.

The application also leverages the existing partnership arrangements Cerner have with Advocate Physician Partners (APP) who will provide their ten year experience of bringing together more than 4,500 physicians from primary and secondary care backgrounds who are committed to improving health care quality, safety and outcomes for patients across Chicago and Central Illinois. Formed as PACS-style care management alliance between independent GPs and Advocate Health Care hospital

system, APP is a leader in population health management and has garnered wide-spread international recognition for its innovative clinical integration program. The comprehensive approach coordinates patient care across the continuum—ensuring care is delivered at the right place and at the right time. This results in more efficiency, improved health outcomes and significant cost savings for patients. We will seek learnings and advisory support for successfully setting up and managing our new care models.

The King's Fund will act as a critical friend to Wirral Health Partners throughout the programme. It will support the programme in identifying and appraising options for the new model, ensuring that it makes best use of the existing evidence. It will also help to identify and share learning from the programme. It may provide targeted organisation development support if needed. The Fund has a longstanding partnership with the Wirral, including through work with primary care providers and supporting clinical leadership in secondary care.

Wirral Health Partners model

The proposed model is built upon an intensive period of stakeholder engagement over the past 18 months under the whole health and social care transformational programme – 'Vision 2018'. This has revealed that without a new integrated approach to the delivery of health and social care, the current model of delivery will not be clinically, operationally or financially sustainable over the next five years. The partner organisations have overseen the development of Integrated care on Wirral, shaped around the parliamentary constituencies of Wirral to provide a local response to patients with complex needs. The approach introduces Integrated Care co-ordination Teams that provide a stepped approach to delivering both planned and unplanned care at home. The approach is both patient centred and responsive to a patient's health and social care needs, striving to avoid hospitalisation or to minimise length of stay. Underpinning referral into these teams is the introduction of a single integrated gateway that will channel all referrals through a managed call centre for screening and triage.

The new model – already in early use - will be further developed through:

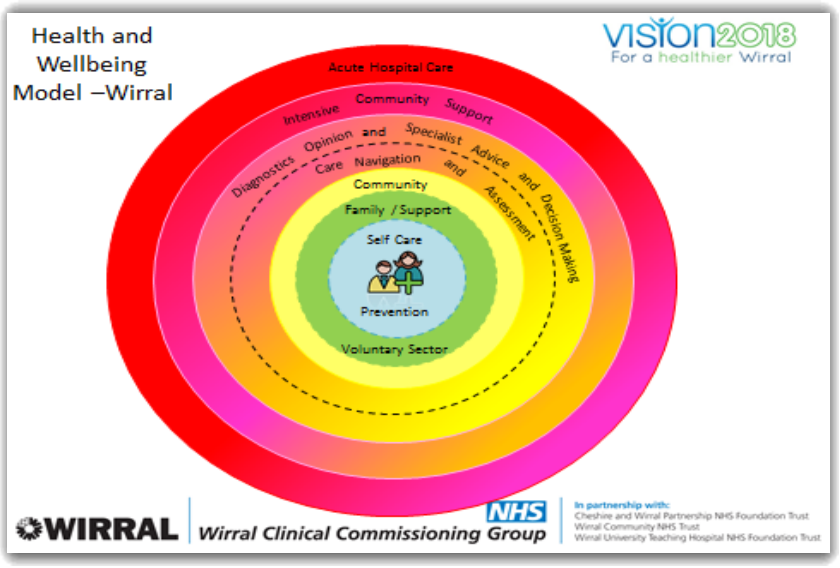
- Integrated care services
- Integrated world class IT systems and advanced predictive analytics
- Patient and citizen engagement and activation
- Aligned incentives and payment models
- Active prioritisation of future workforce planning and implications of new models of care

Integrated care services

There is joint agreement that the principles for the new model of care should be based on a model in which care is provided in an integrated fashion across primary, community and acute sectors and should span social care and connections into the voluntary and third sectors.

The focus of Wirral's health and wellbeing model (Figure 2) is person centred and describes the health and social care provision for 'Mrs Smith' and her family. It considers self-care and independence as a foundation to wellbeing and suggests timely access to public sector services, when necessary. The model describes a care navigation approach to accessing layers of provision as appropriate to individual need, which supports people to live healthier for longer.

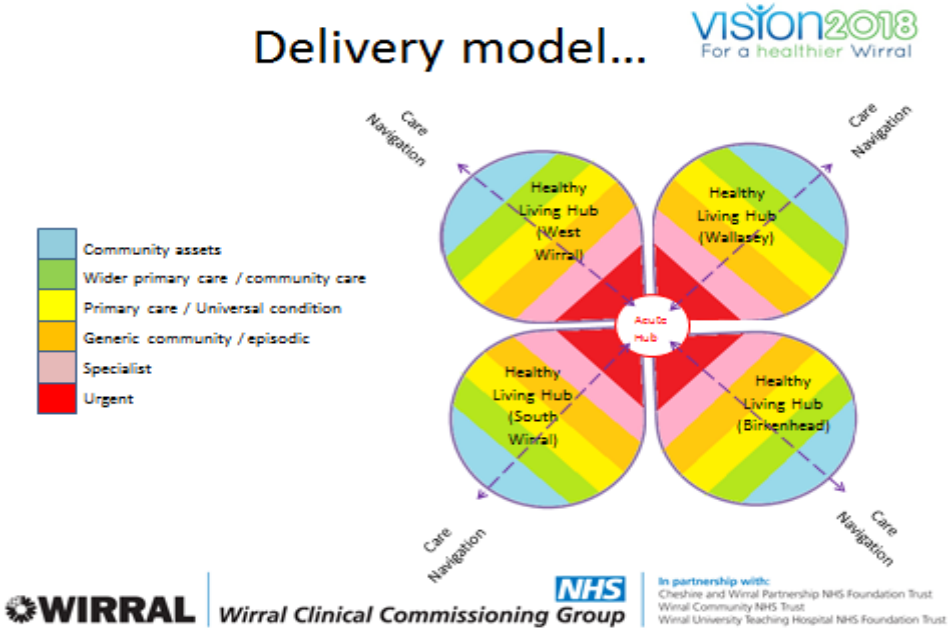
Figure 2: Health and Wellbeing Model



The delivery model is based on a geographic locality structure, linked to currently implemeted models of integrated teams across acute, mental health, community health and social care.

Through this application, the aim is to go further and there is agreement that in order to be successful we need to broaden the project to reach into primary care and community assets. Figure 3 below offers a pictorial representation of what the model will look like deployed across the Wirral.

Figure 3 – Locality Based Care – 'The Flower Model'



We will support this model by overlaying our current and well advanced digital patient record systems with a population health management approach. This would deploy a person-centred population health approach catalysed by identifying care gaps and duplications and moving to supported care navigation to deliver committed outcomes against an incremental move to a capitated budgetary approach across all care settings – maximising learning and best practice from a leading Accountable Care Organisation (ACO) in the USA.

This approach will enable the care provided in each 'petal' (healthy living hub) of the delivery model to be coordinated and monitored through a population health approach. Health and social care professionals, including GPS and hospital based consultants, will be able to provide more care outside of hospital, reduce risk of admission and enable a proactive approach to manage long term conditions.

Integrated world class IT systems and advanced predictive analytics
Critical to the success of delivering new care models is the use of informatics to ensure instant and reliable availability complete information. This was highlighted as one of the top six factors required for success in the King's Fund report[2] analysing ACO models in the context of the UK.

Compared with other health economies, Wirral has a unique level of digitisation. Primary care IT systems are well used and there has been a significant degree of standardisation across the patch. Wirral Hospital Trust has always been a leader in its approach to IT, but in recent years through its partnership with Cerner, the Trust reaffirmed its position as one of the most IT enabled hospitals internationally with the implementation of its digital health care record. ***We will deliver on the Secretary of State's 2018 commitment*** to become a paperless organisation.

Key to the development of our approach and building on the organisation specific care records will therefore be the creation of a health economy wide shared record that can underpin population health management solutions to manage new care models one person at a time. We will leverage APP's ten year history and experience in doing this; they are now on their fourth generation IT solution enabling us to leapfrog generations of learning.

The shared record will not only ensure that all staff have access to the best information to support patients care, but also provide care planning and decision support tools that promote the delivery of evidenced based care pathways across organisational boundaries. This shared system will not replace existing systems, but will integrate tightly with them. Work is already underway to ensure that this can be achieved seamlessly with EMIS, the lead supplier of GP systems in the area.

