



Health and Wellbeing Board

Date:	Wednesday, 17 July 2019
Time:	3.00 p.m.
Venue:	Committee Room 2 - Wallasey Town Hall

Contact Officer: Pat Phillips/Bryn Griffiths
Tel: 0151 691 8488/8117
e-mail: patphillips@wirral.gov.uk / bryngriffiths@wirral.gov.uk
Website: <http://www.wirral.gov.uk>

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 FOR ABSENCE

3. MINUTES (Pages 1 - 8)

To approve the accuracy of the minutes of the meeting held on 20 March, 2019.

4. HEALTHWATCH

Verbal update – Phil Davies, Chair HealthWatch

5. NHS - UPDATE (Pages 9 - 14)

6. UNPLANNED CARE - UPDATE

Verbal report – Jacquie Evans, Assistant Director - Integrated Commissioning Programme

7. HEALTHY WIRRAL PROGRAMME UPDATE (Pages 15 - 54)

8. HEALTHY WIRRAL OPERATIONAL PLAN 2019/20 AND 5 YEAR STRATEGIC PLAN (Pages 55 - 64)

9. **URGENT CARE UPDATE (Pages 65 - 100)**
10. **FEEDBACK ON CARE QUALITY COMMISSION (CQC) REVIEW OF SERVICES FOR LOOKED AFTER CHILDREN AND SAFEGUARDING IN WIRRAL - MAY 2019**

Verbal report – Lorna Quigley (NHS Wirral CCG)
11. **BCF ARRANGEMENTS 2019 - 2020 (Pages 101 - 360)**
12. **UPDATE ON NEIGHBOURHOODS AND NETWORKS**

Verbal update – Graham Hodgkinson, Director for (Adult) Care & Health
13. **REDUCING THE STRENGTH**

Presentation – Dr Elspeth Anwar, Consultant in Public Health
14. **INCREASED INDEPENDENCE AND TRANSFORMING CARE: A LEARNING DISABILITY UPDATE (Pages 361 - 366)**
15. **CHILDREN'S SERVICE IMPROVEMENT**

Presentation – Paul Boyce, Corporate Director for Children Services
16. **SEND**

Presentation – Sue Talbot, Assistant Director Education
17. **WIRRAL TOGETHER FOR CHILDREN YOUNG PEOPLE AND FAMILIES**

Presentation – Carly Brown, Assistant Director, Modernisation & Support, Children's Services
18. **CHESHIRE & MERSEY HEALTHCARE PARTNERSHIP**

Link for information only

<https://www.cheshireandmerseysidepartnership.co.uk/>
19. **DATE OF NEXT MEETING**

The date of the next formal Board meeting is Wednesday 13 November, 2019 at 3:00pm in Committee Room 2 Town Hall, Wallasey.

HEALTH AND WELLBEING BOARD

Wednesday, 20 March 2019

Present: Councillor P Davies (Chair)

Ms N Allen	NHS England
Mr S Banks	Chief Officer, Wirral Health & Care Commissioning
Ms S Edwards	Service Director Ches & Wirral Partnership NHS Foundation Trust (dep for Sheena Cumiskey)
Mr D Eva	Independent Chair, NHS Wirral CCG
Ms J Evans	AD Integrated Commissioning Programme /WUTH
Cllr P Gilchrist	Wirral Council
Mr G Hodgkinson	Director for (Adult) Care & Health
Cllr C Jones	Wirral Council
Cllr I Lewis	Wirral Council
Ms P Simpson	Director of Nursing, WCFT
Mr M Thomas	Mersey Fire and Rescue
Ms J Webster	Director of Health & Wellbeing
Dr S Wells	Chair, Wirral CCG

Apologies

Ms L Bishop	CEO, Clatterbridge Cancer Centre
Mr P Boyce	Corporate Director for Children Services
Ms S Cumiskey	CEO, Ches & Wirral Partnership NHS Foundation Trust
Ms J Holmes	CEO, WUTH NHS Foundation Trust
Ms K Howell	CEO, Wirral Community NHS Foundation Trust
Ms K Prior	Healthwatch
Mr B Simpson	Chair, Strategic Housing Partnership
Ms B Stone	Head of Service, Community Action, Wirral

37 **DECLARATIONS OF INTEREST**

Members were asked if they had any pecuniary or non-pecuniary interests in connection with any item on the agenda and, if so, to declare them and state the nature of the interest.

Councillor Phil Gilchrist declared a non-pecuniary interest by virtue of being the Appointed Governor: Cheshire and Wirral NHS Partnership Trust

Dr Sue Wells declared a non-pecuniary interest by virtue of being a partner in a medical practice.

38 **MINUTES**

That the accuracy of the Minutes of the Health & Wellbeing Formal Board held on 14 November, 2018 be approved as a correct record.

39 **HEALTHWATCH WIRRAL**

Apologies had been received from the Chief Officer at Healthwatch and the Chair of the Committee indicated that this item had been circulated to Board members by email.

Resolved - That the Healthwatch update be deferred to the next meeting of the Health and Wellbeing Board.

40 **MERSEYSIDE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2018**

Sue Redmond—Independent Chair, Merseyside Safeguarding Adults Board attended the meeting to present the first Annual Report of the Merseyside Safeguarding Adults Board and responded to members questions.

As part of The Care Act 2014 all Local Authorities had been required to establish a Safeguarding Adults Board (SAB) for their area, to ensure that people who had care and support needs were protected. The Board operated at a senior level with membership across a wide range of partners and had a statutory responsibility to monitor and evaluate what was done by partner agencies individually and collectively to safeguard and promote the welfare of everyone in the areas covered by the Board

In 2017 Knowsley, Liverpool, Sefton and Wirral Councils had moved from having individual Safeguarding Boards to one combined Board for all 4 areas. This was now known as the Merseyside Safeguarding Adults Board. All partners had agreed that, by coming together and working across the wider footprint, better use could be made of resources therefore providing a more consistent approach by all partners to prevention, training and processes and that a greater impact could be made for local people in raising quality in all services across the area.

The first annual report of the Merseyside Safeguarding Adults Board looked at what had been done in the first year. It looked at the work of the sub groups who did much of the work on behalf of the board and detailed some of the actions that had been completed so far. The report also detailed priorities for the coming year and set out the first priority to hear the voice of people who use services and also the voices of the front-line staff who worked with them.

The Director of Adult Care commented on the benefits of bringing the Boards together and noted that this had been both very valuable and cost effective initiative. On behalf of the Committee the Chair thanked Sue Redmond for the report and presentation and it was;

Resolved – That the report and presentation be noted.

41 **DCS UPDATE : IMPROVEMENT BOARD**

Apologies had been received from the Corporate Director for Children's Services and the Chair of the Committee indicated that this item had been circulated to Board members by email.

Resolved - That the DCS Update: Improvement Board update be deferred to the next meeting of the Health and Wellbeing Board.

42 **HEALTHY WIRRAL**

43 THE NHS 10 YEAR PLAN

Simon Banks, Chief Officer, Wirral Health & Care Commissioning, attended the meeting and presented an overview of the NHS Long Term Plan to the Board and responded to Members questions.

The full report was available on the following link;

<https://www.england.nhs.uk/long-term-plan/>

The Chair thanked Simon Banks for the presentation to the Board and it was;

Resolved – That the presentation be noted.

44 HEALTHY WIRRAL PROGRAMME UPDATE

Simon Banks, Chief Officer, NHS Wirral CCG and Wirral Health and Care Commissioning, presented report that updated Board members on the Healthy Wirral Programme. The Programme supported the delivery of both Wirral 20/20 pledges in relation to Health and Wellbeing, and the delivery of Health and Wellbeing ambitions within 'Wirral Together'.

A summary of progress to date in 2018-2019 was provided in Appendix 1 to the report.

It was reported that in common with all health and care systems across Cheshire and Merseyside, Wirral was expected to establish and implement its plans to achieve the best possible health and wellbeing outcomes for its population within the funding available to the system. The 'Healthy Wirral' programme was regarded as the prime system-wide programme to deliver sustainable and affordable long-term changes to the way that the health and wellbeing of the Wirral Population is supported.

The Healthy Wirral Programme had identified a mission of 'Better health and wellbeing in Wirral by working together' with the clearly stated aim to enable all people in Wirral to live longer and healthier lives by taking simple steps to improve their own health and wellbeing. By achieving this together the very best health and social care services could be provided when people really needed them, as close to home as possible. Delivering this aim required the Wirral partners to rise to four key challenges:

- Acting As One - exemplified in actions and behaviours.
- Clinical sustainability - sustainable, high quality, appropriately staffed, organisationally agnostic services.
- Improving population health - delivering the Healthy Wirral outcomes around better care and better health using a place based approach.
- Financial sustainability - managing with our allocation, taking cost out, avoiding costs, delivering efficiency and better value.

The report outlined the key actions that had been undertaken to date and the proposed next steps to progress the Healthy Wirral Programme.

Resolved – That the report be noted.

45 **PUBLIC HEALTH : HEALTH PROTECTION A CALL TO ACTION**

Julie Webster, Director for Health and Wellbeing, presented a report that outlined the call to action made of Health and Care Partners to prioritise and work as a system to ensure there were robust health protection arrangements in place and deliver against three identified health protection priorities.

It was highlighted that health protection was a set of functions which acted to protect individuals, groups and populations from the impact of infectious diseases, environmental hazards as well as ensuring emergencies were prepared for and responded to. The key issues were set out in the report and emphasised that developments in the way the health of individuals, communities and populations were improved must be accompanied by a renewed focus on the basics of how communities were protected from infectious diseases and environmental hazards. In addition, new threats such as antimicrobial resistance and a rise in healthcare associated infections must be adapted and responded to. Local data had been reviewed and three priorities had been highlighted which were considered to require sustained action across the local health and care system to reduce the burden from health protection issues. These were set out in the report as;

- 1) The development of a system wide approach to Infection Prevention and Control in order to reduce the incidence of healthcare associated infections.
- 2) Reducing antimicrobial resistance.
- 3) Reducing the variation and uptake of cancer screening and national immunisation programmes.

These priorities provided a targeted focus on key challenges where improvement was required, or needs were greatest., in addition , there would be continued assurance that statutory duties to protect health were discharged and that local organisations were resilient to threats to health through effective planning and preparation as well as being equipped to respond to incidents, outbreaks and emergencies.

The report informed that the Wirral Health Protection Group had responsibility to ensure that Wirral had a robust health protection system which effectively controlled and prevented population level health issues. Multi-agency groups would drive delivery against the three identified priorities. The Wirral Health Protection Group would escalate risks to the Healthy Wirral Executive Directors Group and Healthy Wirral Partners Board as required.

Julie Webster informed that no single agency could address these challenges in isolation, nor could the Health Protection Group deliver these priorities independently. In order to deliver the action plans outlined for each of the three health protection priorities it was necessary that all Healthy Wirral Partners renew their focus upon these priorities and commit to action.

Resolved – That;

- 1 **the Call to Action for Healthy Wirral Partners to prioritise and work as a system to ensure robust health protection issues were in place be noted.**
- 2 **delivery against the three health protection priorities identified in the report be supported.**

46 **WIRRAL HEALTH & CARE COMMISSIONING**

47 **UPDATE FROM THE JOINT COMMISSIONING BOARD**

The Director of Health and Care presented a report that provided an update in relation to progress made in integrated commissioning for Wirral. The report included an update in relation to the work of the Joint Strategic Commissioning Board and included an update in relation to leadership activity undertaken on behalf of the Board through Wirral Health and Care Commissioning.

The report informed that Wirral Health and Care Commissioning (WHaCC) had been brought together as a strategic partnership between Wirral Council and NHS Wirral Clinical Commissioning Group (CCG) in order to lead the planning and commissioning of health and care services through a single organisation in order to fulfil the statutory health and care functions of the Council and the CCG. It had also been brought together to enable strategic outcomes to be effectively delivered through a single planning framework and structure. A Section 75 Agreement under the NHS Act 2006 had been in place to enable integrated commissioning that included formal decision-making arrangements and the pooling of resources to fund services.

In 2018/19 pooled funds had been used to fund social care frontline services as well as to fund jointly commissioned services that were accessed by the population of Wirral such as community equipment services, intermediate care services, adaptations, step-up and step-down services etc. This key agreement between the Council and the CCG set out how WHaCC worked and what resources were pooled to achieve better outcomes for the public.

The Joint Strategic Commissioning Board (JSCB) had been established in May 2018 as a Committee of Wirral Council Cabinet meeting together as a Committee in Common with the Governing Body Board of NHS Wirral CCG. The purpose of the Committee in Common was to oversee the commissioning, strategic design and performance management of health and care services in Wirral, based upon commissioning for improved population health, outcomes and quality of service provision.

The report also provided an outline of the duties and responsibilities of the JSCB Cabinet Committee exercising delegated powers of Wirral Council Executive and formulating recommendations for adoption by Wirral Council Cabinet and / or the CCG Governing Body Board, as the case may be. The Director also highlighted the key achievements and progress and set out key initiatives for 2019/2020.

Resolved – That the report be noted.

48 **DEVELOPMENT OF NEIGHBOURHOODS**

The Director of Health and Care provided the Board with a presentation that gave an update on Wirral Neighbourhoods and responded to members questions.

The presentation included place – based working principles, integrated care systems, place-based care in practice healthy Wirral, the Neighbourhood programme structure and frailty PIC worker impact.

The Healthy Wirral video link was available on the following link;

<https://vimeo.com/320741978>

Resolved – That the report be noted.

49 **PARTNER UPDATES**

50 **NHS QUARTERLY - UPDATE**

Nicola Allen, Head of Medical, NHS England (Cheshire & Merseyside) & Lead for Service Change Assurance provided an update for the Board regarding the activities and responsibilities of NHS England. The report outlined the national and regional activities November 2018 to February 2019 together and provided specific updates on priorities of NHS England (Cheshire and Merseyside).

The report informed that as part of closer working arrangements between the two organisations, NHS England and NHS Improvement had announced a new joint senior leadership team - the NHS Executive Group. This would be led by Simon Stevens as the Chief Executive of NHS England, who would lead both organisations. A single, combined post of Chief Operating Officer covering both organisations would be created. This role would report directly to Simon Stevens. The Chief Operating Officer would, for regulatory purposes, also be the identified Chief Executive of NHS Improvement. The seven Regional Directors, the National Director of Emergency and Elective Care and the National Director for Improvement would report directly to the new Chief Operating Officer. Nicola Allen also informed that seven new Regional Directors had also been appointed and joined the NHS Executive Group

The Chair thanked Nicola Allen for providing the update to the Board and it was;

Resolved – That the report be noted.

51 **UNPLANNED CARE - UPDATE**

Jacqui Evans, Assistant Director, Integrated Commissioning Programme provided the Board with an update on progress and developments across the unplanned care system, overseen by A&E Delivery Board. Appendix 1 to the report provided a performance overview.

Resolved – That;

1 the update and ongoing priorities overseen by A&E delivery board be noted.

2 the interdependencies of all partners to the resilient delivery of the 4 hour standard be recognised.

3 the improving position, challenges and priorities for 19/20 be noted.

52 CHESHIRE & MERSEY HEALTHCARE PARTNERSHIP

The following link was provided for information only.

<https://www.cheshireandmerseysidepartnership.co.uk>

53 CWP FORWARD VIEW CARE GROUP DEVELOPMENT

Suzanne Edwards, Associate Director for Specialist Mental Health and LD, NDD and ABI Cheshire & Wirral Partnership NHS Foundation Trust provided Board members with the CWP Forward View Care Group Development. The presentation set out the vision of working in partnership to improve health and well-being by providing high quality person-centred care.