We believe that Cerner's HealtheIntent platform for population health management will also give us the firm underpinnings we need to holistically manage our patients and take on new care models such as capitated payment models. Pulling together information from all organisations information systems across the health and social care economy in real-time will enable us to optimise population health management. In particular we will be able to risk stratify the population to ensure that our interventions are focused on the right patient groups to improve health and wellbeing. The platform is built to support world-leading and published predictive analytics that can be applied in real-time - for example early detection of sepsis across a population, surveillance for diseases, 20% better prediction of readmission, and predicting which venue of care will deliver optimal outcomes past-acute care.

Patient and citizen engagement and activation
This informatics approach will be further supported by a patient empowered and digitally driven approach to personal health management, founded on mobile technology, which offers patients opportunities to understand, connect, monitor and influence their own health. Studies demonstrate that patient engagement is essential to improving health outcomes and that the lack of such engagement is a major contributor to preventable deaths. In fact, it is estimated that 40 percent of deaths in the U.S. are caused by modifiable behavioural issues, such as smoking and obesity. People

[2] Accountable care organisations in the United States and England: Testing, evaluating and learning what works. March 2014. Kings Fund.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/accountable-care-organisations-united-states-england-shortell-mar14.pdf...

with chronic diseases take only 50 percent of the prescribed doses of medications, on average. Fifty percent of patients do not follow referral advice and 75 percent do not keep follow-up appointments.

Our approach to patient engagement is crucial to quality improvement, better patient outcomes, and successful population health management. We will explore the concept of our care teams providing continuous care, promoting patient engagement between visits through a variety of technologies ranging from simple telephones calls through to smartphone based 'apps'. We will take advantage of other new technologies, such as tele-monitoring and social media, to ensure that patients are fully engaged in their own health and wellbeing.

Aligned incentives and payment models
The model would be supported by 'testing' new models of payment, particularly considering the advantages of a capitated budget approach across providers which would incentivise the new model of care to deliver services in a more streamlined way. The deployment of the population health approach is a pre-requisite to enable this remuneration to be tested. There are strong examples from the ACO models in the US and models in Australia, where business model innovation deployed together with care model innovation are both required to deliver a real step change for quality and financial benefits.

Active prioritisation of future workforce planning and implications of new models of care
We know that the NHS and our health community faces some significant challenges in respect of maintaining existing workforce models. Numbers of traditionally developed nursing and medical roles are unlikely to be able to meet demand for existing care models, let alone new models that emphasise a more proactive approach to prevention and community based care. The health community in the Wirral has been at the forefront for a number of years. We have crafted a solid programme for Assistant and Advanced Practitioners and the deployment of Apprentices into NHS roles. We know that workforce pressures and constraints are equally present in primary care and not only is a much more integrated approach to care delivery needed (through the application of the New Care Model approach) but that this also should be accompanied by much greater integration between traditional acute and primary care nursing and medical roles. We commit to using our application to fuel new thinking in respect of these new roles and to act as a workforce vanguard to ensure that this thinking can be promoted across the wider NHS.

Q3. Which model(s) are you pursuing? (of the four described)

When considering which model to pursue, it is important to note that as a health and social care economy we have prioritised developing our thinking about the type of care model we aspire to deliver without the constraint of limiting labels. It was more important for us to agree what and how the new care model would operate than to agree which model it conformed to. This has been a defining manner in securing and maintaining engagement on the core principles of better care, improved outcomes and the use of technology to encourage collaboration. It has been helpful to note from the guidance that the MCP model and PACS model have many shared attributes. This has been in line with our vision of an integrated care model which delivers care across the spectrum of primary, community and acute hospital care.

Our model clearly has an ambition which meets the core criteria of the New Models of Care programme –

- to promote the health and wellbeing of our local population
- to increase the quality of care for our patients
- to improve efficiency for the taxpayer within the available resources

Since the publication of the new care model guidance, we have reviewed the descriptions of the model.

We are confident that our model does cover many of the aspects expected of an MCP, particularly integrating out of hospital care, extending beyond primary care at scale, joining up a care record for out of hospital care, the use of digital technology to deliver a population health approach, running extended community multi-disciplinary teams and an ambition to manage a new type of capitated contract for a segment of registered patients.

In addition, given the leading role and ambition of the acute hospital provider in the development of our integrated care programme, ambitions for digitalisation and the close involvement of mental health

and social care organisations in our model, together with the ambition of our proposal to cover the entire population of the Wirral, our proposal demonstrates many aspects of the PACS model.

We are pleased that it has been recognised that local health economy might contain a combination of different models – MCP and PACS and we certainly agree that this is the case for the Wirral.

It should be noted though that given the scale of our ambition and the opportunity to develop a model covering a wide, but contained, geographic footprint, that we would want to take advantage of the support available to test the PACS model.

Q4. Where have you got to?
(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

How Wirral already meets the pre-requisites of the Five Year Forward View guidance

The Five Year Forward View indicates that applicants will already have in place:

An ambitious vision of what change they want to achieve to the model of care, in order to meet clear identified needs and preferences of their local population
The Wirral has a clearly articulated case for change within Vision 2018, which recognises the health and economic drivers for change, including addressing significant health inequality, the need to maintain the health and wellbeing of the population and the transform of the majority of health care to a community setting coupled with gaps in resources to deliver current shape of care. The current model is acknowledged to be unsustainable – clinically, operationally and financially.

Vision 2018 articulates strong and broadly shared model of future care which is predicated on a locality (constituency) based model of care supported by a committed physically smaller acute hospital provision (which will continue to provide 24/7 A&E services, supported by emergency surgery). This model acknowledges that large volume of current hospital based activity – for example outpatient based management of long term conditions and 'light' diagnostics, should be delivered in a primary and community setting, supported by outreach models of specialist provision.
This proposal outlines the approach we are taking to (1) integrated care services, (2) integrated world-class IT systems and advanced predictive analytics, (3) patient and citizen engagement and activation, and (4) aligned incentives and payment models.

A record of already having made tangible progress towards new ways of working in 2014
The existing development of Vision 2018 and supporting Integrated Care Coordination Teams are now embedded expediting the discharge of admitted patients into home/community based settings, delivered on a locality (constituency) model.

The current IT systems that are in place have laid the foundations for implementation of data required for population health. The richness of clinical data is now enabling clinical transformation of care processes to support new care models. The hospital procured a health information exchange and patient portal to connect with citizens, and commenced work on readmission prevention. In addition a bespoke risk stratification tool has been developed locally across partners to identify patients most at risk of admission to hospital. This information is directly available to all Wirral GPs and identifies patients that would most benefit from referral to Integrated Care co-ordination teams. Work to build upon and integrate this existing technology will enable us to achieve the care navigation function of the Vision 2018 model.

Strong collaborative working between the health and social care community, again achieved through the Vision 2018 programme, has also supported the development of the Urgent care agenda in Wirral. This has led to the implementation of innovative schemes aimed at avoiding unnecessary hospital admission and enabling timely discharge when hospital care is no longer required. An example of this would be the partnership working between Primary Care and the Ambulance service to share clinical responsibility and reduce conveyance of individuals to hospital; a further example is demonstrated by the collaborative work between hospital and community providers to develop a comprehensive

community intravenous antibiotic service to deliver complex therapeutic intervention at home.

A credible plan to move at serious pace and make rapid change in 2015
There is a strong commitment to continue to deliver a new model of care through Vision 2018 work, with existing plans to further develop integrated care. Strong and jointly agreed set of initiatives are in place to drive the Better Care Fund to deliver a range of out of hospital care in 2015, linked to locality (constituency) based delivery of new model of care.
The Better Care Fund (BCF) plan aims to decrease non-elective admissions by 5% by March 2016 and impact on a number of other key indicators such as access to social care, use of long term care home placements and patient experience. A plan to achieve this has been developed and agreed by Vision 2018 partner organisations, and signed off by the Wirral Health and Wellbeing Board and NHS England, as part of the national BCF assurance process. The Wirral plan was "fully assured" by NHS England.
Alongside this the majority of the CCG member practices have submitted a substantial bid to the Prime Ministers Challenge Fund (covering almost 300,000 patients) to pilot and extend access for patients during core hours and increasing the availability of services up to 8pm Monday to Friday and between 10am-8pm on Saturday and Sunday. This model includes the development of Primary Care Access Centres established across the Wirral Peninsula aligned to the delivery model in figure 2.
The Public Health Directorate are in the process of developing a new commissioning model for 2016/17; the rapid development of the Vision 2018 model will provide an excellent opportunity to pilot new public health schemes, giving an opportunity to shape public health thinking. Two key areas of focus in public health will be development of community assets and managing social isolation. Both these areas support Vision 2018 objectives.
Following the tangible progress made in 2014 to establish Integrated Care co-ordination teams, there is a clear plan of further development of these teams in 2015. One of the four integrated teams, located in South Wirral, has been identified as an exemplar to test out expansion of the existing service. It will draw on specialist services such as palliative care teams and community geriatricians to implement plans which reduce readmissions and support people to remain at home – providing an excellent example of primary and secondary care collaboration. Testing the model in South Wirral enables us to better understand and implement the roles of "community connectors" and their link with Care Navigation, a social prescribing model and a system wide directory to support this and further develop asset based community development.

Funded local investment in transformation that is already agreed
Outline agreement of transitional funding to support transformation of Wirral Hospital Trust into one founded on a reduced bed model is already a part of current strategic financial planning intentions. Wirral Hospital Trust has stated its intention in its strategic plan to reduce its physical size, based on the delivery of the above and transformation-enabled through its funded IT implementation strategy for further digitalisation of care services, driving the hospital to full automation in 2015 (HIMSS level 7 out of 7).

Effective managerial and clinical leadership, and the capacity and capability to succeed
The Health and Well Being Board in Wirral has been effective is driving forward the transformational health and social care agenda and is committed to the development of a more integrated and effective out of hospital model of care.
There is a Strategic Leadership Group with CEO leadership across entire health and social care economy, which has developed and sponsored a jointly agreed Vision 2018 process and model of care, with strong clinical engagement at the most senior levels. This is supported by a Vision 2018 Programme Management Office which is in place to monitor this health and social care transformation programme. Well established and robust clinical and professional relationships across primary, secondary care and social care, enabled by sympathetic geography and strong track record of joint education and training.

Strong, diverse and active delivery partners, such as voluntary and community sector organisations
All statutory health and social care organisations are involved and committed to the Vision 2018 process and strong set of voluntary and community sector organisations are already engaged in the vision for new model of care.
The public sector partners have strong relationships with the voluntary and community sector with Community Action Wirral (CAW), being Wirral's social sector infrastructure organisation; it acts as a conduit between local government and the voluntary, community, faith, social enterprise and citizens.

CAW supports and facilitates collaboration between the sectors; and has been fully involved in the Vision 2018 programme in their role to further opportunities for community assets to be recognised and involved. CAW provides a valuable link for strategic partners through their involvement in Wirral's Health and Wellbeing Board.
Wirral currently has 1103 social sector organisations, 54 of these being social enterprise who deliver services and activities that contribute towards improved wellbeing outcomes for the Wirral population.

Positive local relationships, for example the support of local commissioners and communities
The existing Vision partnerships work at a strategic level across commissioners, providers and patient, public and workforce to enable change at a strategic and community level through an integrated approach that ensures the model is built upon the needs of our population. The co-design approach that is embedded into the programme has built positive relationships, a strong case for change and has catalysed initial public engagement in challenges and need for a new solution.
The Vision programme established the Engagement with People Group over 18 months ago and through this we are involving all Wirral communities with Vision 2018. The monthly group is chaired by a member of the Older People's Parliament and includes traditionally underrepresented groups of all ages (including those identified in the 2010 Equalities Act as being most at risk of discrimination), patient group representatives and Healthwatch. The group gives people a voice in service development and changes. Representatives actively engage with their own services user groups to pool information and ideas on equitable health solutions, people's real life experiences and on barriers that people may face.
The group has been integral in co-developing the Vision model for example, providing user insights into the value stream analysis event to enable effective redesign.

The initial cohort will also need to show: the appetite to engage intensively with other sites across the country, and with national bodies, in a co-designed and structured programme of support aimed at :
(a) identifying, prioritising and tackling national barriers experienced locally;
A number of barriers for change have already been identified in local health community work already undertaken, including the deployment of transition funding, risk management and mitigation and data sharing. All of these are barriers which will be present in other local health and social care communities and which the Wirral has made a start on addressing and on which there will be learning for the entire NHS.
(b) Developing common rather than unique local solutions that can easily be replicated by subsequent sites;
Although with geographic and social uniqueness, the advantages of this to test, calibrate and retest new models of care in the Wirral will offer learning across the NHS, particularly with the involvement and expertise of Cerner. Cerner UK and it's EU Collaboration Forum have existing models for sharing best practice and experience and there is agreement for twinning with Advocate in the USA for staff exchange programmes. In addition Wirral has a strong relationship with the King's Fund both across primary and secondary care and the intention is to further galvanise this through the relationship with Cerner to ensure that learning and dissemination can be further catalysed.
(c) assessing progress, through a staged development process;
Strong programme management methodology is already deployed through both existing Vision 2018 and Wirral Cerner Millennium implementation. This can be built upon and replicated in the deployment of New Models of Care.

Q5. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.)

By April 2016 we anticipated we will have addressed:

Cohort's identification – We will have identified the patient and citizen cohorts for managing in new care models. We will have completed analysis of linked data across our local health economy, utilising Joint Strategic Needs Assessment, risk stratification and other mechanisms to pin point cohorts and sub-cohorts of patients requiring disease management or citizens requiring wellness management. We will focus on areas where there is the greatest opportunity for improvement and where there is the greatest chance of impact. We will have validated this work with Advocate Physician Partners and their 10 year experience of understanding who are the most impactable patients. The work will have defined inclusion and exclusion criteria to run in our operational population health management solution so we can identify and act on an individual patient basis as they present or become known to our care system.

Registries and metrics – through co-creation with provider partners, commissioners, patients and third sector we will have completed design of the registries with their inclusion and exclusion criteria for the patient and citizen cohorts, and agreed disease, wellness, performance, patient satisfaction and other metrics for managing these cohorts. We will do this work in collaboration with NHS England and other central bodies that are experienced in metric design. We will also use Advocate Physician Partners extensive history and knowledge of metric design to establish the right governance, as well as prime and test metrics decisions. We will also attribute individual patients to lead clinicians based on algorithms and rules.

Informatics – by April 2016 we will be live with an operational population health management solution that support the delivery of our new care models. The HealtheIntent solution will have aggregated the rich care data from across our provider partner network, unified the terminologies and make available in a real time environment displayed directly to clinicians in the workflows of their EPR systems. The system will have configured the registries and scorecards with attribution made to the lead carers, to be ready to identify gaps in care with proactive surveillance mechanisms for real time identification of patient needs. We will be ready from April 2016 to operate the new care models for these patient cohorts against new value based contracts with our commissioner. We will seek implementation council from Advocate Physician Partners and other Cerner population health clients throughout to learn from best practice.

Patient engagement – patients will have participated in the co-creation of care pathways to support the new care pathways contributing their expectations and insights. We will have worked with patient groups and the third sector to establish the support required for patients and citizens around the new care models. Patients and citizens will be able to engage with the health partners using technology to view their care records and plans, and access utility services for example booking appointments and communicating with their clinicians.

Integrated care models – We will have further developed our deployment of integrated care models including rolling out the current pilot model in Wirral South across the other three constituency teams to expand the existing service, pulling in specialist services such as palliative care teams and community geriatricians to implement plans which reduce readmissions and support people to remain at home – providing a model of primary and secondary care collaboration.

Organisational models – We will have identified a range of options and implemented at least two of them to ensure primary care engagement in the integrated care partnership which will build on the learning we have already gleaned from the implementation of the ACO structure for Advocate Physician Partners, acknowledging a pluralistic approach to primary care engagement from working directly for the partnership on salaried basis, or to continue to act as independent contractors.

Q6. What do you want from a structured national programme?
(Aside from potential investment and recognition: i.e. what other specific support is sought?)

We have committed in our proposal an offer to lead **workforce and informatics research** for the lead cohorts across the nation in collaboration with and on behalf of the national programme. This will include collaboration with the King's Fund utilising their experience in this area from other parts of the UK and internationally. To be successful this work programme will need support from the national programme structure, to help coordinate the lead cohorts and other key bodies that should be involved, and project management related activity.