Resolved- That the report be noted.

54 VOTE OF THANKS - COUNCILLOR PHIL DAVIES

Councillor Phil Gilchrist informed Members that this would be the last meeting of the Board attended by the Leader of the Council – Councillor Phil Davies. On behalf of the Board Councillor Gilchrist thanked Councillor Phil Davies for acting as Chair to the Health and Wellbeing Board, for his direction, for bringing partners together and enabling the build-up of trust. Councillor Phil Davies addressed the Board and commented that it had been a delight to act as Chair and that he believed the Board demonstrated an excellent partnership and stated that Members not remaining in individual silos had to be the way forward. He concluded by offering his best wishes to the Board and thanked Members for their kindness and ability to adopt the spirit of working together.

This page is intentionally left blank

NHS England Quarterly Report to Wirral Health and Wellbeing Board July 2019

1. Purpose of this report

The aim of this report is to update Wirral Health and Wellbeing Board regarding the activities and responsibilities of NHS England and NHS Improvement This report outlines the national and regional activities March 2019 to June 2019 together with specific updates on priorities of NHS North West

2. NHS England and NHS Improvement: Working Together

From 1 April 2019, NHS England and NHS Improvement came together to act as a single organisation. The Boards of NHS England and NHS Improvement will continue to operate separately meeting as committees in common. The two Boards share an integrated management team.

The North West Region (one of seven new regional teams) has recently announced a number of new executive appointments. The Regional Executive team structure with confirmed appointment at 1st July 2019 is described below:

North West Regional Director:	Bill McCarthy
NW Medical Director:	David Levy
NW Chief Nurse:	Jackie Bird
NW Director of Finance	Jonathan Stevens
NW Director of performance and Improvement:	Graham Urwin
NW Director of Strategy and Transformation:	Clare Duggan
NW Director of Commissioning	Linda Charles-Ozuzu

The integrated staffing structure for NHS England and NHS Improvement below executive level will be formally consulted on with staff through July and August 2019.



3. Planning

Following the publication of the NHS Long Term Plan in January 2019 there have been a number of important further supporting publications:

3.1. **The Interim NHS People Plan**

The interim plan focuses on actions for 2019/20 acknowledging the scale of the workforce challenge facing the NHS. Despite recent increases in staff numbers, it sets out how the NHS needs to recruit, retain and develop more staff to meet rapidly growing demand for 21st century healthcare.

The plan focuses on three key areas – recruiting more staff; making the NHS a great place to work; and equipping the NHS to meet the challenges of 21st century healthcare

How the NHS will rapidly increase the number of NHS staff, deliberately starting with the nursing workforce where the current vacancy pressure is greatest. The plan sets out how the NHS will:

- Immediately increase the number of undergraduates studying nursing with an offer to universities of more than 5,700 extra hospital and community placements for student nurses this year
- Rapidly expand the number of staff in recently created new roles including increasing the number of nursing associates to 7,500, offering a career route from healthcare support work to registered nursing
- Launch a new campaign, in conjunction with Mumsnet, to inspire more nurses to return to the NHS
- Quickly grow the number of nurses and doctors recruited from overseas via a new approach that will agree national “lead recruiter” agencies with the expertise to support the local NHS with international recruitment.

How to make the NHS “the best place to work”, addressing current concerns from frontline staff on the pressures they face, and improving retention rates. The plan sets out how the NHS will:

- Rapidly address current pensions issues which are discouraging experienced doctors and nurses from doing extra work for patients and causing them to think hard about remaining in the NHS

- Conduct a major staff engagement exercise this summer, led by new Chief People Officer, Prerana Issar, to create an explicit offer to staff covering issues they say matter to them for example, access to flexible working, career development and the best possible support from line managers.
- Ensure more support and development for frontline NHS managers, from ward to board, including the development of a new leadership compact covering the standards and behaviours leaders can expect of each other and a doubling of the size of the NHS Graduate Trainee scheme.

How to equip staff and NHS frontline organisations to provide 21st century healthcare including the need to join up health and care and take advantage of digital technology, genomics and other innovations. The plan sets out how the NHS will:

- Devolve significant responsibilities for workforce planning to the emerging integrated care systems.
- Develop new models of multi-disciplinary working to support the Long-Term Plan's ambition to integrate primary and secondary care.
- Launch a national consultation exercise to establish what the NHS, patients and the public require from 21st century medical graduates.
- Expand the NHS Digital Academy, deliver intensive digital skills training for boards and senior leaders, and develop the pipeline of digital experts in the NHS to support the Long-Term Plan's drive to fully harness digital technology.

A full People Plan will follow this interim Plan, translating this national vision into detailed, costed action plans, alongside a detailed implementation plan for the NHS Long Term Plan as a whole. The full plan will follow the government's next Spending Review when the total investment available for education and training and for digital and capital transformation is due to be confirmed.

3.2. Long Term Plan Implementation Framework

Following the publication of the NHS Long Term Plan, NHS England and NHS Improvement committed to publishing an implementation framework, setting out further detail on how it would be delivered. The framework can be found here: www.longtermplan.nhs.uk.

Local systems are working hard to develop draft versions of their five-year strategic plans. These plans will clearly describe the population needs and case for change in each area,

then propose practical actions that the system will take to deliver the commitments set out in the NHS Long Term Plan.

The framework summarises these commitments alongside further information to help local system leaders refine their planning and prioritisation. This includes detail about where additional funding will be made available to support specific commitments and where activity will be paid for or commissioned nationally.

3.3. Designing Integrated Care Systems in England: [Guide to designing ICS](#)

The NHS Long-Term Plan set the ambition that every part of the country should be an integrated care system by 2021.

It encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations and offer well-coordinated efficient services to those who need them.

This overview is for all the health and care leaders working to make that ambition a reality, whether in NHS acute or primary care, physical or mental health, local government or the voluntary sector.

It sets out the different levels of management that make up an integrated care system, describing their core functions, the rationale behind them and how they will work together.

4. Delivery

4.1. Primary Care Networks

Around 7,000 practices across England – more than 99% – have come together to form more than 1,200 Primary Care Networks (PCNs). PCNs typically serve populations of 30,000 – 50,000.

GPs will recruit multi-disciplinary teams, including pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers, freeing up family doctors to focus on the sickest patients.

Locally, across Cheshire and Merseyside NHS England has secured £6million investment for 2018 – 2020 to support Primary Care Networks of which there are currently 55 formed with 98.7% of practice joining a PCN this year.

4.2 Workforce

The PCN initiative comes alongside efforts to recruit more GPs as part of the NHS Long Term Plan.

The latest figures show an increase of 300 more family doctors on the previous quarter, and the number of young doctors choosing to train as GPs now at a record high after increasing by 750.

There are also thousands more nurses, pharmacists and other healthcare professionals working in general practice than there were just a few years ago.

Another 20,000, who will also include social prescribing link workers, are being recruited to work alongside GPs.

Up to a third of appointments do not need to be with a family doctor, and the new recruits will free up GPs to spend more time with patients who need them most, offering longer appointments to those who need them.

Locally there are number of initiatives being pursued, including:

- Development of Physician Associate roles with 5 employed on Wirral LIFT
- Clinical Pharmacists – an additional 66 (whole time equivalent) clinical pharmacists working in general practice covering 55% of the total population of Cheshire and Merseyside.
- Practice Manager Development- -supported 40 practice managers and their deputies
- GP Retention schemes – e.g. WirralDocs Chamber Organisation

4.3. Streaming patients to community pharmacies.

We have developed pathways and services by which patients are now streamed to community pharmacies when they need help with their medicines. By doing this we release capacity in services that previously undertook these activities.

When patients need medicines urgently NHS111 now sends a NHS Urgent Medicine Supply Advanced Service (NUMSAS) referral to a community pharmacy conveniently located for the patient and open at that time that the patient needs the service. This frees up time in local urgent care services.

When patients are discharged from hospital with new or changed medicines the new NHS Transfer of Care around Medicines (TCAM) service sends electronic details of the changes

and details of the support that patients might need to their regular community pharmacy. This releases time in busy hospital discharge services.

Within Wirral the NUMSAS service handles around 250 referrals a month both in-hours and out-of-hours. The TCAM service is already operational at 10 C&M hospital trusts including Mental Health Trusts; such as Countess of Chester and Cheshire Wirral Partnership. The TCAM service is due to be launched at Arrowe Park Hospital by October

ENDS

Nicola Allen

Head of Medical & Lead for Service Change Assurance
NHS England & NHS Improvement – North West

1st July 2019

REPORT TITLE	<i>Healthy Wirral Update</i>
REPORT OF	<i>Healthy Wirral Programme</i>

REPORT SUMMARY

This matter affects all Wards within the Borough, and supports the delivery of both Wirral 20/20 pledges in relation to Health and Wellbeing, and the delivery of Health and Wellbeing ambitions within ‘Wirral Together’.

In common with all health and care systems across Cheshire and Merseyside, Wirral is expected to establish and implement its plans to achieve the best possible health and wellbeing outcomes for its population within the funding available to the system. The ‘*Healthy Wirral*’ programme is seen as the prime system-wide programme to deliver sustainable and affordable long term changes to the way that the health and wellbeing of the Wirral Population is supported.

The *Healthy Wirral* Programme has identified a mission of ‘*Better health and wellbeing in Wirral by working together*’ with the clearly stated aim to enable all people in Wirral to live longer and healthier lives by taking simple steps to improve their own health and wellbeing. By achieving this together we can provide the very best health and social care services when people really need them, as close to home as possible. Delivering this aim requires the Wirral partners to rise to four key challenges:

- **Acting As One** – exemplified in actions and behaviours. Delivering net system benefit
- **Improving population health** – delivering the *Healthy Wirral* outcomes around better care and better health using a place based approach.
- **Clinical sustainability** –sustainable, high quality, appropriately staffed, delivered across organisational boundaries.
- **Financial sustainability** – managing with our allocation, taking cost out, avoiding costs, delivering efficiency and better value.

This paper outlines the key actions that have been undertaken to date and the proposed next steps to progress the *Healthy Wirral* Programme.

RECOMMENDATION/S

The Health and Wellbeing Board is asked to note the contents of this report.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

- 1.1 The purpose of the report is to inform the Health and Wellbeing Board, no further action by the Health and Wellbeing Board is required except to note the report.

2.0 OTHER OPTIONS CONSIDERED

- 2.1 The *Healthy Wirral* Programme represents a system wide approach to the commissioning and delivery of health and care transformation on Wirral in order to achieve clinically and financially sustainable place based care. As such there is no alternative option to consider for the system.

3.0 BACKGROUND INFORMATION

2018/19 has been a year of development for the *Healthy Wirral* programme, commencing with a significant re-establishment of the programme; the development of a partners board with an independent chair, the creation of the programme team and the establishment of a comprehensive programme of primary and enabling work streams A summary of our progress to date in 2018-19 is being captured within a *Healthy* Annual Report, the final draft of which is provided at Appendix 1.

3.1 Revised governance and infrastructure

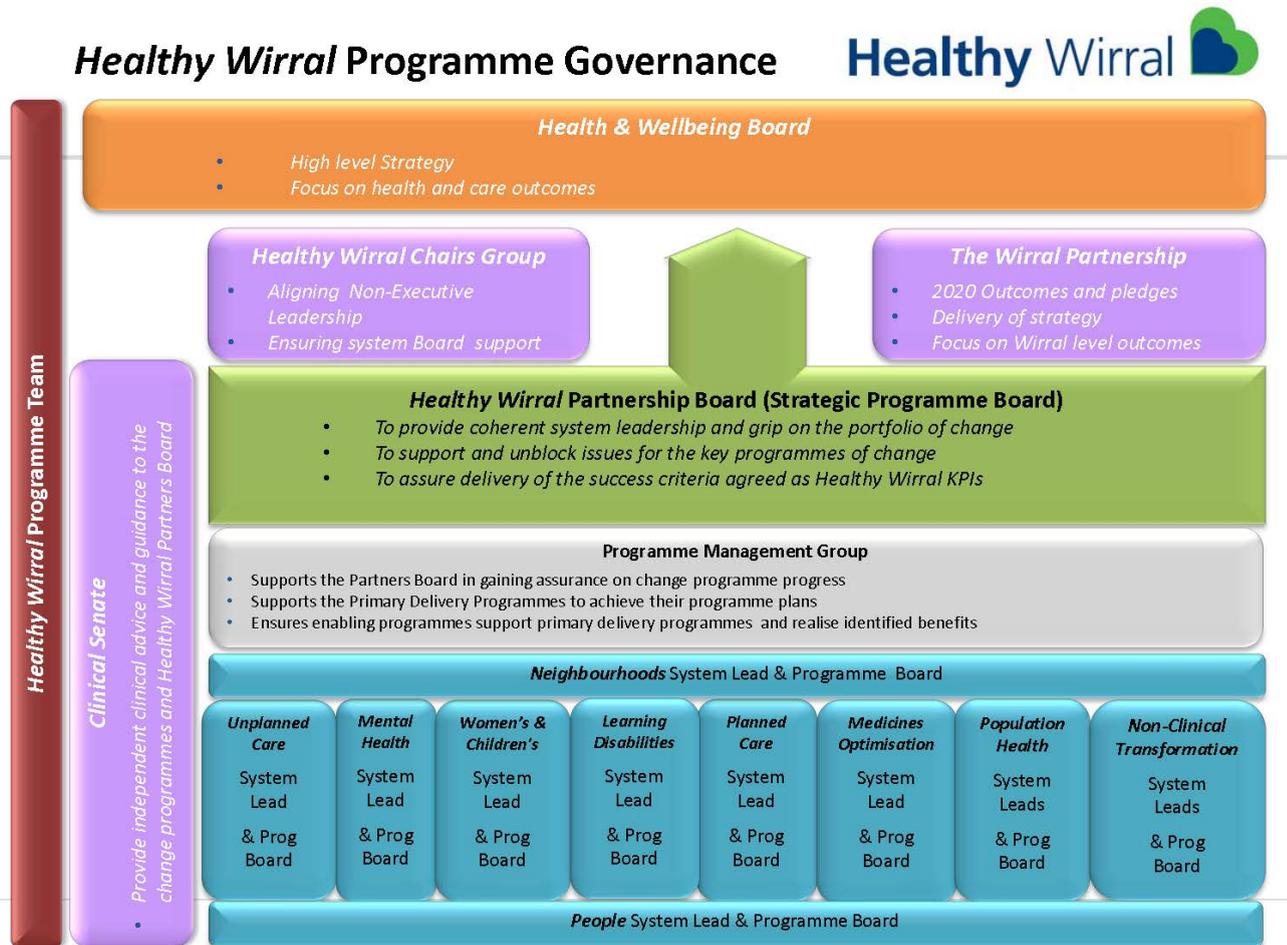
The *Healthy Wirral* programme progress against key objectives continues to be reported to the *Healthy Wirral* Partners Board on a monthly basis. Following the completion of the review of the programme governance and infrastructure, the *Healthy Wirral* Partners Board has revised its terms of reference with the aim of increasing the rigour of programme oversight as a Programme Board, with a formal programme of programme progress reporting by system leads and executive sponsors.