As is likely to be the case from other Lead Cohort applications, and as identified in the recent NHS England – King's Fund new care models event, we will need specific help with the following:

- **Payment and contract models** – We will seek support from Monitor and NHS England in establishing suitable payment models that will work in our locality and ensure we can manage the risk of transition. This will include being able to 'test' and modify payment and contract models and ensure that existing levels of reimbursement are not reduced, particularly whilst testing and evaluation is under way. This may require transitional support (see below).

- **Identifying the right metrics** – We will rely upon support from various national bodies including

NICE to establish a robust set of metrics for managing the specific patient diseases and wellness cohorts. This will include the need for informatics support perhaps from HSCIC in how to baseline these metrics.

- **Leadership and leverage for large scale replication of change** – Whilst we are keen to drive forward this programme based on the work we have already delivered, we will need support from national leaders and experienced facilitators to further leverage the opportunities we have identified across the full spectrum. This will be particularly true for the developing thinking around organisational form and the legal and regulatory aspects of the development of new models.

- **Workforce redesign and impact** – We know that in order to be sustainable we will need to move outside of traditional roles within both the primary and secondary care workforce, blending skills from both to develop hybrid roles. We will need support from education and training bodies to enable us to do this in the best way and which leads to changes in how health and social care professionals are trained and educated.

- **Transition support** – We will need support for managing the transition from fee for service model to value based population health care models. This could include financial support for the investment we need to make for double running some operational aspects. But would also include support dealing with stresses that innovation brings and dealing with legacy perverse incentives. For example success in the care model will mean that there will be less admissions and readmissions to hospital with less beds but because the patients that are there are appropriately, so we might anticipate that there will be an increase in their average length of stay, increase in mortality rates or readmission rates as they are sicker patients. This will need support from NHS England and Monitor and Care Quality Commission regulators as we rebalance the management of patients across our systems and then adapt our demand and capacity assumptions to ensure that we address this rebalancing with differentiated workforce models (for example).

As noted in the application we are supplementing the potential national support with that of an International ACO and King's Fund support as we believe this will help us more rapidly learn form best practice globally and take the most rigorous approach that we can.

WIRRAL COUNCIL

Health and Wellbeing Board

15 April 2015

SUBJECT:	**Better Care Fund - update**
WARD/S AFFECTED:	**All Wards**
REPORT OF:	**Graham Hodkinson, Director of Adult Social Services**
RESPONSIBLE PORTFOLIO HOLDER:	**Councillor Christine Jones, Adult Social Care and Public Health**
KEY DECISION?	**Yes**

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an overview of the latest position of the Better Care Fund (BCF).

1.2 The BCF was signed off with assurance from NHS England in September 2014.

1.3 The BCF represents partnership working between the Clinical Commissioning Group (CCG), Local Authority and key providers.

2.0 BACKGROUND AND KEY ISSUES

2.1 There has been a recent review of the original schemes to ensure that they remain aligned with Vision 2018, the CCG 5-year plan and in line with the considerable financial challenges the Health and Social Care economy faces.

2.2 The economy will be performance measured against its ability to reduce emergency admissions through BCF investment. This figure was originally set at a reduction of 5%, against 2014/15 baseline by 31 March 2016. However, in light of A&E performance over the winter period and the challenging admissions trajectory, Wirral has revised its position to a target of 3.5%. This remains a significant challenge, equal to a reduction of approximately 6 admissions a day.

2.3 There is a national requirement for the BCF to be managed via a pooled budget by April 2015. Resources will be pooled through a Section 75 agreement, which sets out governance arrangements including how risks such as under performance or overspend against individual schemes will be managed. It has been agreed that the pooled budget will be hosted by the local Authority. The CCG Director of Finance has jointly written the Section 75 request. The Director of Adult Social Services and the CCG Director of Finance will directly oversee the governance of the pooled budget.

2.4 As a consequence of both the realigned target and revision of schemes, the revised priorities and investments are included (Appendix 1)

2.5 The revised proposal (Appendix 1) increases the overall pooled budget from £33,368,863 to £35,021,863 and increases the contingency from £1,781,900 to £4,213,260.

2.6 Given the ambitious transformational programme; implementation and performance management of the schemes are the key priority. The BCF leads for the CCG and Local Authority will report monthly into the Joint Strategic Commissioning Group and quarterly progress to the Health and Wellbeing Board.

2.7 A monthly Steering Group with providers is in place as is a monthly performance group to monitor performance and progress against the suite of national BCF targets, including the 3.5% reduction of unplanned admissions.

2.8 Periodic reporting to the Local Area Team and NHS England continues.

2.9 The BCF will remain closely aligned with the Systems Resilience Group and help drive the urgent care agenda.

3.0 RELEVANT RISKS

3.1 The BCF brings both opportunities and risks. The performance related element of the fund equates to a maximum potential risk of £7.206m being withheld by NHS England to offset the element of activity not reduced in the Acute sector. This equates to a maximum risk of £5.909m for the CCG and £1.297m for the Council. The risk sharing arrangement has previously been agreed at Health and Wellbeing Board on a 82% CCG/18% DASS basis.

4.0 OTHER OPTIONS CONSIDERED

4.1 N/A

5.0 CONSULTATION

5.1 Public and stakeholder consultation took place during 2014.

5.2 Engagement continues with providers via Systems Resilience Group/Urgent Care Recovery Plan Group and monthly Steering Group.

6.0 OUTSTANDING PREVIOUSLY APPROVED ACTIONS

6.1 N/A

7.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

7.1 Voluntary Community and Faith organisations are key stakeholders in the development of Vision 2018.

8.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

8.1 For 2015/16, the total joint resource available is £35,021,863.

9.0 LEGAL IMPLICATIONS

9.1 The Section 75 (pooled budget) is a formal legal agreement, setting out specific risk share agreements.

10.0 EQUALITIES IMPLICATIONS

10.1 Has the potential impact of your proposal(s) been reviewed with regard to equality?
No because there is no relevance to equality. Consideration of Equality Impact Assessment will be given to specific scheme proposals.

11.0 CARBON REDUCTION AND ENVIRONMENTAL IMPLICATIONS

11.1 N/A

12.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

12.1 N/A

13.0 RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board;

13.1 approve the revised priorities.

13.2 note the progress and monitoring arrangements with regard to the section 75 pooled budget agreement.

14.0 REASON/S FOR RECOMMENDATION/S

14.1 Wirral Council and CCG are required to establish a pooled budget to deliver the BCF priorities.

4.2 NHS England requires Wirral Council and CCG to deliver against national requirements identified in the BCF.

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APPENDICES

Appendix 1 : Revised scheme summary
Appendix 2 : Summary of key changes

BACKGROUND PAPERS/REFERENCE MATERIAL

BRIEFING NOTES HISTORY

Briefing Note	Date

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

APPENDIX 1

No		Original	Assumed Savings	Amendments See 26	Budget adjustments	Reprofile	Revised Contingency	SRG Funding	
1	Wirral independence	1,610,710			1,700,000	3,310,710			
2	Community care of the elderly service	622,000				622,000			
3a	Third Sector Spend - CCG	1,392,621	(147,473)			1,245,148			
3b	Third Sector Spend - Adults DASS	935,130				935,130			
4	ICCTs Investment / Neighbourhood 7 Day Working	3,104,690		(3,104,690)		0			
5	Care Homes Scheme	468,000	(368,000)			100,000			
6	Flexible social care support at night	516,000				516,000			
7	Care arranging team	27,000		(27,000)		0			
8	Care and support bill implementation	976,000			(47,000)	929,000			
9	Investment in social services in the community	4,396,824		(100,000)		4,296,824			
10	Carers (joint commission)	1,325,000				1,325,000			
11	Homeless service	93,279				93,279			
12	Step up step down (IMC reablement)	7,370,082		(7,370,082)		0			
13	Integrated discharge team	1,011,000		(1,011,000)		0			
14	Admission prevention services	621,000		(621,000)		0			
15	IV antibiotics & blood transfusion	400,000				400,000			
16	Early Supported Discharge	996,428				996,428		(996,428)	
17	NWAS demand reduction schemes	146,000				146,000		(146,000)	
18	NWAS - Street Triage	180,000				180,000			
19	Dementia LES	37,000				37,000			
20	Early onset dementia	145,000				145,000			
21	Specialist Alcohol Unit	996,000	(996,000)			0			
22	Alcohol Triage Service	325,000	(325,000)			0			
23	Complex Needs Service	250,000				250,000			
24	Direct joint MH posts	415,909				415,909			
25	Dementia nurses	75,290				75,290			
26	Revised 7 Day working / Community Provision			11,726,868		11,726,868		(£684,950 funded by srm-winter pressure element-beds and MDT)	
27	Contingency	1,781,900	1,836,473	506,904		4,125,277	(2,343,377)		
28	DFG	2,073,000				2,073,000			
29	Social Capital	1,003,000				1,003,000			
30	Joint Post Finance	75,000				75,000			
		33,368,863	0	0	1,653,000	35,021,863	(2,343,377)	1,826,950	

Better Care Fund	Scheme Number	New Scheme 15/16	Implementation	Total Investments	
				2014/15	2015/16
Early Intervention & Prevention				£000	£000
Wirral independence	1		2	461	461
Telecare (incl PH)				750	750
Wirral independence (CCG CES budget)				0	-
Falls				400	400
Total Early Intervention & Prevention				**1,611**	**1,611**
Keeping People in their Local Communities					
Community care of the elderly service	2	✓	2	0	622
CCG third sector spend	3		2	0	1,393
DASS third sector spend (not mitigation adds to pool)				0	935
ICCTs Investment / Neighbourhood 7 Day Working	4	✓	2/3	0	3,105
Care homes schemes	5	✓	2	0	468
Flexible social care support at night	6		1	0	516
Care arranging team	7		1	27	27
Care and support bill implementation	8		3	335	976
Investment in social services in the community	9		2	4,396	4,396
Carers (joint commission)	10		2	765	1,325
Homeless service	11		2	0	93
Homeless Support Services				-	-
Total Keeping People in their Local Communities				**5,523**	**13,856**
Step Up / Step Down Services					
Beds					
IMC beds				1,274,000	1,274,000
Transitional beds				983,000	983,000
Supported Extra care (2 adapted flats)				20,000	20,000
MDT					-
GP (70 beds)				200,000	200,000
Therapies IMC (35 beds)				451,000	451,000
Therapies trans					-
Social workers (4 wte)				144,000	144,000
Reablement (4 wte)				120,000	120,000
Admin (2 wte)				50,000	50,000
Manager (1 wte)				45,000	45,000
CHC nurse				34,000	34,000
Other					-
Winter short breaks				44,000	44,000
contingency spot purchase				15,000	15,000
Reablement				2,100,000	3,166,211
7 day working				516,000	516,000
Pump prime - AT add'l resource				307,871	307,871
Step up step down (IMC reablement)	12	✓	1/2	6,305	7,370
Integrated discharge team	13		1/2	1,011	1,011
Admission prevention services	14		1	621	621
IV antibiotics & blood transfusion	15	✓	1	0	400

Early Supported Discharge	16	✓	1	0	996
NWAS demand reduction schemes	17	✓	1	0	146
NWAS - Street Triage	18	✓	1	0	180
Total Step Up / Step Down Services				**7,937**	**10,725**
Mental Health including Drug & Alcohol Services					
Dementia LES	19	✓	1	0	37
Early onset dementia	20		1	0	145
Specialist Alcohol Unit	21	✓	3	0	996
Alcohol Triage Service	22	✓	2	0	325
Complex Needs Service	23	✓	1	0	250
Direct joint MH posts	24		1	416	416
Dementia nurses	25		1	75	75
Total Mental Health including Drug & Alcohol Services				**491**	**2,244**
Contingency				0	1,782
Disabilities Facilities Grant				0	2,073
Social Care capital grant				0	1,003
Joint post (Finance)				75	75
Total Better Care Fund 15/16				**15,637**	**33,368**

Better Care Fund	Scheme Number	New Scheme 15/16	Implementation	Total Investments 2014/15 £000	Total Investments 2015/16	Total Investments 2015/16 £000	Anticipated Expenditure	CCG 2015/16 £000	WBC 2015/16 £000	Impact on Non-Elective Admissions (Per Day)	Impact on Non-Elective Admissions (Per Day) £	Impact on Non-Elective Admissions 5% reduction target £	Narrative NEL admissions	Impact on Occupied Bed Days	Narrative Occupied bed days
Early Intervention & Prevention															
Wirral independence				461	460,710	461	461	461	-						
Telecare (incl PH)	1		2	750	750,000	750	750	500	250	0.45	£656	£112,863	3.6% of Top 30 emergency admissions can be linked to Falls. Assumption is 25% can be prevented through appropriate AT with another 25% through the Care Home Schemes (Education & Awareness, etc.)	790	Avg. Length of Stay All Ages & All admissions = 4.82 x 164 avoided admissions
Wirral independence (CCG CES budget)				0	0	-	-	-	-						
Falls				400	400,000	400	400	-	400						
Total Early Intervention & Prevention				**1,611**	**1,610,710**	**1,611**	**1,611**	**961**	**650**	**0.5**	**£656**	**£112,863**		**790**	
Keeping People in their Local Communities															
Community care of the elderly service	2	✓	2	0	622,000	622	622	622	-	2	£2,914	£501,615		5,481	7.55 for people 65+ x 730 avoided admissions
CCG third sector spend	3		2	0	1,392,621	1,393	#REF!	1,393	-	-				500	Scheme bid indicates potential to work with 500 older people to support earlier discharge. Assumption of 1 day per person reduction
DASS third sector spend (not mitigation adds to pool)				0	935,130	935	935	-	935						
ICCTs Investment / Neighbourhood 7 Day Working	4	✓	2/3	0	3,104,690	3,105	#REF!	3,105	-	2	£3,094	£532,600		5,481	7.55 for people 65+ x 730 avoided admissions
Care homes schemes	5	✓	2	0	468,000	468	#REF!	468	-	0.45	£656	£112,863	3.6% of Top 30 emergency admissions relate to Falls of which a significant number will relate to Falls in Care Homes Assumption 25% can be avoided	1,606	Avg. Length of Stay <65 due to Falls = 9.79 days x 164 avoided admissions
Flexible social care support at night	6		1	0	516,000	516	516	516	-	-				-	
Care arranging team	7		1	27	27,000	27	27	27	-	-				-	
Care and support bill implementation	8		3	335	976,000	976	976	976	-	-				-	
Investment in social services in the community	9		2	4,396	4,396,000	4,396	4,396	4,396	-	-				-	
Carers (joint commission)	10		2	765	1,325,000	1,325	1,325	980	345	0.14	£204	£35,113	estimated one per week	251	Avg. Length of Stay All Ages & All Admission Types = 4.82 x 52 avoided admissions
Homeless service	11		2	0	93,279	93	93	93	-						
Total Keeping People in their Local Communities				**5,523**	**14,005,720**	**13,856**	**#REF!**	**12,576**	**1,280**	**4.6**	**£6,868**	**£1,182,191**		**13,319**	
Step Up / Step Down Services															
Beds															
IMC beds				1,274,000	1,274,000	1,274,000		274,000	1,000,000						
Transitional beds				983,000	983,000	983,000		983,000	-						
Supported Extra care (2 adapted flats)				20,000	20,000	20,000		20,000	-						
MDT				-	-	-		-	-						
GP (70 beds)				200,000	200,000	200,000		200,000	-						
Therapies IMC (35 beds)				451,000	451,000	451,000		451,000	-						
Therapies trans				-	-	-		-	-						
Social workers (4 wte)				144,000	144,000	144,000		144,000	-						
Reablement (4 wte)				120,000	120,000	120,000		120,000	-						
Admin (2 wte)				50,000	50,000	50,000		14,000	36,000						
Manager (1 wte)				45,000	45,000	45,000		45,000	-						
CHC nurse				34,000	34,000	34,000		34,000	-						
Other				-	-	-		-	-						
Winter short breaks				44,000	44,000	44,000		44,000	-						
contingency spot purchase				15,000	15,000	15,000		15,000	-						
Reablement				2,100,000	3,049,451	3,166,211		2,114,211	1,052,000						
7 day working				516,000	516,000	516,000		516,000	-						
Ramp prime - AT add'l resource				307,871	307,871	307,871		307,871	-						
Ramp up step down (IMC reablement)	12	✓	1/2	6,305	7,253,322	7,370	7,370	5,282	2,088	0.56	£816	£140,452	estimated four per week	1,003	Avg. Length of Stay All Ages & All Admission Types = 4.82 x 208 avoided admissions
Integrated discharge team	13		1/2	1,011	1,011,000	1,011	1,011	1,011	-	-				1,000	Estimate of completed assessments in 2014-15 = 500. Reduce Section 2 to discharge time by 2 days
Admission prevention services	14		1	621	621,000	621	621	621	-	1	£1,457	£250,807		1,759	Avg. Length of Stay All Ages & All Admission Types = 4.82 x 365 avoided admissions
IV antibiotics & blood transfusion	15	✓	1	0	400,000	400	400	400	-	1	£1,457	£250,807		1,759	Avg. Length of Stay All Ages & All Admission Types = 4.82 x 365 avoided admissions
Early Supported Discharge	16	✓	1	0	996,428	996	996	996	-	-				3,360	280 days per month
NWAS demand reduction schemes	17	✓	1	0	146,000	146	146	146	-	3	£4,371	£752,422		5,278	Avg. Length of Stay All Ages & All Admission Types = 4.82 x 1095 avoided admissions
NWAS - Street Triage	18	✓	1	0	180,000	180	180	180	-	2	£2,914	£501,615		3,519	Avg. Length of Stay All Ages & All Admission Types = 4.82 x 730 avoided admissions
Total Step Up / Step Down Services				**7,937**	**10,607,750**	**10,725**	**10,725**	**8,637**	**2,088**	**7.6**	**£11,015**	**£1,896,103**		**17,678**	
Mental Health including Drug & Alcohol Services															
Dementia LES	19	✓	1	0	37,000	37	37	37	-	0.28	£408	£70,226	estimated two per week	364	Avg. Length of Stay Dementia <65 = 3.5 x 104 avoided admissions
Early onset dementia	20		1	0	145,000	145	145	145	-	0.28	£408	£70,226	estimated two per week	364	Avg. Length of Stay Dementia <65 = 3.5 x 104 avoided admissions
Specialist Alcohol Unit	21	✓	3	0	996,000	996	-	996	-	0.23	£335	£57,686	Estimate of 552 presentations at A&E of which 29.85% are admitted. Assuming 50% of admissions can be avoided	267	Avg. Length of Stay Dementia <65 = 3.25 x 82 avoided admissions
Alcohol Triage Service	22	✓	2	0	325,000	325	-	325	-	0.28	£408	£70,226	estimated two per week	338	Avg. Length of Stay Dementia <65 = 3.25 x 104 avoided admissions
Complex Needs Service	23	✓	1	0	250,000	250	250	250	-	0.26	£379	£65,210	Estimate of 189 avoided presentations assuming 50% would have been admitted	309	Avg. Length of Stay Dementia <65 = 3.25 x 95 avoided admissions
Direct joint MH posts	24		1	416	415,909	416	416	416	-	-				-	
Dementia nurses	25		1	75	75,290	75	75	75	-	-				-	
Total Mental Health including Drug & Alcohol Services				**491**	**2,244,199**	**2,244**	**923**	**2,244**	**-**	**1.3**	**£1,938**	**£333,574**		**1,642**	
Contingency				0	1,781,900	1,782	-	1,782	-						
Disabilities Facilities Grant				0	2,073,000	2,073	2,073	-	2,073						
Social Care capital grant				0	1,003,000	1,003	1,003	-	1,003						
Joint post (Finance)				75	75,000	75	75	75	-						
Total Better Care Fund 15/16				**15,637**	**33,401,279**	**33,368**	**#REF!**	**26,274**	**7,094**			**3,524,731**			
							#REF!								