Additionally, in order to ensure that its membership is more reflective of the Place system it operates within, it has been agreed to extend the membership of the board to include the following system partners:

- Clatterbridge Cancer Centre NHS Foundation Trust

- Community Action Wirral
- Healthwatch Wirral
- *Healthy Wirral Clinical Senate*

The final governance structure is represented in the diagram below:



3.2 System Sustainability Plan and 5 Year Strategic Plan

The *Healthy Wirral* System Recovery Plan has been developed by provider Directors of Finance, the *Healthy Wirral* Finance Lead, Wirral Health and Care Commissioning Chief Finance Officer and Turnaround Director. The document was submitted to NHS England and NHS Improvement on 28th June 2019.

The System Sustainability Plan and the 2019/20 *Healthy Wirral* Operating Plan (covered in a separate report to the Board) are providing the basis for system discussions and activity to establish and agree the *Healthy Wirral* 5-year Strategic Plan. Work is underway to develop a supporting narrative around the delivery of the *Healthy Wirral* programme and the associated requirements of the Long Term Plan based on the available planning guidance which will form

the draft plan in preparation for submission in the autumn of 2019. A programme of activity for system partners will be established to ensure system engagement and input into the plan.

3.3 Transformation Fund

The 2019/20 budget approved by the Cheshire and Merseyside Health and Care Partnership System Management Board in January 2019 included a 0.5% top slice of allocations of which 0.1% would be retained as a contingency fund, 0.2% would be made available non-recurrently during the year to enable programmes to move from planning to delivery and 0.2% released back to Place systems to support the development of Place.

For *Healthy Wirral* this represented a return of the top slice equivalent to £1.08M to support transformation related to the component programmes for our place development. In common with all place systems, accountability for the delivery of change and return on investment will be subject to the application of a ten point plan for identifying 'what good looks like' at a place level.

Following the presentation of proposals to the *Healthy Wirral* Partners Board in March 2019 a proportion of this funding was committed in order to maintain the momentum of a number of investments made from 2018/19 resources. This included programme support for key work streams, and the extension of a neighbourhood based pilot of personal independence coordinators (PIC) supporting social prescribing.

A set of criteria were identified and agreed with the Board and an application process and timescale agreed for the allocation of the remaining funds. The criteria were linked to the system priorities considered essential to the implementation of place; agreed by system partners as:

- Development of neighbourhoods and community assets
- Managing Non-elective admissions demand
- Outpatient Redesign
- Medicines Optimisation
- Shared services across Wirral
- Development of new models of care.

- Delivery of Population Health approaches and benefits
- Delivery of 2019/20 Operational Plan outcomes

Following a panel scrutiny of the bids received, the *Healthy Wirral* Partners Board approved further allocation of the following resources:

- Programme Support for the Planned and Unplanned care, Medicines Optimisation and Mental Health programmes
- General Practice Enhanced Co-ordinated Care Locally Commissioned Service. This will build on the development of Primary Care Networks and their support for Wirral Neighbourhoods
- Delivering a Co-ordinated approach for Wirral's 3rd Sector response to Neighbourhoods, focusing on the design & delivery of a Leadership Programme that supports the development of neighbourhood working, building understanding and knowledge of the sector within the system and vice versa and facilitating a consensus for a Wirral Wide integrated service directory.

3.4 Neighbourhood Development

Work is continuing to establish the Neighbourhood teams supported by the Neighbourhood Transformation manager to ensure that a resilient approach is adopted. Key developments in this period are outlined below:

- 3.4.1 The *Healthy Wirral* Senior Change Team who are taking forward the Neighbourhood development programme have refreshed their programme plan and delivery structure
- 3.4.2 Work has been undertaken to optimise the Multi-disciplinary structure continuing across practices and including all key partners. This is aligned with the development work to establish a clear target operating model with agreed high level principles and approach, and key deliverables have been defined.
- 3.4.3 Following the approval of the Third Sector Transformation bid, work has commenced with Community Action Wirral and other third sector partners to establish and deliver the 3rd Sector response to Neighbourhoods outlined above and work is underway to support the creation of Community Leads for Neighbourhoods.

3.4.4 Wirral Health and Care Commissioning alongside NHS England have approved in principle 5 PCN submissions received via the Primary Care Committee. Ratification by NHS England by 30th June is awaited. System partners will then commence work with the Primary Care Networks, and their Clinical Directors to establish clear and effective relationships between and Neighbourhoods and networks.

3.5 Organisational Development

The People and Workforce Development programme has made considerable progress, with both Human Resources and Organisational Development support now in place for both Wirral and West Cheshire place programmes.

3.5.1 Work has commenced with Wirral neighbourhoods to undertake a capability gap analysis using the 'Aligning Capability' model to support the development the People and Workforce plan for neighbourhoods and the comprehensive system wide strategy and People plan for the delivery of place based care at a neighbourhood level across Wirral and Cheshire West.

3.5.2 The People work stream is supporting system and place Organisational Development at a number of levels, including the leadership development aspects of the 3rd Sector response to Neighbourhoods initiative described earlier, and a system culture and capability programme for system leaders through the *Healthy Wirral* Partners Board.

3.5.3 The pilot leadership programme for neighbourhoods, supported by the North West Leadership Academy has commenced with two of the three scheduled sessions delivered to a wide range of partners including G.Ps, Practice Managers, Community Matrons, Social Care Managers, Third Sector leaders and managers. The focus has been on building relationships, culture and values. Participants have found the programme so far to be enlightening and valuable in making wider system connection to support communities.

3.6 Specific Programme Progress

Following significant programme development and programme planning, 2019/20 is expected to be characterised by a strong focus on delivery of these plans and work toward achieving their defined benefits. Programme Delivery highlights include:

- 3.6.1 The Urgent Care Programme has focused effort on work to address streaming and triage. The Emergency Care Intensive Support Team (ECIST), with the support of NHS England and NHS Improvement, will be working with the operational leads from provider organisations and Wirral Health and Care Commissioning (WHCC) to deliver a sustainable solution to streaming and triage that moves Wirral nearer towards a clinical model that would support an Urgent Treatment Centre and a combined approach
- 3.6.2 The Planned Care Programme has started work in earnest on four key priority areas, namely outpatient redesign, gastro-intestinal conditions, respiratory care and Chronic Obstructive Pulmonary Disease (COPD), and Cardio Vascular Care. Outpatient redesign is focusing on the identification of opportunities where primary and community services can support demand and provide more responsive locality based approaches. The Cardiovascular Disease and Respiratory work streams are exploring the key synergies between their work plans with regard to prevention and rehabilitation, and the redesigned community heart failure service has fully commenced.
- 3.6.3 The Medicines Optimisation Programme Board has been established which will formalise the already significant progress made within this work stream in support of better medicines management across Wirral, resulting in improved outcomes for patients and efficient management of medicines resources. The work undertaken so far has placed Wirral on the map as a leader in the integration of approaches, and on the delivery of medicines value, with high cost drug costs falling by 1% in Wirral compared to an average 2% rise in costs across Cheshire and Merseyside.

3.7 Wirral Care Record and Population Health Intelligence

This programme is developing a number of technical projects which are fundamental to the delivery of our population health improvement ambitions on Wirral and will enable the successful delivery of the wider *Healthy Wirral* transformation work.

3.7.1 Health Information Exchange (HIE). This is providing real time information exchange, currently between Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Primary Care, Wirral Community Health and Care NHS Foundation Trust (WHCT) and Wirral Hospice St Johns. Usage of the HIE in May alone exceeded 30,000 incidences.

3.7.2 The Wirral Care Record which includes disease and wellness registries and longitudinal healthcare record. The Go live Criteria for the Wirral Care Record have been met and Programme Board have given authority to proceed with the launch. The programme team are developing a communication and engagement plan with relevant communication material identified with the aim of establishing system knowledge of the operating capabilities and usage of the system ready for a full launch in September.

3.7.3 *HealthAnalytics* is the data analytics tool. Good progress has been made with data validation and with building the information dashboards. A training agenda has been finalised and delegates identified by the Population Health Intelligence sub-group. Work underway to ensure robust governance arrangements in respect of analytics

4.0 FINANCIAL IMPLICATIONS

4.1 2018/19 System Position

Significant financial pressures have emerged in recent years on Wirral, particularly in Acute Care and commissioned out of Hospital Packages of care. The Wirral Health system ended 2018/19 with an overall deficit of 26.5m. In 2018/19, Wirral Clinical Commissioning Group (CCG) delivered £11.7m (60%) of its QIPP savings target, alongside a further reduction in independent sector

activity and continued development in better system working via the launch of the *Healthy Wirral* Programme.

WUTH has delivered a £9.6m in efficiencies, representing 72% of its overall Cost Improvement Plan (CIP), together with an operational deficit of £33.0m being £8m adverse to plan. Both WHCT and Cheshire and Wirral Partnership NHS Foundation Trust (CWP) have delivered their CIP plans at £2.5m and £1m respectively, and have exceeded their control totals, reporting £3.7m and £0.7m (Wirral Share) surpluses respectively, largely due to additional STF support.

The CCG delivered a £2m surplus in 2018/19 in line with the control total set by NHS England, being able to achieve this position due to an extra £5m support received from NHS England during Quarter 4 of the financial year. This is summarised in the table below:

I&E Performance (Incl. STF) Surplus / (Deficit)	I&E Performance to date		
	Plan	Actual	Variance
	£,000	£,000	£,000
CWP (Wirral proportion)	246	742	496
Wirral Community	2,193	3,723	1,530
WUTH	(25,042)	(33,008)	(7,966)
Wirral CCG	2,000	2,003	3
Wirral LA	0	0	0
Total	(20,603)	(26,540)	(5,937)
note : the above excludes impairments and other below line adjustments			

4.2 System Overview for 2019/20

The approach taken by the Wirral system for 2019/20, is for all partners to work together to help support providers deliver their control totals in order to secure the external funding of £20million. The sum of individual organisational control totals amount to a small system surplus of £1.1m.

The individual organisational control totals have been set at very challenging levels, resulting in a planned CIP / QIPP requirement of £40.4million, being

7.5% of the total CCG's allocation, (5.7% of total CCG and provider costs within the economy) which clearly is not achievable in one year without taking high risk actions. It is highly likely therefore that the system will produce a deficit of c. £14mil, residing in the CCG's financial position, in order for the providers to deliver their Control Total's and for the system to receive the external funding. Without the external £20mil, the system faces a deficit of at least £34mil.

Therefore, key actions now focus on:

- The delivery of 3-5 year system wide recovery and sustainability plan
- The delivery of a challenging system wide efficiencies programme
- Continuation of the *Healthy Wirral* collaborative system management approach, as NHS Wirral CCG will continue to work in collaboration with its partners to support overall system recovery and continued sustainability.
- A well-developed set of mitigation plans against to address key risks

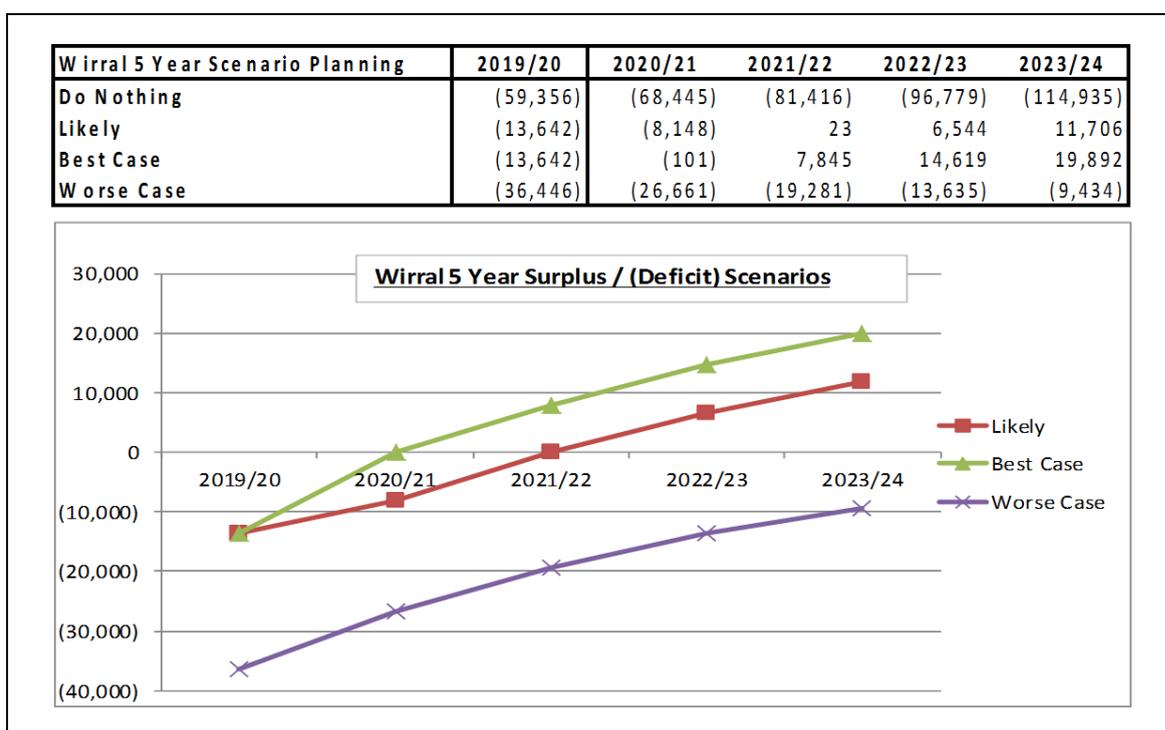
NHS Wirral CCG remains confident that, with its robust internal financial governance system, and the commitment of Wirral partners to a 'system' solution, it can work towards fulfilling its statutory financial duties and lay the foundation for sustained financial recovery.

4.3 System Financial Recovery Plan

The proposed plans for 2019/20 see the Wirral "Place" working together as an overall system, largely to deliver genuine improvements for patients and to return the "Place" to financial sustainability in the longer term. The resultant "System" net risk overall is a potential £13.6m deficit across all partners which is currently held within the CCG's plan. The Wirral system collectively has an overall QIPP/CIP target of £40.4m of which £18.6m is unidentified and represents part of the "system" overall net risk.

This system wide approach enables the Wirral "Place" to unlock £20m of national support without which the overall system "gap" for 2019/20 would be closer to £32.5m. Prior to this approach being agreed the initial underlying system "gap" was £45m (before central funding), with both the CCG and WUTH increasing their QIPP/CIP targets to support the system position.

Working together as a “System” It is proposed that the overall underlying “net risk” is recovered via CCG allocation growth over the next 5 years to return the system to a healthy sustainable overall recurrent surplus by 2023/24. This assumes that CCG growth will be made available each year to support provider inflation and unavoidable cost pressures, with the balance taken to fund the system deficit. All other cost pressures and growth must be contained and managed via organisational ‘Business as Usual’ savings, productivity and system change supported by initiatives delivered through the *Healthy Wirral* Programme, and the Cheshire & Merseyside HCP programmes. This is summarised in the graph below:



In supporting the plans above, *Healthy Wirral* system partners have also committed to delivering future system sustainability. System efficiencies will be sought through the agency of key *Healthy Wirral* primary and core programmes and the delivery of effective place-based neighbourhood health and care approaches. Our plans for 2019/20 are being aligned with longer term transformation priorities to ensure that changes can be achieved that are sustainable at a system level

5.0 LEGAL IMPLICATIONS

The *Healthy Wirral* programme will be delivered within the statutory and legal frameworks set for health and care in England.

6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

These are being considered within the *Healthy Wirral* programme and provided by the participant organisations.

7.0 RELEVANT RISKS

The *Healthy Wirral* Partners Board has developed a Board Assurance Framework that will identify the principles risks to the delivery of the strategic programme aims and how these will be mitigated. The most significant risks are a further deterioration of the financial position of the Wirral health and care economy and of associated clinical and performance standards. These can only be mitigated by the adoption of an “acting as one” approach to sustainability planning.

8.0 ENGAGEMENT/CONSULTATION

Engagement and consultation will take place as the programme progresses at all stages. Communications and Engagement is identified as a key enabling work stream for the programme and a communications and engagement strategy is being developed.

9.0 EQUALITY IMPLICATIONS

The *Healthy Wirral* programme will give due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people and who share a protected characteristic (as cited under the Equality Act 2010) and those who do not share it. The *Healthy Wirral* programme will also give regard to the need to reduce inequalities between patients in access to, and outcomes from health and care services and to ensure services are provided in an integrated ways where this might reduce health inequalities. Moreover the *Healthy Wirral* programme comprises a wide range of delivery projects and the governance structures in

place for the programme require the work streams to individually review their equality, quality and privacy impact assessments.

REPORT AUTHOR: **Julian Eyre**
Healthy Wirral Programme Manager
telephone: (0151) 651 0011 ext 401169
email: Julian.eyre@nhs.net

APPENDICES

Appendix 1 Draft *Healthy Wirral* Annual Report 2018/19

REFERENCE MATERIAL

SUBJECT HISTORY (last 3 years)

Council Meeting	Date



Healthy Wirral Place Programme

Annual Report for 2018-19

[Type text]

Contents	Page
Introduction by <i>Healthy Wirral</i> Independent Chair and Senior Responsible Officer	3
Mission Statement and Vision	4
Executive Summary	5
<i>Healthy Wirral</i> System Achievements in 2018/19	7
<i>Healthy Wirral</i> Programme Development	7
Developing our Place Programme	9
Integration of Health and Care systems and partners	10
<i>Integrating Health and Care Commissioning</i>	<i>10</i>
<i>Integrating Health and Care Provision</i>	<i>11</i>
Primary Programme Development	11
<i>Planned Care</i>	<i>11</i>
<i>Unplanned Care</i>	<i>12</i>
<i>Mental Health</i>	<i>12</i>
<i>Learning Disabilities</i>	<i>12</i>
<i>Women, Children and Families</i>	<i>13</i>
<i>Medicines Optimisation</i>	<i>13</i>
People, Organisational Development & Leadership	14
Population Health Management	15
<i>Population Health Intelligence</i>	<i>15</i>
<i>Population Health Priorities</i>	<i>16</i>
Transformation	17
Financial Overview for 2018/19 and Year End Position	18
Financial Plan for 2019/20 And 5-Year System Sustainability Strategy Overview	20
<i>Healthy Wirral</i> System Operating Plan for 2019/20	22
Our 5 Year Strategic Plan	23

[Type text]

Introduction to the *Healthy Wirral* Annual Report



Simon Banks
Healthy Wirral
Senior Responsible Officer



David Eva
Healthy Wirral
Independent Chair

We are very pleased to introduce the *Healthy Wirral* Annual Report for the year 2018/19

This is the first report of this kind and represents a significant development in our partnership to deliver better health and care through a place based approach on Wirral. We can only achieve this through the support and efforts of all our system partners, and we hope that the progress during the past year highlighted in this report demonstrates our overall commitment to work together to achieve sustainable improvements in the health and wellbeing of the people of Wirral. 2018/19 has been a year of consolidation of our partnerships and building our future plans. 2019/20 and beyond will see the delivery of these plans through our system operational plan, which will provide the basis for our long term strategy. Wirral continues to face significant challenges but we are confident that the progress we have seen in the last year will continue to bear fruit and allow us to work with our citizens and staff to build a *Healthy Wirral* to be proud of.

[Type text]

Healthy Wirral: Wirral's Integrated Health and Care System

Wirral system partners recognise that it will only be through collective, actions as an integrated care system that we will deliver the best population health and wellbeing outcomes.

Our mission is:

'Better health and wellbeing in Wirral by working together'

In order to deliver this mission *Healthy Wirral* partners have agreed a broad vision which is:

'To enable all people in Wirral to live longer and healthier lives by taking simple steps of their own to improve their health and wellbeing. By achieving this together we can provide the very best health and social care services when people really need them, as close to home as possible'.

This vision stresses the importance of preventing ill health and our people being cared for in the right place at the right time. Recognising also the need to live within our means as a system, we also aim to maximise the value of the 'Wirral Pound', by ensuring that this is invested in place based care that will deliver evidenced based, quantifiable quality outcomes for the population of the Wirral. This requires our system partners to work collaboratively to deliver sustainable transformation across the system and support the following fundamental principles:

1. **Acting As One** – exemplified in actions and behaviours. Delivering net system benefit
2. **Improving population health** – delivering the *Healthy Wirral* outcomes around better care and better health using a place based approach.
3. **Clinical sustainability** –sustainable, high quality, appropriately staffed, delivered across organisational boundaries.
4. **Financial sustainability** – managing with our allocation, taking cost out, avoiding costs, delivering efficiency and better value.

EXECUTIVE SUMMARY

In common with all health and care systems across Cheshire and Merseyside, Wirral is expected to establish and implement its plans to achieve the best possible health and wellbeing outcomes for its population within the funding available to the system. The '*Healthy Wirral*' programme is seen as the prime system-wide programme to deliver sustainable and affordable long term changes to the way that the health and wellbeing of the Wirral Population is supported.

2018/19 has been a year of development for the *Healthy Wirral* programme, commencing with a significant re-establishment of the programme; the development of a partners board with an independent chair, the creation of the programme team and the establishment of a comprehensive programme of primary and enabling work streams.

The establishment of robust governance for the programme has involved the engagement and active participation of all system partners. This partnership has been formalised through the development of a memorandum of understanding; approved by system partner boards and governing bodies and enshrining partner commitment to 'acting as one' and adopting the principles of the controlled expenditure programme (CEP-Lite) to ensure that transformation plans are sustainable and make the best use of the 'Wirral Pound'.

The commitment to a place based approach to health and care delivery has centred on the establishment of a multi-agency and multi-disciplinary approach to supporting and caring for communities based on natural populations of 30,000- 50,000 people, and working closely with both statutory and voluntary services. The development of nine neighbourhoods has involved the engagement of all health and care sectors, and developing leadership at community level to act on population intelligence to find local solutions to local health and wellbeing challenges. This has been supported in no small part by the establishment of neighbourhood leadership teams, co-ordinated by G.P Neighbourhood Co-ordinators and involving key professionals and community leaders. In 2018/19 the primary challenge identified was the support of people whose level of frailty placed them at considerable risk and led to frequent unscheduled hospital admissions. Each Neighbourhood will have its own story to tell

[Type text]

about how they have approached their population challenges. The case study below is just one example of how working together and taking a holistic approach to identifying solutions can yield real improvements for individuals as well as releasing time to care for professionals.

Mrs A was frail lady of 85 who had been suffering from recurrent Urinary Tract Infections and problems with her medication, which had meant she had requested lots of GP home visit appointments in the last year. The frailty lead at her G.P Practice referred her to a Personal Independence Co-ordinator (PIC) who arranged to meet Mrs A and conduct a full holistic assessment through guided conversation.

Mrs A said that although she had a good supportive family, during the day she was feeling a little lonely and isolated. She had recently moved from Liverpool into sheltered accommodation on the Wirral, and although she often joined in with the coffee mornings she did not feel very connected to the community. She felt she was supported very well as she had a package of care, a falls detector and family visiting who support her with shopping.

The PIC worker arranged to keep regular contact with Mrs A and also connected her to Age UK Wirral Telephone Befriending service. To help improve her health the PIC purchased a "Hydrate motivational straw water bottle" for Mrs A and discussed the importance of drinking at regular intervals to reduce reoccurring Urinary Tract Infections. They also discussed whether further falls prevention support would be helpful.

During the first 3 months that Mrs A received support from PIC she had 5 G.P appointments, whereas in the previous year she had contacted the G.P 68 times. Mrs A reports that she feels much better following the PIC worker support and has found the regular befriending contact very helpful. She is regularly drinking more water using the measured bottle and has suffered much less urinary tract infections as a result

The achievements by Wirral partners outlined in this report are indicative of a significant shift within Wirral Place and commitment from our system to establishing an integrated care partnership that is focused on population health improvement as its primary objective. The development and agreement of a system operational plan has been a clear symbol of system partner intentions to collaborate and remove organisational barriers to progress. The development of an ambitious and sustainable 5-year strategy for *Healthy Wirral* will provide palpable proof of system shift from planning to delivery against our identified priorities.

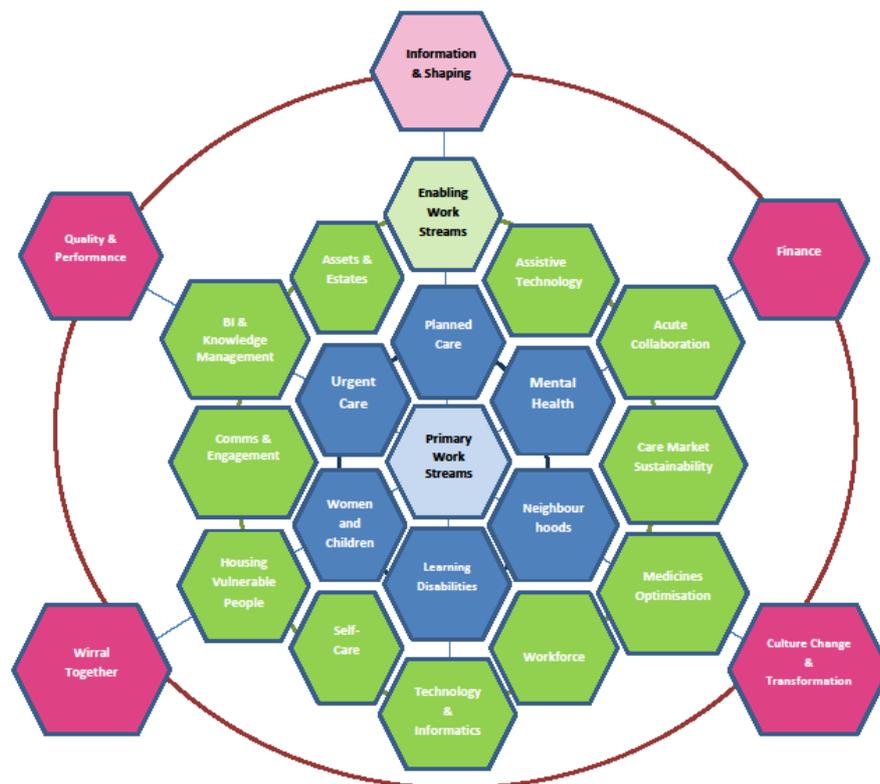
Achievements in 2018/19

Healthy Wirral Programme Development

System leaders across Wirral have recognised that improving population health and delivering effective and affordable Health and Care services on Wirral will only be possible through a coordinated and integrated approach to the commissioning and delivery of services through a place based approach and focused on the needs of people within the communities they live in. In early 2018 a series of whole system events were held, aimed at reviewing the progress of work to date and to commit organisations and resources to the re-establishment of a comprehensive place-based programme to deliver the vision of *Healthy Wirral*.

By April 2018 a programme team had been fully established, comprising an Independent Chair to lead the *Healthy Wirral* Partners Board, a Senior Responsible Officer, Programme Manager and Finance Lead. The work of senior system leaders including this team has guided the programme development and some key system changes designed to accelerate transformation outcomes, characterised by a number of key achievements through the year.

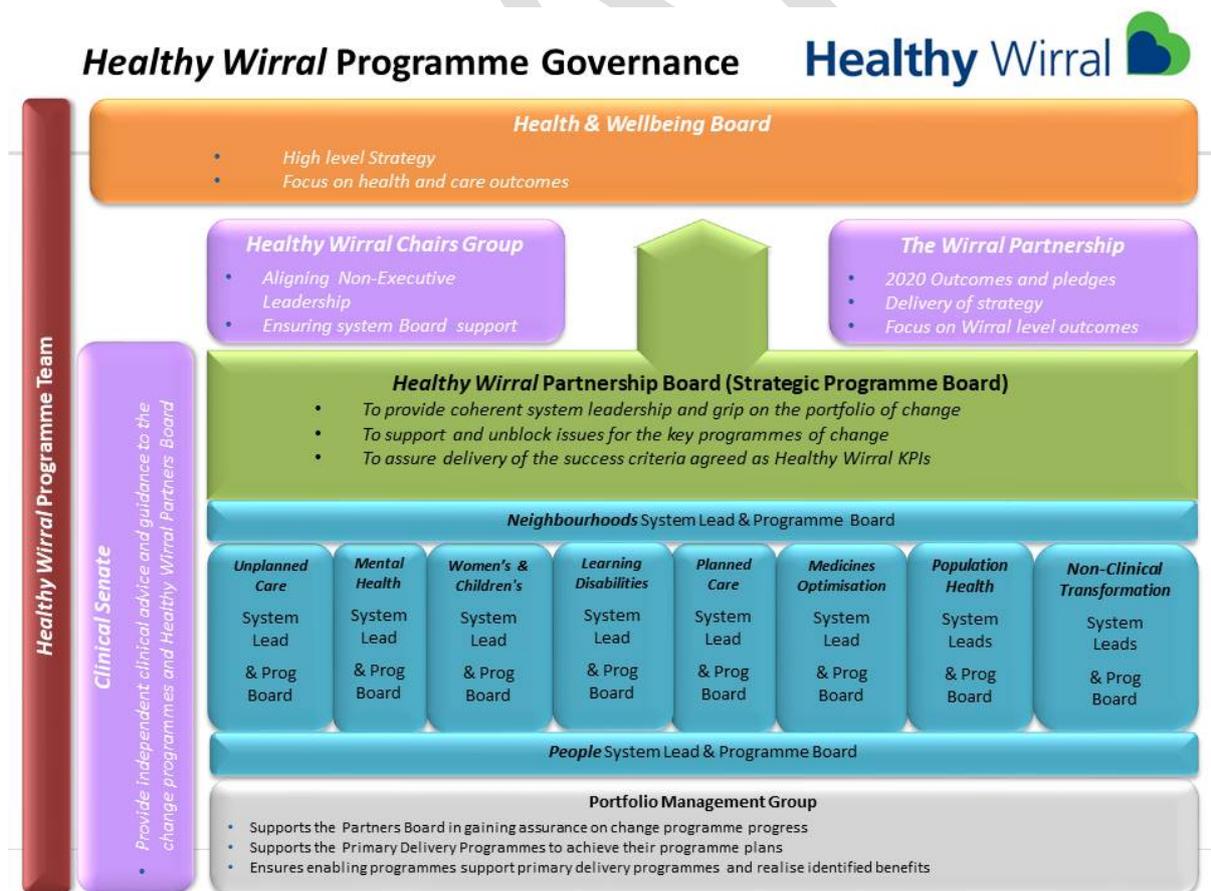
A detailed programme structure was developed to reflect the breadth of change programmes and the need for significant enabling support to achieve sustainable, large scale change and integration of transformation effort to deliver a place based system. Initially the programme consisted of 6 primary programmes and 11 enabling programmes, summarised in figure 1 below.



[Type text]

The *Healthy Wirral* programme team worked closely with system colleagues and the *Healthy Wirral* Partners Board to identify executive sponsors and system leads for all of these programme work streams. Each work stream was asked to develop a programme summary and plan on a page to clearly identify their programme plans, expected outcomes and benefits, and how their work stream integrated with other programmes, and in particular the development of neighbourhood based approaches.