APPENDIX 2

Scheme No	Service	Detail of Change	Original Funding	Revised funding		BCF
				BCF	SR	
1	Wirral Independence.	£1.7m, CCG Community equipment budget, now added to BCF fund.	£1,610,710	£3,310,710		+ 1.7m
3a)	CCG 3rd Sector Investment.	Efficiency of £147k via contact review.	£1,392,621	£1,245,621		-147,000
8)	Care and Support bill implementation.	Revised lower mandatory figure from NHS England. Taking account of Wirral having no prison allocation.	£976,000	£929,000		-£47,000
9)	Protection of social care services.	Reduced amount by £100k	£4,396,000	£4,296,000		-£100,000
16	Early supported discharge.	Proposed funding for Systems Resilience monies for 2014/15. Anticipated monitoring with scheme 26+ efficiency in 2016/17	£996,428		£996,428	-996,428
17	NWAS demand reduction.	Proposed funding for Systems Resilience monies for 2014/15.	146,000		146,000	-146,000
21	Specialist Alcohol Service.	Decision for commission not to progress, based on data evidence, PH commission and revised 5% - 3.5% target.	996,000			-996,000
22	Alcohol Triage Service.	Decision for commission not to progress, based on data evidence, PH commission and revised 5% - 3.5% target.	325,000			-325,000
4,7,12,13, 14 Revised to Service 26 (see Section 3/app 2).	Revised 7 Day & Rapid Community Service.	Revised 7 day offer to target 7 day discharge, admission avoidance with Rapid GP access for community support (see section 3 for details).	12,133,772	11,726,868	684,950	-406,904

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NHS ENGLAND

ACCOUNTABILITY REPORT TO WIRRAL HEALTH & WELL BEING BOARD

April 2015

1 CONTEXT

NHS England is the national body, tasked by Government, to improve health and care, underpinned by the NHS Outcomes framework and the NHS Constitution. The mandate given to NHS England sets out objectives and deliverables for the next two years. NHS England has established agreements for successful working alongside Public Health England, and Monitor. A concordat with the LGA recognises Health and Wellbeing Boards as system leaders comprising of membership drawn from Local Government, CCG's and NHS England.

NHS England is responsible for three main activities- system development, assurance and commissioning. NHS England undertakes some commissioning on behalf of the NHS directly, rather than through local government or CCG's. This commissioning is in five areas: Offender, Military, Public Health, Primary Care and Specialised Services.

These areas were retained by NHS England due to the scale and geography of commissioning, the expertise required and to drive England wide service standards in these areas, so they are not impacted by local variation.

2. THIS REPORT

NHS England provides a quarterly Accountability report to each Health and Wellbeing Board. This report outlines national and regional context together with specific update on priorities that the Area Teams are responsible for delivering and how these priorities are progressing.

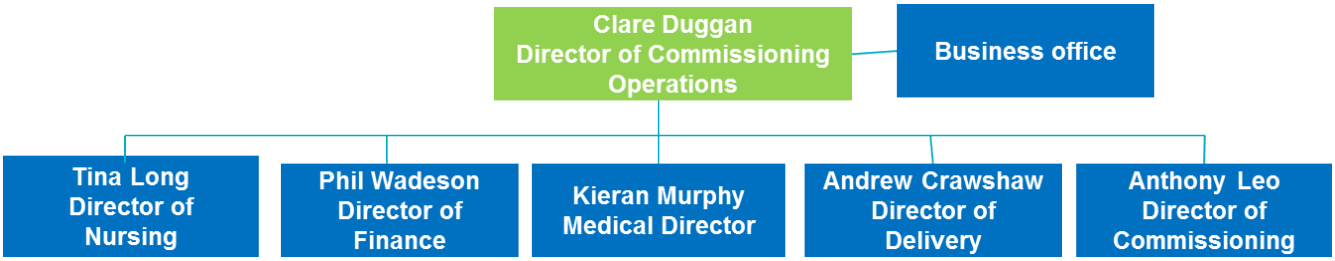
This report gives an update on NHS England, progress on the Two Year Operational Plans as well as the development of the Cheshire and Merseyside Business Plan for 2015/16.

3 NHS ENGLAND UPDATES

Organisational Alignment & Capacity Programme

You will recall from the last report that NHS England was reviewing its operational arrangements to ensure that our structures are fit for purpose and within available funding going forward. This has resulted in the merger of two area teams to form the Cheshire & Merseyside Team. Our functions will remain the same for now as there is no change envisaged currently. However we will be working closely with our CCG partners to continue to develop their leadership role and take on wider commissioning responsibilities over time specifically for Primary Care and Specialised Services.

The senior management team for the Cheshire & Merseyside Team is as follows:



As a result of the changes, we have reviewed who will be attending each of the Health and Well being Boards across the patch going forward and Andrew Crawshaw, Director of Delivery will be attending these meetings in future.

Development of Co-Commissioning Arrangements with Local CCGs

In May 2014, NHS England invited clinical commissioning groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

There has been a strong response from CCGs wishing to assume co-commissioning responsibilities and there are three models CCGs could take forward:

- Greater involvement in primary care decision making;
- Joint commissioning arrangement; or
- Delegated commissioning arrangement.

Locally we are pleased to be putting in place the following arrangements with each of the Clinical Commissioning Groups. This is subject to agreement with each of the CCG Governing Bodies by the end of March:

Delegated	Joint	Greater Involvement
NHS St Helens CCG	NHS Southport And Formby CCG	NHS Wirral CCG
NHS Liverpool CCG	NHS Eastern Cheshire CCG	NHS South Sefton CCG
NHS Knowsley CCG	NHS Warrington CCG	
NHS Halton CCG	NHS Vale Royal CCG	
	NHS South Cheshire CCG	
	NHS West Cheshire CCG	

This means that from 1 April, over 70 percent of CCGs will take on greater commissioning responsibility for GP services under the new co-commissioning arrangements.

There will be further opportunities for CCGs to assume greater joint commissioning responsibilities throughout 2015 and beyond and we will continue to support CCGs in this.

For further information, please visit: https://www.england.nhs.uk/commissioning/pc-co-comms/

Prime Ministers Challenge Fund

On 30 September 2014, the Prime Minister announced a second wave of 'Access Pilots', with further funding of £100m for 2015/16. NHS England are leading the process and overseeing the new pilots when they have been announced.

Cheshire & Merseyside Sub Regional Team have received eight bids and were asked to review and make recommendations for the national panel. The panel looked for a broad geographical spread of pilots and assessment of the breadth of the prioritised bids to ensure that there is a good spread of innovation.

We are expecting an announcement of those that have been successful in their application in the coming weeks.

New Care Models Programme - Vanguard sites

NHS England has announced the first 29 'vanguard' sites that will transform care for five million patients across England. The sites, supported by the New Care Models Programme, have been chosen from 269 applications to trail blaze new ways of providing more joined-up, personal care for patients and increase efficiency.

Groups of nurses, doctors and other health staff from across the country put forward their ideas for how they want to redesign care in their areas, and now the NHS will be backing 29 of the most innovative plans, with the aim of bringing home care, community nursing, GP services and hospitals together for the first time since 1948.

Drawing on bespoke packages of national support and a £200 million transformation fund, from April the vanguards will develop local health and care services to keep people well, reduce demand and improve productivity.

The vanguards will take the national lead on the development of game-changing care models:

- multispecialty community providers (MCPs) – moving specialist care out of hospitals into the community;
- integrated primary and acute care systems (PACS) – joining up GP, hospital, community and mental health services, and;
- models of enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services.

For patients, this could mean fewer trips to hospitals as cancer and dementia specialists hold clinics local surgeries, one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

Locally we have the following vanguard sites:

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Health Partners is made up of: Wirral University Hospital NHS Foundation Trust; Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Trust; Wirral Clinical Commissioning Group; GPs on the Wirral; Wirral Metropolitan Borough Council; Cerner UK Ltd, Advocate Physician Partners ACO (USA based); and the King's Fund.

Wirral Health Partners will accelerate a new model of integrated care across primary and secondary care providers, supported by a technology enabled population health model. Integrated care teams will be expanded to reduce readmissions and support people to remain at home through primary/secondary care collaboration. Following implementation, the new model will work by identifying older people who are at potential risk of serious fracture following minor falls that result in emergency admission. With approval of the patient, care plans will be developed, home assessments carried out and aids added to reduce the probability of falls happening. With this support, patients are able to stay in her home and potentially avoid a serious fracture.

Primary Care Cheshire

A new Multispecialty Community Provider will now be developed in West Cheshire, an area in North West England with a population of 330,000. The lead partners for developing this model locally are NHS West Cheshire CCG and Primary Care Cheshire (a single entity). They are being joined by a further three participating partners: Cheshire & Wirral NHS Partnership Foundation Trust, Countess of Chester NHS Foundation Trust and Cheshire West and Chester Local Authority.

Under the plans put forward, patients can expect better and more integrated support from different local health and care services, with a particular focus on young children, managing long-term conditions and supporting elderly patients.

To this end, the new partnership will be launching 3 new programmes as part of their model: 'Starting Well' will focus on ensuring the best start in life for babies, children and young people in the local area; 'Being Well' will enable greater collaboration between local services and the several clusters of GP practices, supported by integrated teams, to help people manage long-term conditions, and; 'Ageing Well' will focus on excellent care for the frail/complex wherever they are living (including those in care homes).

For more information, please visit: http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/

GP Infrastructure Bids

The Primary Care Infrastructure Fund is a four year £1billion investment to accelerate improvements in GP premises and infrastructure.

This is part of the additional NHS funding, announced by the Government in December last year, to enable the direction of travel set out in the Five Year Forward View.

This new funding, alongside our incremental premises programme, is designed to accelerate investment in increasing infrastructure, accelerate better use of technology. In the short term, it will be used to address immediate capacity and access issues, as well as lay the foundations for more integrated care to be delivered in community settings.

In January 2015, we invited bids for investment in 2015/16. The deadline for this wave of bids has now closed. There will now be an internal review of the bids received and an announcement of those that have been successful in due course.

4. PROGRESS ON NHS ENGLAND TWO YEAR OPERATIONAL PLANS

The 2 year operational plan represents the first 2 years of a 5 year strategic plan. The Sub Regional Team is committed to driving improvements to secure equity of access and a reduction in variation in the services all patients across Cheshire & Merseyside and the North West (for specialised services) receive.

An update is provided below for each area of direct commissioning:

Primary Care

NHS England (Cheshire & Merseyside) have carried out a successful procurement of Community Dental Services. Detailed below is a list of the new service providers from 1st April 2015. The majority of contracts tendered were awarded and will be in place for 3 years. The new contracts will allow for more detailed data to be gathered, which help to inform a health needs assessment that will be carried out during the life of these contracts. The information collected will be used to inform future commissioning of these key services, for some of the most vulnerable patients in society.

List of the successful bidders across Cheshire and Merseyside following the CDS procurement;

- Out-of-Hours Urgent Dental Care (Cheshire & Merseyside) – Revive Dental Care Ltd
- In-Hours Urgent Dental Care (Liverpool) – Atlantic Dental Practice
- Adult & Paediatric Special Care (Cheshire West & Wirral) – Wirral Community NHS Trust
- Adult & Paediatric Special Care (Cheshire East & Warrington) – East Cheshire NHS Trust
- Adult & Paediatric Special Care (Knowsley/Liverpool/Sefton) – Liverpool Community Health NHS Trust
- Adult & Paediatric Special Care (Halton/St Helens) – Bridgewater Community NHS Foundation Trust
- Paediatric Exodontia (Cheshire West & Wirral) - Wirral Community NHS Trust
- Paediatric Exodontia (Cheshire East & Warrington) – Bridgewater Community NHS Foundation Trust
- Paediatric Exodontia (Knowsley/Liverpool/Sefton) – Liverpool Community Health NHS Trust
- Paediatric Exodontia (Halton/St Helens) – Bridgewater Community NHS Foundation Trust

For those services where contracts have not been awarded; Dental Helpline / Triage Service for Cheshire and Merseyside and the In-Hours Urgent Care Dental Service across Cheshire, Warrington, Wirral, Knowsley, Sefton and Halton and St Helens, there are robust contingency plans that have been developed to ensure that these services will be provided from 1st April 2015;

- The Dental Helpline / Triage service will be provided by Revive Dental Care Ltd, who are also the new Out-of-Hours Urgent Dental Care provider.
- The In-Hours Urgent Dental service will be provided from a variety of general dental practices across the patch, which will greatly improve access for patients, who require urgent dental treatment and are not regular attenders at a general dental practice.

Public Health

Seasonal Flu 14/15 Campaign:

Previous Area Team footprint	Over 65s	All under 65s at risk	Pregnant women	2 and 3 year olds	Health Care Workers
Cheshire, Warrington and Wirral	75.2%	51.9%	50.6%	43.7%/ 48.4%	64.1%
Merseyside	76.5%	54%	47.2%	38.2%/ 37%	76%
Comments	Both ATs have exceeded the 75% target and Merseyside is the highest in England.	Both ATs performance is down on last years in % terms, but are nevertheless in the top 5 in England.	Both teams have improved uptake in pregnant women by a large portion. CWW is the highest achieving AT	This is only the second year of the childhood flu programme so lower rates are expected than with other more established age cohorts.	Mersey is currently highest performing AT for HCW vaccination

0-5 transition to Local Authorities:

All 9 Local Authorities have agreed contracting arrangements for 15/16 in advance of them assuming commissioning responsibility for 0-5 services in October 2015. We are working hard with all LAs and Providers to ensure contract sign off. The weekly 0-5 contract tracker provides the national team of progress to date. We are working with those Authorities who have issues with their proposed allocation from the Department of Health for 0-5 services and are staying close to the national team and updating them on progress. We are confident that resolution will be found by using the in-year adjustment process and are maintaining good relationships with all of our authorities in order to progress.