System partners were asked to support these work streams and the overall governance of the programme. As part of a process of continuous review including the input from programme management experts, an amended programme infrastructure and governance was proposed which has reduced complexity and increased programme accountability and visibility to the *Healthy Wirral* Partners Board who have assumed a portfolio programme board role. The revised programme structure and governance are summarised in figure 2 below:



Developing our Place Programme

A focus on providing services at the most appropriate local 'place' level has led to the establishment of our Place Based Care System based on supporting health and delivering care at the most appropriate level. Our vision is for services to be delivered through 51 General Practices, nine neighbourhoods and one district. Each of the nine neighbourhoods is made up of a population of between 30- 50,000 residents using health and care needs of the population as the building stone for the geographic boundary.

Primary care leaders, including General Practice (GPs), will be at the centre of the Place Based Care System, transforming community-based services and care pathways for a defined population.

Neighbourhood networks consist of an integrated workforce, with a strong focus on partnerships spanning primary, secondary, mental health and social care and importantly community and voluntary groups. They will also utilise the support (assets) available in their area to the benefit of their particular population. The aim is to improve outcomes for people and to deliver consistent and continuity of care.

The neighbourhood leadership teams have been established during 2018-19; led by a GP to ensure co-ordination of the neighbourhood team in the delivery of health and care pathways. There is a clear focus on the delivery of prevention, early intervention and proactive care to reduce the demand for reactive and specialist care.

Our vision for Neighbourhoods is:

Together we will provide effective care, as close to the resident's home as possible, delivered by the right person at the right time

Our plans to deliver this involve:

- Organisation of **care around people's holistic needs** - physical health, mental health and social care.
- Development of services that are **clinically and financially sustainable** through greater integration of care, **reduction in duplication** across a pathway and **flexibility in approach** of delivery to meet local population needs.
- **Collaboration** and involvement with a **wider range of organisations** from different sectors, including the identification and use of 'community assets'
- **Partnership working with families, carers and public** and local neighbourhoods to transform the way that services are delivered and improve the **focus on population health and wellbeing**.

[Type text]

- **Sharing of expertise** and skills from different organisations to benefit how health and care is delivered.
- Making **community-based care the central focus** of the health and care system
- Releasing GP time to enable more **effective, efficient and sustainable practices**

We have made significant progress in defining and establishment of Neighbourhoods. GP Co-ordinators have been appointed to each of the nine neighbourhoods, leadership teams have been established and meet regularly. The neighbourhood teams have focused their early activity on the identification and management of frailty within their population, producing both neighbourhood level and practice level frailty plans submitted and commencing delivery of their action plans. Significant work has been undertaken in the alignment of resources and improving the links of community resources within neighbourhoods. Third sector links and provision have also been established and strengthened. This work has been supported by the development of robust and detailed population health intelligence aggregated at a neighbourhood level with the introduction of Neighbourhood intelligence profiles.

This work has been undertaken and overseen by the Senior Change Team, which comprises key clinical and organisational leaders from across the Wirral partnership. The work of this team and the neighbourhood leadership teams provides a firm basis for Wirral to continue to meet the ambitions of *Healthy Wirral*; working closely with Primary Care Networks and other key partners to ensure collective effort is aligned to develop an effective and responsive Place Based Care System focused on improving the health and wellbeing outcomes for our population

Integration of Health and Care systems and partners

Integrating Health and Care Commissioning

NHS Wirral CCG and sections of Wirral Council came together from May 2018 to form a single commissioning function, Wirral Health and Care Commissioning (WHaCC). WHaCC will jointly commission all age health, care and public health services for the Wirral population. WHaCC will be responsible for setting the commissioning agenda and will lead the development of a Place Based Care System (PBCS) in Wirral. The focus will be on people and place, not on organisations. The transformation of service delivery is expected to reduce need for high cost acute care and improve health and wellbeing, reducing the need for long term care. The aim is to improve the outcomes for the people of Wirral and also to deliver sustainable services, both clinically and financially. Placed based care is being developed in response to the challenges Wirral health and care system faces of

[Type text]

constrained funding, increasing demand, fragmentation of services and the need to deliver better health, better care and better value for the people of Wirral.

Integrating Health and Care Provision

Following negotiations between key health and care partners in Wirral, adult social care services were transferred into Wirral Community NHS Foundation Trust in June 2017. Following this, in August 2018 the all Age Disability Social Care teams were transferred into Cheshire and Wirral Partnership NHS Foundation Trust. This has served to integrate the frontline assessment and support planning processes for vulnerable adults and older people across the health and care delivery pathway, and which will provide joined up seamless health and social care delivery services for Wirral people.

Following a period of stabilisation and integration of these teams into their new organisations, and organisational development processes to establish strong operational and contract management processes, it is planned that 2019/20 will be a year of transformation, establishing true integration of health and care teams, enabling integrated partnership working for local people through strong multi-disciplinary teams operating at a neighbourhood level

Primary Programme Development

Planned Care

Significant work has been undertaken in year to support the development of effective planned care, focusing on improvement of referral to Treatment times and the transformation of Musculo-skeletal (MSK) services.

Wirral implemented a new MSK Integrated Triage Service in 2018; this applies the key principles of the MSK First Contact model and is achieving reductions to diagnostics and reductions in secondary care referrals in line with the model.

A key development within the 2018/19 planned care programme was the redesign of heart failure services, and the development of a community heart failure service. This has been successfully launched and includes community based intravenous diuretic therapy.

In order to ensure that the planned care programme is focused on the areas that can will have the greatest impact for the system, the programme team and the Planned Care Board have undertaken a mapping process to identify the key priorities. The team have worked with the Right Care and Model Hospital teams as part of this process and have identified the following priority areas which they have commenced their clinical redesign and transformation programmes:

[Type text]

- Cardio-vascular disease, building on the successful work undertaken in Heart Failure re-design in 2018-19, including prevention, rehabilitation and early supported discharge for stroke.
- Respiratory/ Chronic Obstructive Pulmonary Disease (COPD) services to include prevention diagnosis, management, admission avoidance and monitoring
- Gastrointestinal services, including diagnostic, community and secondary care pathways
- Out Patients redesign, working with hospital colleagues, primary care and community services to identify alternative approaches and community based support.

Unplanned Care

Notable progress has been made in relation to the delivery of improvements to our urgent and unplanned care in Wirral. This has included delivering and maintaining Delayed Transfer of Care (DToC) performance, establishing streaming from Emergency Department (ED) to Primary Care with a new model in place since November 2018. The Wirral Single Point of Access is now fully co-located, bringing together 3 areas (mental health, physical health and social care duty). The High Impact change model work undertaken has supported the delivery of a Trusted Assessor model for our Transfer to Assess service, effective teletriage and improved support to care homes, which is showing reductions in ED attendances and calls to 111 and 999.

Mental Health

Our vision is to establish an integrated service with seamless patient pathways, aligning primary and secondary mental health services and integrated with community level interventions including social prescribing.

Good progress to achieve our vision has been made to date. Action has been focused on the Talking Together, Live Well Wirral programme which has been developed within the wider Improving Access to Psychological Therapies (IAPT) service specification written during 2018. A procurement exercise undertaken, resulting in award to Insight Healthcare who deliver the IAPT service in line with a number of strategic partners, both statutory and third sector from April 2019.

Learning Disabilities

National specifications for both the Community Learning Disability Teams and Assessment and Treatment Units have been localised and are being implemented across Cheshire & Wirral, with Wirral leading this work. Non recurrent pump priming monies have been obtained from NHS England to support the delivery of the Intensive Support Service function of the Community Learning Disability Teams across Cheshire & Wirral. Recurrent money for this function has now also been

[Type text]

identified from the planned redesign of short breaks services and this will support the long-term delivery of the Transforming Care Programme.

Work has commenced to increase the number of health checks completed, including health action plans. A scoping exercise has commenced to establish the reasons for low completion rates which involves the GP lead for LD, business intelligence teams and health facilitators from Cheshire and Wirral Partnership NHS Foundation Trust. A draft information pack has been developed for primary care and inclusion at GP members/neighbourhood sessions.

A project group for Stopping over medication of people with a learning disability and /or autism (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) has been established and pilot projects have been completed. Information has been disseminated to primary care and initial work regarding awareness/e learning for GPs has been completed and will be progressed in 19-20.

As part of the All Age Disability Strategy Action Plan Wirral has achieved an increase to 50% in the number of people with a long-term condition or disability who are employed. This is an increase from 37% at the start of the Wirral Plan in 2015/16.

Women, Children and Families

The Healthy Child Programme (0-19 years) provides a framework to support collaborative work and more integrated delivery of services for children and young people. The 0-5 element of the Healthy Child Programme is led by health visiting services and the 5-19 element is led by school nursing services, providing place-based services and working in partnership with education and other providers. Additional support around Health Improvement including areas such as emotional health and wellbeing, sexual health and substance misuse further compliments this offer. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families that are in need of additional support and children who are at risk of poor outcomes. The 0-19 Service has been in operation in Wirral for just over 4 years and has seen progress in a number of areas, including uptake of developmental reviews for children, the implementation of integrated reviews and the establishment of health and wellbeing hubs in 4 localities to increase access to services.

Medicines Optimisation

The Medicines Value Programme for Wirral has been established to improve health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews to ensure we are getting the best value from our medicine's expenditure. The programme has made good progress in 2018-19, building a firm foundation for transformation work in 2019-20. A multi sector partner group established which has been formally established as the

[Type text]

programme board for the Medicines Optimisation transformation programme. A workforce map for all sectors has been completed and communicated and a successful system educational event has been held.

GP practice based Clinical Pharmacists (GPCPs) commenced working across both primary and secondary care in April 2018. The programme is now live in 13 practices. A development linked to this programme has been the introduction of the deteriorating patient which allows community pharmacists to directly contact GPCPs where they have concerns.

Biosimilar medicines are biological medicines which is highly similar to another biological medicine already licensed for use and have been shown not to have any clinically meaningful differences from the original biological medicine in terms of quality, safety and efficacy. A Biosimilar oversight group has established which has delivered significant system savings based on the delivery of a range of biosimilar drugs.

The Medicines Optimisation in Care Home (MOCH) programme commenced in 2018-19 and staff recruited as part of an NHS England Pilot in January to support existing care home pharmacists.

Mental Health medicines developments have included targeted electronic referrals to Community Pharmacy; concentrating on antidepressant medicines use review (MUR) to support suicide prevention, antipsychotic MUR to support relapse prevention, and improved adherence with medicines for diabetes or hypertension and inhalers to support admissions prevention. Targeted electronic referrals have also commenced to notify of Clozapine treatment alerting community pharmacists to likely complications such as bowel obstruction, dyscrasias, and the impact of smoking and other drug interactions on clozapine levels in order to reduce admissions. An in-reach service to the Wirral University Teaching Hospitals Trust has been agreed to support medicines optimisation for mental health medicines in response to the National Confidential Enquiry into Patient Outcome and Death report (**NCEPOD**) which reviews clinical practice and identifies potentially remediable factors in the practice of patient care..

A 4-month NHSE funded STOMP pilot across 3 GP practices has been undertaken during which all patients with learning difficulties and concurrent antipsychotic prescriptions were reviewed by specialist mental health pharmacist.

Work commenced on the development of Health-e-Intent population health intelligence platform to analyse medicines practice and drive performance improvements relating to antimicrobial and antibiotic prescription

People, Organisational Development & Leadership

[Type text]

Wirral partners have a shared ambition to develop an effective and sustainable workforce, whose capability (capacity, competence and confidence) is aligned to the vision and aims of *Healthy Wirral*. This has resulted in a commitment to delivering a place-based approach to the development of a Wirral People strategy and delivery plan.

Wirral is adopting a system approach to mapping system capability and modelling future workforce needs. Aligning this work to the wider place-based programmes of work and working in partnership with system colleagues in Cheshire West, Wirral will implement an *Aligning Capability* model to analyse current issues and future needs.

A primary focus of this work will be integration with the core and primary transformation programmes to ensure that future workforce needs are addressed. As the key agent of the delivery of place-based health and care, neighbourhood/primary care network development will be the initial priority for the People programme.

Working closely with wider system partners across Wirral during 2018/19 has led to the development of a number of initial strategic priorities. These have been incorporated into the key system deliverables for 2019/20 and will be used to inform the Wirral long term People strategy. A successful bid was made to the Cheshire and Merseyside Local Workforce Advisory Board to support the delivery of these priorities, and in particular establish our innovative approach to understanding and analysing system and people capability in order to build a strong workforce, organisational and people strategy. Key elements of this include:

- Mapping and evaluation of system capability including workforce requirements and gaps
- Aligning Capability gap analysis of neighbourhoods to inform Wirral and local neighbourhood People and Organisational Development delivery plans
- Development of Wirral People Strategy and Delivery Plan
- Establishment and delivery of a research programme to evaluate the programme and methodology, to ensure shared learning across the Cheshire and Merseyside Health and Care Partnership footprint and beyond
- Building on the system capability profiles to develop a single system offer for new roles, aligned to our place and neighbourhood programme
- Explore the opportunities for joint education and training programmes to support system organisational and workforce development

Following successful engagement with the North West Leadership Academy Wirral is working in partnership with North West Employers to deliver a Neighbourhood and Network Leadership Development programme to support integrated system leadership and co-production, and develop leadership skillset for network leaders.

[Type text]

Population Health Management

Population Health Intelligence

Healthy Wirral partners have established an integrated Population Health Intelligence Work Programme with the Aim of Improving the health and wellbeing of our communities through the effective use of population health intelligence.

The programme delivery group has brought together subject matter experts from across the Wirral health and care system and provides a strategic lead for Healthy Wirral Population Health Intelligence. The programme aims to support the use of intelligence, including the analytics opportunities offered by the developing Wirral Care Record to identify opportunities to improve care quality, efficiency and equity. The programme will also support and evaluate service transformation

The programme group is working to improve understanding of the analytical capacity and capability within the system and develop a plan to meet future analytical capability requirements, and have undertaken a comprehensive skills audit in support of this. Key system benefits that have been identified include:

- Enhancing the experience of care
- Improving the health and well-being of the population
- Reducing per capita cost of health care and improve productivity
- Addressing health and care inequalities
- Increasing the well-being and engagement of the workforce

In support of this work system partners have implemented the Health Information Exchange (HIE) system which allows clinicians to view live clinical information across the key Wirral providers, establishing a real time profile of care to support effective clinical decision making

On-going work to develop the Wirral Population Health Management System (Wirral Care Record) has included integration, standardisation and merging of data for primary and secondary care, including validation and testing of data. A key area of progress has been the development and implementation of the five initial registries (Adult and Paediatric Diabetes, Adult and Paediatric Asthma and COPD) together with two additional registries for frailty and end of life.

Population Health Priorities

Public Health information and the analytical work undertaken by system colleagues, including the Wirral Intelligence Service have provided a clear set of priorities to focus on in terms of population health planning and management. Our focus this year has been and will continue to be on the following priorities in 2019/20:

[Type text]

- *Alcohol Misuse* through encouraging a responsible relationship with alcohol through opportunistic early identification and brief advice (IBA), and supporting those who need help with alcohol misuse through strong engagement, treatment and recovery
- *Smoking* through early intervention with children and young people, ensuring robust and easy to navigate smoking cessation pathways that are seamless between care sectors and through targeted campaigns to promote smoking cessation
- *Air Quality improvement* through working with colleagues across the Liverpool City Region and North West to develop the approach locally
- *Wirral Residents and Health Inequalities* through ensuring our plans are aligned with the Wirral 2030 plan, physical regeneration strategies and the development of the 'Wirral Together' approach to working with local people
- *Self-care* through creating whole population health and wellbeing by mobilising community assets and building social networks, developing a proactive and universal offer of support to people with long term physical and mental health conditions to improve their ability to self-manage
- *Health Protection Priorities for Wirral* through the development of a system wide approach to Infection Prevention and Control, reducing antimicrobial and antibiotic resistance and reducing the variation and uptake of cancer screening and national immunisation programmes.