Health Visitor growth:

CWW is on track to meet the trajectory and Merseyside is on track to exceed the workforce trajectory. The team have worked extremely hard with local Providers to make this happen with real effort going into this work to turn performance around

Mersey trajectory 304.8 wte HVs by March 15	Position at December 2015 as per MDS submission: 310.67 wte HVs
CWW trajectory: 272.9 wte HVs by March 15	Position at December 2015: 271.85

Specialised Commissioning

There are a number of significant service issues that are currently being addressed by the Specialised Commissioning Team in partnership with key Cheshire, Warrington and Wirral colleagues. These include:

- Neurorehabilitation

The Cheshire and Merseyside Rehabilitation Network (CMRN) has been asked to consider the benefits and potential timescales associated with becoming an ODN. The CMRN and CWWAT highlighted the shortfall of CCG-commissioned level 2 services for Cheshire patients together with potential solutions to Cheshire CCGs.

Agreement was not reached on an interim or long term solution and is subject to further work at individual CCG level.

- Upper GI Cancer

Specialist upper GI cancer (oesophago-gastric) services are configured around two SMDTs, at Aintree and LHCH. Warrington patients flow to LHCH and Wirral to the Aintree SMDT. National guidance and the service specification indicate that for the volume of surgical activity being undertaken, there should be a single team providing services for the population of Merseyside.

Providers have failed to reach a collaborative solution which would bring services on to a single acute site in line with external clinical advice. LHCH has subsequently proposed that specialist surgery currently undertaken on the LHCH site is transferred to Royal Liverpool in order to meet this recommendation for the population served by this SMDT.

Strategic discussions are underway between CWW AT and CEOs which may resolve this issue and avoid the need for procurement in line with Health Liverpool strategic aims. This may involve a two stage move with integration of the LHCH SMDT on to the Royal Liverpool site and then transfer of the Aintree SMDT to Royal Liverpool, pending CEO agreement. If a procurement is required to establish a single SMDT/surgical service for Merseyside, this will be initiated in March 2015 as a single 'lot' alongside the procurement of upper GI cancer in Greater Manchester.

- Adult HIV

An implementation plan has been developed and communicated to HIV providers and public health local authority Chief Officers. The plan outlines the planned stages in developing a formal networked model of care within Cheshire & Merseyside. The paper was well received and is now in the implementation phase. Whilst the network is in development, the initial focus is on clinical governance where plans are in place to develop a service level agreement between the hub (the Royal Liverpool) and the spokes to formalise network links as per April 2015 contracting arrangements.

- Mental Health

CAMHs tier 4: Phase 1 procurement is now complete and with the opening of beds in other areas capacity within the NW is considered sufficient to meet needs. Additional case management capacity has been recruited to strengthen the management of the system across the North West. These new posts will be operational by December.

A piece of work has recently been completed looking at patients coming in and out of the North West. This has shown an increase in out of North West placements for 6 people from the North West but an increase in 144 patients from outside the North West being placed in the North West Providers. This has been raised nationally as an issue. There are significant issues relating to financial performance and case management capacity that are being addressed.

- Cancer Pathway Review for Mid Cheshire

As part of the strategic partnership Stronger Together between Mid Cheshire and UHNM, a review of cancer pathways is being undertaken commencing January 2015. A Programme Board, led by South Cheshire CCG will be established to oversee this work in conjunction with NHS England. Any change in current arrangements will need to ensure Monitor principles are satisfied and will lead to improved outcomes. A steering group including Provider CEOs is also being established.

We are currently in the process of developing our Business Plan for 2015/16 and will be sharing this with key stakeholders in due course.

Andrew Crawshaw
Lead Director

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WIRRAL COUNCIL

Committee Name **Wirral Health & Wellbeing Board**
Meeting Date **15th April 2015**

SUBJECT:	Wirral's Pharmaceutical Needs Assessment
WARD/S AFFECTED:	All
REPORT OF:	Fiona Johnstone, Director of Public Health
RESPONSIBLE PORTFOLIO HOLDER:	Cllr Chris Jones
KEY DECISION?	Ratification of Wirral's Pharmaceutical Needs Assessment

1.0 EXECUTIVE SUMMARY

The formal consultation for Wirral's new Pharmaceutical Needs Assessment (PNA) is now complete. To meet the deadline for publication of the 1st April 2015 the Chair approved the document in March, the board is therefore asked to ratify the Chair's action.

2.0 BACKGROUND AND KEY ISSUES

- Pharmaceutical Needs Assessments (PNAs) are carried out to assess the pharmacy needs of the local population. The PNA presents an overview of local pharmaceutical service provision; reviewing access, range and adequacy of service provision and choice of provider to build on the sectors capacity and capability to help address health inequalities and support self-care.

- NHS England will rely on the PNA when making decisions on applications to open new pharmacies. To be included on a pharmaceutical list, providers must prove they are able to meet a pharmaceutical need as defined by the PNA.

- Each Health and Wellbeing Board was required to publish its first pharmaceutical needs assessment by 1st April 2015. The new PNA can be accessed at www.info.wirral.nhs.uk/pna

- The Health and Wellbeing Board is required to publish revised assessments within three years or when significant changes to need for pharmaceutical services are identified.

3.0 RELEVANT RISKS

The list of pharmacies within the PNA is correct as at 14th November 2014 (when NHS England confirmed registered providers). Details are subject to periodic change and the website will be updated as and when necessary.

4.0 OTHER OPTIONS CONSIDERED

Not applicable

5.0 CONSULTATION

- A public survey conducted in January 2014 yielded 1,192 responses (the survey was originally sent out to 50,000 residents). Responses were overwhelmingly positive. Small numbers raised concerns over specific operational issues, but there were no significant service gaps identified.
- Formal consultation on the draft PNA took place from 3rd November 2014 to 12th January 2015. This included consulting with community and hospital providers, local pharmacies, Clinical Commissioning Group, Local Medical Committee, Local Pharmaceutical Committee, local Healthwatch, other professional bodies, voluntary and community groups, patients and the public
- A total of 22 responses were received during the formal consultation period
- Half of the responses related to specific points of accuracy and the necessary amendments have now been made to the document.
- The remaining responses included:
    - Positive feedback about the clear, comprehensive nature of the document
    - Comments about pharmacies needing to improve their accessibility for people who are deaf, blind or visually impaired.
    - Comments about pharmacies needing to improve their accessibility for those whose first language is not English
    - Suggestions as to how pharmacies might expand the range of services on offer (for example by providing flu jabs).
    - Suggestions as to how the branding of Wirral services might be improved in order to ease identification.

6.0 OUTSTANDING PREVIOUSLY APPROVED ACTIONS

None

7.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

None

8.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

None

9.0 LEGAL IMPLICATIONS

Decisions made by NHS England regarding market entry based on the findings of the PNA are open to appeal and legal challenge.

10.0 EQUALITIES IMPLICATIONS

Has the potential impact of your proposal(s) been reviewed with regard to equality?

No because, Wirral is generally very well served by community pharmacies. There is

currently one pharmacy for every 3,402 residents, which compares extremely favourably to the national average of one pharmacy for every 5,000 resident population. More services are delivered in the most densely populated areas of the borough.

The public consultation, which yielded 1,192 responses was overwhelmingly positive. Small numbers raised concerns over specific operational issues, but there were no significant service gaps identified.

11.0 CARBON REDUCTION AND ENVIRONMENTAL IMPLICATIONS

None

12.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

NHS England will rely on the PNA when making decisions on applications to open new pharmacies

13.0 RECOMMENDATION/S

To meet the deadline for publication of the 1st April 2015 the Chair approved the document in March, as the March board meeting was cancelled the board is therefore asked to ratify the Chair's action.

14.0 REASON/S FOR RECOMMENDATION/S

The board has a duty to publish a local PNA by 1st April 2015

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APPENDICES

BACKGROUND PAPERS/REFERENCE MATERIAL

- Wirral's Pharmaceutical Needs Assessment - www.info.wirral.nhs.uk/pna

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Wirral Health & Wellbeing Board	9th July 2014
Wirral Health & Wellbeing Board	12th November 2014

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