Transformation

Transformation effort has been significantly focused upon the development of Place on Wirral. This has been characterised by a number of primary developments to deliver Integrated Neighbourhood Hubs and enabling programmes to establish related infrastructure including our Urgent Care strategy and Single Point of Access development.

Following the work in 2017-18 with system leaders and clinicians across Wirral and supported by AQuA to develop a Strategic Outline Case that formed the basis of developing our target operating model we developed Healthy Wirral Partners Board which is overseeing the key work streams involved in the delivery of the model and associated pathways.

The development of the Wirral Integrated Commissioning Strategy establishes a Place based commissioning and care transformation programme designed to deliver fundamental change in order to achieve Place based and Population health focused care and support on Wirral.

A fundamental element of the Wirral Place programme is the development of our neighbourhood infrastructure. This builds on the integration we have already achieved through the development of four integrated health and social care hubs (ICCH's), plus more recently on the organisational integration of adult social care

[Type text]

assessment and provision into Wirral Community NHS Foundation Trust and the development of an integrated commissioning function for health and social care.

Our Senior Change Team brings together all system partners including clinical leaders, and they have been responsible for building an understanding of what neighbourhood and networks will require both clinically and organisationally, including the development of pilot programmes to inform the final operating model. The neighbourhood based model is seen as a key element of delivering our ambition for an effective and comprehensive pathway for our population, and transformation effort in 2018-19 has focused initially on our frail population and building strong place based links with primary care having already made significant progress with integrating community services.

Funding to support Transformation in 2018-19

System partners have committed resources of circa £186k to support the establishment and development of the *Healthy Wirral* transformation programme team, including the independent chair, programme manager and finance lead roles. This resource has supported the wider transformation effort across the programme, and has successfully attracted further transformation funding from a number of sources to support the *Healthy Wirral* programme.

Working closely with system partners, the programme team successfully gained £600k of transformation funding from the Cheshire and Wirral Health and Care Partnership to support the development of place. This funding has been focused on a number of key initiatives including:

- Establishing and supporting the development of neighbourhoods. This has included the recruitment of 9 G.P Neighbourhood Co-ordinators who have worked to bring together a multi-agency team together to support local development, including the delivery of neighbourhood plans designed to better support frail people within the neighbourhoods and reduce non-elective admissions to hospital. Practice teams including G.P and practice manager time support was provided to support primary care involvement in this programme. Programme management input was also established for the neighbourhood programme, and to support community partner development and redesign to align resources with neighbourhoods.
- Building our business intelligence capacity and capability through the development of systems to support real time dashboards to support management of frailty, undertake risk stratification and understand variance across the system
- Supporting Organisational Development to create and align system leadership and capacity to 'act as one' in the delivery of system transformation and establish truly integrated approaches to the commissioning and provision of care on Wirral.

£184K has been successfully awarded from Health Education England Local Workforce Advisory Board (LWAB) to support our 'aligning capability' People

[Type text]

programme and a further £6k from the NHS North West Leadership Academy to support leadership development for neighbourhood and primary care network teams

FINANCIAL OVERVIEW FOR 2018/19 AND YEAR END POSITION

The Wirral Health and Care system continues to face significant challenges to achieve financial recovery and sustainability. The Healthy Wirral programme recognises and supports the aspiration to live within our means as a system and the aim to maximise the value of the Wirral pound, by ensuring that this is invested in place based care that will deliver evidenced based, quantifiable quality outcomes for the population of the Wirral.

Income & Expenditure Performance

I&E Performance (Incl. STF) Surplus / (Deficit)	Plan £,000	Actual £,000	Variance £,000
CWP (Wirral proportion)	246	742	496
Wirral Community	2,193	3,723	1,530
WUTH	(25,042)	(33,008)	(7,966)
Wirral CCG	2,000	2,003	3
Wirral LA	0	0	0
Total	(20,603)	(26,540)	(5,937)

note : the above excludes impairments and other below line adjustments

The table above shows a system deficit of £26.5m for 2018/19 (£5.9m off plan), however this was an improved position on the forecast outturn predominantly due to additional provider sustainability incentive funding for both Wirral Community Health and Care Trust and Cheshire and Wirral Partnership at £1.9m received at the year end.

There were a number of key pressures across the system in year, primarily due to outsourcing costs for elective activity due to non-elective demand at the beginning of the year, along with costs for additional beds at Clatterbridge hospital, CCG costs relating to out of hospital packages of care and a shortfall in delivering the required savings plan at both WUTH and WCCG. Non recurrent support and contingency offset pressures however for the CCG to bring them back into balance at the year end.

Cost Improvement Plan (CIP)/Quality, Innovation, Productivity and Prevention (QIPP) Savings Plan

[Type text]

CIP/QIPP Performance	Plan	Actual	Variance
	£,000	£,000	£,000
CWP (Wirral proportion)	980	980	0
Wirral Community	2,500	2,502	2
WUTH	11,000	9,568	(1,432)
Wirral CCG	19,639	11,682	(7,957)
Wirral LA	1,500	1,500	0
Total	35,619	26,232	(9,387)

The table above shows system savings delivered of £26.2m against a plan of £35.6m. Although the savings delivered were significantly below plan due to the challenging target required for the CCG the overall system savings achieved represents delivery of almost 4% which is a great achievement.

Underlying System Deficit

Although the system deficit for 2018/19 is £26.5m there are a number of non-recurrent benefits which mask the real underlying deficit to be carried forward for the system at c£45m and will be factored into the 2019/20 plan and the long term financial recovery plan.

FINANCIAL PLAN FOR 2019/20 AND 5-YEAR SYSTEM SUSTAINABILITY STRATEGY OVERVIEW

The approach taken by the Wirral system for 2019/20 is for partners to work together to help providers deliver their control totals in order to secure external central funding of c£20m. The system has also recognised that savings plans need to be recognised on a cost out basis and not on a tariff basis. System partners have acted collaboratively with agreed and aligned contract activity and financial baselines across the system, however in so doing the financial risk for the system now lies with WCCG.

The table below summarises the 2019/20 plan with a planned system deficit of £1.1m to reconcile to individual control totals and a risk adjusted deficit of £13.6m to reflect the CCG financial risk of £14.8m.

[Type text]

Wirral System Summary (excl LA)	WUTH	WCT	CWP (prop'n)	WCCG	System Total
	£,000	£,000	£,000	£,000	£,000
19/20 deficit before CIP/QIPP and central monies	(32,005)	(1,995)	(1,117)	(24,245)	(59,362)
CIP/QIPP	13,201	2,000	965	24,245	40,411
MRET central funding	6,282				6,282
PSF allocation	6,872	990	304		8,166
FRF allocation	5,650				5,650
19/20 Submitted Net Planned Surplus / (Deficit)	0	995	151	0	1,146
Risk adjustment				(14,793)	(14,793)
Risk adjusted Planned Surplus / (Deficit)	0	995	151	(14,793)	(13,647)

Definitions:

MRET	Marginal Rate Emergency Tariff
PSF	Provider Sustainability Fund
FRF	Financial Recovery Fund

A key outcome of the current HW programme will be the development of a whole system plan to achieve system financial sustainability, through service transformation and the delivery of challenging system wide efficiency and cost improvement programmes.

There are a number of organisational specific CIP/QIPP savings schemes, however there are a number of key system programmes which have been prioritised in 2019/20.

In supporting the delivery of these plans, Healthy Wirral system partners have also committed to delivering future system sustainability, adopting the principles of the Capped Expenditure Programme; CEP-Lite. System efficiencies will be sought through the agency of the *Healthy Wirral* core and primary programmes and the delivery of effective place-based neighbourhood health and care approaches.

Key system-wide efficiencies will be implemented in 2019/20 through an agreed whole system focus on the following priorities:

- Outpatient redesign – delivering the reform required in the Long-Term Plan and shifting services towards neighbourhoods/Primary Care Networks.
- Non-Elective Admissions reform and improving flow through reduced Length of Stay predominantly for High Intensity Users.
- Medicines Optimisation – working as a system to reduce waste, support effective prescribing and reduce cost.
- Developing Neighbourhoods/Primary Care Networks as service delivery networks and shifting services towards them.

[Type text]

- Further developing community out of hospital care approaches.

2019/20 plans are being aligned with long term transformation priorities to ensure that change can be achieved that is sustainable at a system level.

The approach to delivering system sustainability will be to contain costs via the transformation priorities and subsequently utilise the growth element within the CCG allocations and therefore reduce the CCG and system deficit. This will be further developed in our 5 year sustainability strategy.

Clear mechanisms have been established to ensure that the system is effectively monitoring the impact of efficiencies on the quality of care. The following key governance strands have been put in place to enable this:

- All the programme boards for the key primary programmes have clinical oversight and leadership, for example the Planned Care Board is chaired by the CCG Medical Director
- Wirral is developing an independent Clinical Senate to provide oversight, clinical leadership and challenge to programmes. The senate has representation from across the clinical and professional community of Wirral health and care commissioning and provision.
- All programmes are subject to Quality and Equality impact assessment processes established and overseen by the Director of Quality and Safety for Wirral Health and Care Commissioning

Healthy Wirral System Operating Plan for 2019/20

Following the agreement of the 5-year settlement for the NHS and the development of the NHS Long Term Plan in 2019, guidance has been provided to clarify the expectations of all integrated care systems to produce organisational level and coherent system level operational plans for 2019-20. This year is identified as a foundation year to lay out the groundwork for implementation of the long term plan and the up-front funding for providers is given with the requirement that each NHS organisation delivers its agreed financial position. The production of operating plans for 2019/20 will support the development of a broader 5-year strategic system plan. In addition to delivering the requirements of the NHS Long Term Plan, *Healthy Wirral* partners have recognised this as an opportunity to set out our ambitions for place based population health and care and align this with Wirral system planning including the Wirral 2030 plan.

[Type text]

As an outcome of a *Healthy Wirral* system event in November 2018 and subsequent discussions, all partners committed to a joint approach to the completion of a Wirral System Operating Plan for 2019/20. Following the publication of full guidance by NHS England in January 2019, system partners, led by the *Healthy Wirral* have worked to deliver the expected milestones, and submitted a draft system operating plan on 12th February 2019. The *Healthy Wirral* Partners Board took oversight of the delivery of the plan and approved the final version on 28th March 2019 and the final plan was submitted to NHS England and the Cheshire and Merseyside Health and Care Partnership on 4th April 2019. Key to this plan is the alignment with system partner operational plans particularly in respect of strategic intent and priorities, financial and activity assumptions.

Our 5 Year Strategic Plan

Our 2019/20 Operating Plan provides a strong basis for system wide discussions and activity to establish and agree a *Healthy Wirral* 5-year Strategic Plan. Our ambition is to develop a draft plan by July 2019 in preparation for submission in the autumn of 2019.

In support of this work the *Healthy Wirral* programme team have developed a 'Plan on a Page' (Summarised in Figure 3) setting out our broad strategic ambitions and our approach to delivering transformational change. These plans will provide a framework for *Healthy Wirral* partners, supported by the programme team, to build on the work undertaken in 2018/19 to draft this strategy and establish a comprehensive engagement process with the Wirral community to co-design the plan.

Figure 3: Healthy Wirral Plan on a Page

PLACE Title	<i>Healthy Wirral</i>	
PLACE purpose/vision	To enable all people in Wirral to live longer and healthier lives by taking simple steps of their own to improve their health and wellbeing. By achieving this together we can provide the very best health and social care services when people really need them, as close to home as possible	
Why are we doing this?	Wirral has significant population health challenges. We have an ageing population and significant variation in health and wellbeing outcomes across our geography. Demand on the system is increasing and without significant transformation there will be insufficient funding to maintain the quality and standards that we want our population to experience.	
How are we going to do it?	<p>We will take a place-based system approach to transforming our services to ensure they meet the changing needs of our population and allow us to deliver safe and effective care within the resources available to us. We will do this by:</p> <ol style="list-style-type: none"> 1. Acting as One: Exemplified in actions and behaviours. Delivering net system benefit 2. Clinical Sustainability: Sustainable, high quality, appropriately staffed, organisationally agnostic services. 3. Improving Population Health: Delivering the Healthy Wirral outcomes around better care and better health using a place based approach. 4. Financial Sustainability: Managing with our allocation, taking cost out, avoiding costs, delivering efficiency and better value 5. Effective Engagement - working with our public and patients to promote self-care by involving them in all decisions made about them. 	
How we will work together?	<ul style="list-style-type: none"> • We will actively engage and work collaboratively and in good faith at all times in connection with the Healthy Wirral programme and be open, honest and transparent in all dealings. • We will jointly own the financial challenge and any agreed actions to address this and put mechanisms in place to ensure patient safety is not put at risk. • We will ensure the effective stewardship of financial resources and will share skills, knowledge, experience and resources effectively and in a prioritised way to sustainably deliver the best possible health and care outcomes for the people of Wirral. • We will engage effectively with clinicians and operational leads across the system, to deliver transformational change through the development of place-based, clinically effective and organisationally agnostic health and care pathways. We will work collectively and in partnership with Wirral people to deliver improved population health. 	
What will be the outcome(s)?	Big 5 – larger deliverables (require more investment/potentially more sensitive/controversial)	Fast 5 – JDI's/quick wins
	Wirral Organisational Development strategy implemented to deliver integrated place-based care	Effective Neighbourhood based operating model
	Integrated Urgent Care Transformation	Reduction in Non-elective admissions and ED attendances for frail and high intensity service users
	Sustainable financial strategy	Improved care and value outcomes through the implementation of Medicines Optimisation approaches
	Implementation of Population Health Programme and full adoption of the Wirral Care Record	Improved care outcomes and efficiency through shared service approaches within neighbourhoods

[Type text]

	Improved patient experience and increased care closer to home through Out-patient redesign	Identification of key specialties and pathways for redesign in 2019/20 based on Right Care and GIRFT data.
What will the benefits be?	<ul style="list-style-type: none"> • Children are supported to have a healthy start in life • People are supported to have a good quality of life • Inequalities in healthy life expectancy are reduced • People are supported to be as independent as possible, and when they need care can access timely responsive and high quality care and support, and have informed choice and control over services • People feel safe and respected and are kept safe and free from avoidable harm • People and their families can access jargon free information and are engaged in the setting of their outcomes and the management of their care, from organisations that talk to each other • People are supported by skilled staff, delivering seamless, person centred care • People access acute care only when they need to • Financial Balance is achieved • People can access shared and integrated information • Interventions happen earlier to prevent health problems 	
Main Milestones	Milestone:	By When:
	<i>Healthy Wirral</i> System Operational Plan	April 2019
	<i>Healthy Wirral</i> 5 Year System Sustainability Strategy	Autumn 2019
Interdependencies	Which other programmes or outputs is the Place programme reliant upon?	What will the Place programme enable elsewhere in the health system?
	Carter at Scale (Non-clinical) programme	Shared learning around Place based workforce strategy
	Cardio-vascular programme	Health and Care Integration
	Workforce Programme	Shared learning on Neighbourhood Leadership development

This page is intentionally left blank



HEALTH AND WELLBEING BOARD

17TH JULY 2019

REPORT TITLE	<i>HEALTHY WIRRAL SYSTEM OPERATING PLAN 2019/20 AND 5 YEAR STRATEGIC PLAN</i>
REPORT OF	SIMON BANKS, CHIEF OFFICER, WIRRAL HEALTH AND CARE COMMISSIONING AND NHS WIRRAL CLINICAL COMMISSIONING GROUP AND SENIOR RESPONSIBLE OFFICER, <i>HEALTHY WIRRAL</i>

REPORT SUMMARY

NHS England published the NHS Long Term Plan on 7th January 2019. This was accompanied by full planning guidance for 2019/20 setting out “must do” deliverables and financial allocations. The guidance set out an expectation that one year operational plans for 2019/20 would need to be submitted to NHS England and NHS Improvement by 4th April 2019. Each system is also required to have five year sustainability plans by autumn 2019 that deliver the requirements of the NHS Long Term Plan at a local level. The *Healthy Wirral System Operating Plan 2019/20* is attached to this report.

This matter affects all Wards within the Borough.

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board notes the *Healthy Wirral System Operating Plan 2019/20* and the intention to engage further with the public and politicians in respect of the development of the *Healthy Wirral 5 Year System Sustainability Strategy Plan*.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

- 1.1 The Health and Wellbeing Board has been asked to note the *Healthy Wirral* System Operating Plan 2019/20 as it is an extension of work already underway in our health and care economy. The Health and Wellbeing Board has been asked to note the intention to engage further with the public and politicians in respect of the development of the *Healthy Wirral* 5 Year System Sustainability Strategy Plan as this will be occurring between June and September 2019. The *Healthy Wirral* 5 Year System Sustainability Strategy Plan will come back to the Board during this time frame.

2.0 OTHER OPTIONS CONSIDERED

- 2.1 No other options have been considered as national guidance set out an expectation that one-year operational plans for 2019/20 would need to be submitted to NHS England and NHS Improvement by 4th April 2019. There is also an expectation that five year plans will be submitted in autumn 2019.

3.0 BACKGROUND INFORMATION

- 3.1 NHS England published the NHS Long Term Plan on 7th January 2019. This was accompanied by full planning guidance for 2019/20 setting out “must do” deliverables and financial allocations. The guidance set out an expectation that one year operational plans for 2019/20 would need to be submitted to NHS England and NHS Improvement by 4th April 2019.
- 3.2 These one-year operational plans would follow on from and complete the commitments set out in the NHS Five Year Forward View that were already in the strategic plans of health and care organisations in England. The intention is that 2019/20 is a baseline year from which each system would produce a 5 year strategic plan, through engagement with local people, which will demonstrate how they will be delivering the goals set out in the NHS Long Term Plan.
- 3.3 Through the *Healthy Wirral* programme all partners have agreed to “act as one” and submit a one-year operating plan for the Wirral health and care economy. This document is attached to this paper. It was submitted to the Cheshire and Merseyside Health and Care Partnership and NHS England and NHS Improvement on 4th April 2019 along with the financial plans for the system. Our *Healthy Wirral* plan will be aggregated with the plans from the other eight places in Cheshire and Merseyside as part of the Cheshire and Merseyside Health and Care Partnership’s plan.
- 3.4 The Operating Plan for 2019/20 and associated work on finance and activity will be the starting point for the development of a *Healthy Wirral* 5 Year System Sustainability Strategy Plan. This will be taken forward through the *Healthy Wirral* programme approach. A draft plan will need to be in place for June 2019. Public and political engagement on the draft plan will take place during summer 2019. The

final plan will be submitted to the Health and Care Partnership and NHS England and NHS Improvement in autumn 2019. The *Healthy Wirral* 5 Year System Sustainability Strategy Plan will come back to the Board during this time frame.

4.0 FINANCIAL IMPLICATIONS

4.1 The system financial position is addressed in the *Healthy Wirral* System Operating Plan 2019/20.

5.0 LEGAL IMPLICATIONS

5.1 There are no legal implications as a result of this report.

6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

6.1 The *Healthy Wirral* System Operating Plan 2019/20 will be delivered within existing resources.

7.0 RELEVANT RISKS

7.1 Whilst good progress has been made in delivering the aims of the *Healthy Wirral* Programme, there remains significant system risk related to the financial challenge the system continues to face and the delivery of true place-based care in partnership. The high-level strategic risks are being addressed and mitigated as part of the Board Assurance Framework for the *Healthy Wirral* Partners Board.

8.0 ENGAGEMENT/CONSULTATION

8.1 There is no requirement for engagement/consultation on the *Healthy Wirral* System Operating Plan 2019/20. Public and political engagement on the development of the *Healthy Wirral* 5 Year System Sustainability Strategy Plan will take place during summer 2019.

9.0 EQUALITY IMPLICATIONS

9.1 Throughout the development of this paper and the *Healthy Wirral* System Operating Plan 2019/20 all parties have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

REPORT AUTHOR: *Simon Banks*

Chief Officer, Wirral Health and Care Commissioning and NHS Wirral CCG and Senior Responsible Officer, Healthy Wirral

telephone: (0151) 651 0011

email: simon.banks1@nhs.net

APPENDICES

Healthy Wirral System Operating Plan 2019/20

BACKGROUND PAPERS

- NHS Long Term Plan: <https://www.england.nhs.uk/long-term-plan/>
- Planning Guidance and CCG Allocations: <https://www.england.nhs.uk/deliver-forward-view/>

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Joint Strategic Commissioning Board	28th May 2019

JOINT STRATEGIC COMMISSIONING BOARD

Healthy Wirral System Operating Plan 2019/20

Risk Please indicate	High N	Medium Y	Low N
Detail of Risk Description	<p>Whilst good progress has been made in delivering the aims of the <i>Healthy Wirral</i> Programme, there remains significant system risk related to the financial challenge the system continues to face and the delivery of true place-based care in partnership. The high-level strategic risks are being addressed and mitigated as part of the Board Assurance Framework for the <i>Healthy Wirral</i> Partners Board.</p>		

Engagement taken place	Y
Public involvement taken place	N
Equality Analysis/Impact Assessment completed	N
Quality Impact Assessment	N
Strategic Themes	
To empower the people of Wirral to improve their physical, mental health and general wellbeing	Y
To reduce health inequalities across Wirral	Y
To adopt a health and wellbeing approach in the way services are both commissioned and provided	Y
To commission and contract for services that: <ul style="list-style-type: none"> • Demonstrate improved person-centred outcomes • Are high quality and seamless for the patient • Are safe and sustainable • Are evidenced based • Demonstrate value for money 	Y
To be known as one of the leading organisations in the Country	Y
Provide systems leadership in shaping the Wirral Health and Social Care system so as to be fit for purpose both now and in five years' time.	Y

**JOINT STRATEGIC COMMISSIONING BOARD
(Committee in Common)**

Meeting Date:	28th May 2019
Report Title:	<i>Healthy Wirral System Operating Plan 2019/20</i>
Lead Officer:	Simon Banks, Chief Officer, Wirral Health and Care Commissioning and NHS Wirral CCG

INTRODUCTION / REPORT SUMMARY

NHS England published the NHS Long Term Plan on 7th January 2019. This was accompanied by full planning guidance for 2019/20 setting out “must do” deliverables and financial allocations. The guidance set out an expectation that one year operational plans for 2019/20 would need to be submitted to NHS England and NHS Improvement by 4th April 2019. The *Healthy Wirral System Operating Plan 2019/20* is attached to this report.

This matter affects all Wards within the Borough.

RECOMMENDATIONS

It is recommended that the Joint Strategic Commissioning Board notes the *Healthy Wirral System Operating Plan 2019/20* and the intention to engage further with the public and politicians in respect of the development of the *Healthy Wirral 5 Year System Sustainability Strategy Plan*.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

- 1.1 The Joint Strategic Commissioning Board has been asked to note the *Healthy Wirral* System Operating Plan 2019/20 as it is an extension of work already underway in our health and care economy. The Joint Strategic Commissioning Board has been asked to note the intention to engage further with the public and politicians in respect of the development of the *Healthy Wirral* 5 Year System Sustainability Strategy Plan as this will be occurring between June and September 2019. The *Healthy Wirral* 5 Year System Sustainability Strategy Plan will come back to the Board during this time frame.

2.0 OTHER OPTIONS CONSIDERED

- 2.2 No other options have been considered as national guidance set out an expectation that one-year operational plans for 2019/20 would need to be submitted to NHS England and NHS Improvement by 4th April 2019.

3.0 BACKGROUND INFORMATION

- 3.1 NHS England published the NHS Long Term Plan on 7th January 2019. This was accompanied by full planning guidance for 2019/20 setting out “must do” deliverables and financial allocations. The guidance set out an expectation that one year operational plans for 2019/20 would need to be submitted to NHS England and NHS Improvement by 4th April 2019.
- 3.2 These one-year operational plans would follow on from and complete the commitments set out in the NHS Five Year Forward View that were already in the strategic plans of health and care organisations in England. The intention is that 2019/20 is a baseline year from which each system would produce a 5 year strategic plan, through engagement with local people, which will demonstrate how they will be delivering the goals set out in the NHS Long Term Plan.
- 3.3 Through the *Healthy Wirral* programme all partners have agreed to “act as one” and submit a one-year operating plan for the Wirral health and care economy. This document is attached to this paper. It was submitted to the Cheshire and Merseyside Health and Care Partnership and NHS England and NHS Improvement on 4th April 2019 along with the financial plans for the system. Our *Healthy Wirral* plan will be aggregated with the plans from the other eight places in Cheshire and Merseyside as part of the Cheshire and Merseyside Health and Care Partnership’s plan.

- 3.4 The Operating Plan for 2019/20 and associated work on finance and activity will be the starting point for the development of a *Healthy Wirral* 5 Year System Sustainability Strategy Plan. This will be taken forward through the *Healthy Wirral* programme approach. A draft plan will need to be in place for June 2019. Public and political engagement on the draft plan will take place during summer 2019. The final plan will be submitted to the Health and Care Partnership and NHS England and NHS Improvement in autumn 2019. The *Healthy Wirral* 5 Year System Sustainability Strategy Plan will come back to the Board during this time frame.

4.0 FINANCIAL IMPLICATIONS

- 4.1 The system financial position is addressed in the *Healthy Wirral* System Operating Plan 2019/20.

5.0 LEGAL IMPLICATIONS

- 5.1 There are no legal implications as a result of this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

- 6.1 The *Healthy Wirral* System Operating Plan 2019/20 will be delivered within existing resources.

7.0 RELEVANT RISKS

- 7.1 Whilst good progress has been made in delivering the aims of the *Healthy Wirral* Programme, there remains significant system risk related to the financial challenge the system continues to face and the delivery of true place-based care in partnership. The high-level strategic risks are being addressed and mitigated as part of the Board Assurance Framework for the *Healthy Wirral* Partners Board.

8.0 ENGAGEMENT/CONSULTATION

- 8.1 There is no requirement for engagement/consultation on the *Healthy Wirral* System Operating Plan 2019/20. Public and political engagement on the development of the *Healthy Wirral* 5 Year System Sustainability Strategy Plan will take place during summer 2019.

9.0 EQUALITY IMPLICATIONS

- 9.1 Throughout the development of this paper and the *Healthy Wirral* System Operating Plan 2019/20 all parties have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

REPORT AUTHOR: *Simon Banks*

*Chief Officer, Wirral Health and Care Commissioning and
NHS Wirral CCG*

telephone: (0151) 651 0011

email: simon.banks1@nhs.net

APPENDICES

Healthy Wirral System Operating Plan 2019/20

BACKGROUND PAPERS

- NHS Long Term Plan: <https://www.england.nhs.uk/long-term-plan/>
- Planning Guidance and CCG Allocations: <https://www.england.nhs.uk/deliver-forward-view/>

HISTORY

Meeting	Date

This page is intentionally left blank



HEALTH AND WELLBEING BOARD

17 JULY 2019

REPORT TITLE	<i>URGENT CARE TRANSFORMATION</i>
REPORT OF	<i>NESTA HAWKER, DIRECTOR OF COMMISSIONING AND TRANSFORMATION, NHS WIRRAL CCG</i>

REPORT SUMMARY

The transformation of urgent care in Wirral has been a priority for commissioners for some time and following preparatory work a formal transformation programme was commenced in 2016. This programme sought to ensure that any review of the Wirral Urgent Care system met the needs of patients now and in the future, provided excellence in clinical quality and was able to meet the NHS constitutional standards through sustainable services.

The context for the review was the numerous urgent care services, including Walk in Centres and Minor Injury/Illness Units which had different opening hours and services. Whilst these venues are locally valued and recognised by communities, they did not provide consistency in service provision and as a result many patients defaulted to using the Accident and Emergency (A&E) Department at the Arrowe Park Hospital Site

RECOMMENDATION/S

As a result of the public consultation, the recommendations are for NHS Wirral Clinical Commissioning Group (CCG) Governing Body to approve all of the following:

A) Implementation of a 24-hour Urgent Treatment Centre (UTC) at the Arrowe Park Hospital Site

B) All-age walk in access in each community hub:

- Wallasey – Victoria Central Hospital (8am-8pm) reduction of 2 hours from current provision
- Birkenhead – Birkenhead Medical Centre (8am-8pm) increase of 2 hours from current provision
- South Wirral – Eastham Clinic (12pm-8pm) no change from current provision
- West Wirral – UTC at Arrowe Park Hospital Site (24-hours) increase of 10 hours from current provision

C) Changes to Gladstone (formerly Parkfield) and Moreton Minor Injury Units

- Gladstone (formerly Parkfield) Minor Injury & Illness Unit, New Ferry
- Moreton Minor Injury & Illness Unit, Moreton Health Clinic, Moreton

Changes to the Minor Injury & Illness Units are in accordance with proposals outlined in the report, notably section 3.3.

D) Dressings

- It is proposed to develop a specific planned/bookable dressing service within the West Wirral/Moreton area to ensure continuity of service for residents.

The recommendations above have all been costed within the current financial envelope of £4.2m and can deliver the anticipated urgent care activity.

Summary of costs	£	Appointments
Urgent Treatment Centre	2,176,986	73,664
Community offer	1,608,001	85,201
Redesign costs	412,891	
Total	4,197,878	158,865

OVERALL RECOMMENDATIONS

Implementation of a 24-hour UTC

All-age walk in access in each community hub:

- Wallasey – Victoria Central Hospital (8am-8pm) reduction of 2 hours from current provision
- Birkenhead – Birkenhead Medical Centre (8am-8pm) increase of 2 hours from current provision
- South Wirral – Eastham Clinic (12pm-8pm) no change from current provision
- West Wirral – UTC at the Arrowe Park site (24-hours) increase of 10 hours from current provision

Gladstone Minor Injury and Illness Unit (formerly Parkfield Minor Injury and Illness Unit) & Moreton Minor Injury and Illness Unit.

In accordance with the proposals set out in this report, we recommend that the current minor injuries and illness units at Moreton and Gladstone Medical Centre (formerly Parkfield Minor Injuries & Illness) are replaced with access to urgent GP/Nurse appointments in local GP practices as part of the GP extended access scheme. This will be further supported by an enhanced NHS 111 service and a planned/bookable dressing service in the Moreton area. The rationale for this recommendation is as follows:

On review of the current number of people attending Gladstone, this activity can now be provided by additional GP appointments through the GP Extended Access Scheme. There are approximately 75 attendances per week currently in the Gladstone Minor Injury and Illness Unit. The number of appointments provided through this scheme will be 82 per week which will be still be delivered from the immediate locality.

On review of the current number of people attending Moreton Minor Injury and Illness Unit this activity can now be provided by additional GP appointments through the GP Extended Access Scheme. There are approximately 90 attendances per week currently in the Moreton Minor Injury and Illness Unit. The number of urgent appointments provided through this scheme will be 64 per week which will be delivered from the immediate locality. We acknowledge the high proportion of dressings activity (46%) delivered from Moreton Minor Injury Unit and are working with the Primary Care Networks to develop a specific planned/bookable dressing service within the West Wirral/Moreton area to ensure continuity of service for residents.

Residents will also be able to access retained walk in facilities at the following locations:

- Eastham Clinic
- Victoria Central Hospital
- Miriam Medical Centre

In reaching the decision for the above recommendations, a full quality and equality impact assessment have been completed which provide full details of our considerations and mitigations.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

- 1.1 The transformation of urgent care in Wirral has been a priority for commissioners for some time and following preparatory work a formal transformation programme was commenced in 2016. This programme sought to ensure that any review of the Wirral Urgent Care system met the needs of patients now and in the future, provided excellence in clinical quality and was able to meet the NHS constitutional standards through sustainable services. This review does not include the high number of urgent, on the day appointments that are provided in normal opening times of GP practices and pharmacies in Wirral.
- 1.2 The context for the review was the numerous urgent care services with different names, including Walk in Centres (WIC) and Minor Injury/Illness Units (MIU) which had different opening hours and services. Whilst these venues are locally valued and recognised by communities, they did not provide consistency in service provision and as a result many patients defaulted to using the Accident and Emergency Department at Arrowe Park Hospital.
- 1.3 NHS England, having commenced a national programme to transform urgent care services published requirements for the introduction of new mandated Urgent Treatment Centres across England in 2017. This is in addition to wider improvements to urgent care services including NHS 111 and the further expansion and provision of additional appointments with GP practices outside of normal opening hours.
- 1.4 During the consultation period there was strong opposition with regard to the proposed changes to the current walk-in facilities. Therefore, these recommendations are responsive to the feedback received and reflect a willingness by commissioners to listen and reflect the views of the public.

2.0 OTHER OPTIONS CONSIDERED

- 2.1 Please refer to Appendix 1 (Business Case).

3.0 BACKGROUND INFORMATION

- 3.1 A 'Case for Change' document was developed by commissioners in 2018 and this was published at the commencement of a pre consultation 'Listening Exercise' in February 2018. The Listening Exercise was an opportunity to talk to service users, stakeholders and staff about current services and this quantified the early scoping work undertaken by commissioners.
- 3.2 Options modelling commenced and preparatory work for a formal consultation commenced in April 2018, this included proceeding through the NHS England Service Change Assurance Process.

- 3.3 The mandated requirement for an Urgent Treatment Centre (UTC) was considered by the NHS Wirral Governing Body in February 2018 and having reviewed the evidence and rationale decided to approve the intent to locate the UTC at Arrowe Park site adjacent to Accident and Emergency (A&E). This decision was central to the development of the final options for consultation.
- 3.4 The final options for consultation proposed either a 24-hour or 15- hour UTC supported by the provision of urgent access to GP/nurse appointments within local areas along with a dressings (wound care) service and a retained walk in facility for children. The proposals included the ending of adult walk in facilities across five locations in Wirral with the exception of the facility located at the Arrowe Park site which will be developed into the UTC.
- 3.5 Throughout the entire formal consultation process, commissioners have ensured that due process has been adhered to in line with both our internal commissioning requirements and the statutory public duties relating to consultation and engagement.
- 3.6 Consultation commenced on 12th September 2018 and concluded on 20th December 2018. This included an extensive range of engagement activity across Wirral with both the public and stakeholders. Statutory scrutiny requirements were met by attendance at a joint scrutiny committee of Wirral Council and Cheshire West and Chester Council in November 2018.
- 3.7 The consultation attracted a significant amount of campaigning activity, centred specifically in the Wallasey, Birkenhead North and Eastham areas.
- 3.8 The Clinical Senate for Greater Manchester, Lancashire and South Cumbria visited Wirral during the consultation period to provide an independent clinical view of the proposals. During the visit members of the senate visited urgent care locations and spoke with staff about services and their views on the current urgent care system as well as the proposed new model of care. The resulting recommendations have been considered as part of the post consultation analysis.
- 3.9 An independent analysis of the consultation was commenced in early 2019 and this identified a significant amount of opposition to the proposals, especially in relation to the proposed closure of WIC/MIU venues, however, respondents most favoured the option of having a 24-hour UTC rather than 15-hours.
- 3.10 A number of alternative proposals were also submitted during the consultation period which have received due consideration and assessment.
- 3.11 After consideration of all the available evidence, a final recommendation is made which has considered public and stakeholder opinion but also minimises the risk of over provision across the local urgent care system.

4.0 APPENDIX

- 4.1 Supporting information can be found in Appendix 1 - Wirral Urgent Care Transformation Business Case.

4.2 Additional information can also be found in this document referencing further supporting evidence relating to options considered, financial information, engagement and the consultation process which can all be reviewed via the NHS Wirral CCG website: <https://www.wirralccg.nhs.uk/get-involved/public-consultations/urgent-care-consultation-update/>

5.0 FINANCIAL IMPLICATIONS

5.1 Please refer to Appendix 1 (Business Case).

6.0 LEGAL IMPLICATIONS

6.1 Please refer to Appendix 1 (Business Case).

7.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

7.1 Please refer to Appendix 1 (Business Case).

8.0 RELEVANT RISKS

8.1 If Governing Body do not agree to the recommendation to transform the urgent care pathway, the risk will be the continuation of an inconsistent offer in the community. The risk of not implementing an Urgent Treatment Centre (UTC) would mean not meeting the national mandate set out by NHS England to implement a UTC to address key elements of urgent and emergency care which would have a number of negative implications:

- Not meeting the Accident & Emergency (A&E) 4-hour standard (95% of patients should be admitted, transferred or discharged within 4 hours of arrival to A&E)
- Overcrowded A&E departments which many people attending inappropriately when they could be treated in a more appropriate setting
- Ambulance turnaround delays increasing delays for patients in the community awaiting an ambulance
- Variation in the local offer supporting the delivery of urgent care
- The current service provision does not provide a consistent offer of urgent care

9.0 ENGAGEMENT/CONSULTATION

9.1 Please refer to Appendix 1 (Business Case).

10.0 EQUALITY IMPLICATIONS

10.1 Equality and Quality Impact Assessments were undertaken as part of the original proposals and can be found on the Wirral Urgent Care website: <http://www.wirralurgentcare.co.uk/>. Following the consultation further Equality and Quality Impact Assessments were undertaken and can also be found on the website.

REPORT AUTHOR: *Nesta Hawker*

Director of Commissioning and Transformation

Telephone: (0151) 651 0011

Email: nesta.hawker@nhs.net

APPENDICES

Appendix 1 Wirral Urgent Care Transformation Business Case

BACKGROUND PAPERS

Supporting information can be found online at the NHS Wirral CCG website:
<https://www.wirralccg.nhs.uk/get-involved/public-consultations/urgent-care-consultation-update/>

This page is intentionally left blank

APPENDIX 1

WIRRAL URGENT CARE TRANSFORMATION BUSINESS CASE

Table of Contents

1. Overview	4
1.1 Background	4
1.2 The Case for Change	4
1.3 Scope	5
1.4 Pre-Consultation Process and Considerations	5
1.5 Location of Urgent Treatment Centre	7
1.6 Wider Considerations Informing Option for Consultation	7
1.7 Final Options for Consultation	9
1.8 NHS England Service Assurance Process	10
2. Consultation Process	11
2.1 Public Consultation	11
2.2 Key Messages from Consultation Analysis and Public Feedback	11
2.3 Childrens (0-19) Service	13
3. Clinical Senate Review	13
3.1 An Independent Review	13
3.2 Options Appraisal	14
3.3 Equality Impact Assessments	17
4. Financial Analysis	17
4.1 Financial Envelope	17
4.2 Summary of Costs	17
4.3 Urgent Treatment Centre Costs	18
4.4 Community Offer Costs	19
4.5 Methodology for Calculating the Numbers of Appointments	20
4.6 The Calculation of Whole Time Equivalent (WTE)	21
4.7 The Calculation of the Enhancements	21
4.8 Consumables	21
4.9 Estates	22
4.10 Staffing Implications	22
4.11 24-hour versus 15-hour Urgent Treatment Centre	22

5. Final Recommendations	23
5.1 A 24-hour UTC at the Arrowe Park site	23
5.2 All Age Walk-in Access	23
5.3 Changes to the Minor Injuries Units	24
5.4 Dressings	25
5.5 Areas of High Deprivation	25
6. Risks	25
7. Conclusion	26
8. Supporting Documentation	28

1. OVERVIEW

1.1 Background

1.1.1. The NHS Long Term Plan outlines the ambition to ensure patients get the care they need urgently and alongside this, relieve pressures on Accident and Emergency department (A&E). It is recognised nationally that there is unnecessary pressure on Accident and Emergency departments and other parts of the urgent and emergency care system. Wirral is not immune to these issues.

1.1.2. The introduction of nationally mandated Urgent Treatment Centres (UTCs) will address the following key elements of urgent and emergency care:

- A&E 4 hour standard (95% of patients should be admitted, transferred or discharged within 4 hours of arrival to A&E). There is acknowledgment that across the system, performance against 4 hour standard is suffering which negatively impacts on patient experience.
- Overcrowded A&E departments with many people attending inappropriately when they could be treated in a less acute environment, leading to delays for patients in need of emergency interventions
- Ambulance turnaround delays increasing delays for patients in community awaiting an ambulance.
- Variation in the local offer supporting the delivery of urgent care.

1.2. The Case for Change

1.2.1. Almost half of patients who went to Arrowe Park Hospital's A&E last year had an illness or injury that could have been treated elsewhere. Our Case for Change evidences that almost 50% of Arrowe Park A&E attendances in 2016/17 were classified as minor cases. (<http://www.wirralurgentcare.co.uk/wp-content/uploads/2018/09/case-for-change.pdf>)

1.2.2. This puts undue pressure on Wirral's only A&E and means that some of the most vulnerable and poorly people in Wirral are experiencing long waits for the care they need. As well as this the issues below were considered:

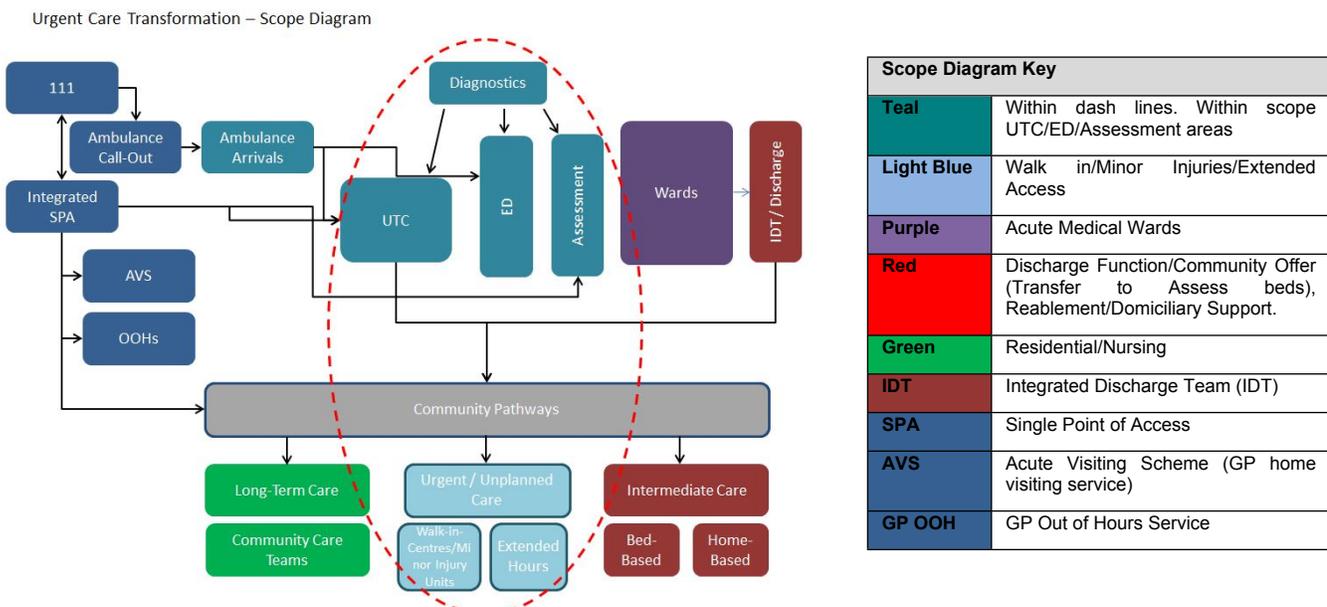
- Variation - Wirral residents recognised the need for change. The Listening Exercise, conducted in February quantified the previous engagement and this helped to inform the options development for consultation.

- The cost envelope for delivering urgent care in Wirral remains the same. The UTC is mandated, with its 27 standards having to be consistently implemented to improve the overall offer of urgent and emergency care. This means that we have to use our financial resources more efficiently and deliver both the UTC and community offer within the existing cost envelope. The only new funding for increasing access to care is linked to the £2.2 million for investment in extended access to primary care, offering additional GP and Nurse appointments during evenings and weekends (8am-8pm, 7 days per week).
- Sustainability - We need to ensure that we create a sustainable and future proof urgent care offer for the people of Wirral. We know that the healthcare needs of people are changing, for example increasing number of older, frail people living longer with multiple long term conditions and we need to develop options that are tailored to meeting these evolving needs. By redesigning the way in which we deliver urgent care, we can use our resources more efficiently to create a sustainable and patient centred service.
- Baseline Activity Data -The table below demonstrates the annual activity for urgent care services across Wirral in 2017/18 across the Walk-in Centres and MIUs. This indicates the demand across these services.

Site	Activity 17-18
Victoria Central Hospital Walk-In Centre	39,318
Arrowe Park Hospital Walk-In Centre	32,021
Eastham Walk-In Centre	12,967
Miriam Minor Injury Unit	17,211
Moreton Minor Injury Unit	4,464
Parkfield Minor Injury Unit	3,755
Total	109,736

1.3. Scope

1.3.1 The following diagram shows the overall scope of the Urgent Care System of which there is a wider transformation programme which includes all the areas in the diagram below (Please see Appendix 1 Operational Plan). The areas within the dashed lines illustrate what was within the scope of the transformation programme. It is important to recognise that whilst this is our clear priority, any transformation has to be seen within the wider urgent care system.



1.4. Pre- Consultation Process and Considerations

1.4.1. Engagement in relation to urgent care services commenced as early as 2009 and continued until the completion of Value Stream Analysis (VSA) workshops in 2016 which signaled the commencement of the transformation programme. The previous engagement activity had identified many common themes that are replicated across England and this was used to inform the VSA workshops with providers, stakeholders and patient representatives.

1.4.2. One of the common themes from the engagement activity since 2009 was the view that people are confused about the range of urgent care services available due to different service offerings and opening times. This was further explored during focus groups and visits to urgent care venues completed in February 2018.

1.4.3. In February 2018, we sought to supplement earlier engagement by opening a pre consultation Listening Exercise. This included an online survey, focus groups,

stakeholder engagement meetings and visits to urgent care locations to speak with people using services during this period. Focus groups were targeted on the basis of the initial equality analysis and activity data. Stakeholder engagement included a dedicated session with the Joint Overview and Scrutiny Committee – Wirral Council (Adults and Childrens) (12th November, 2018) as well as attendance at the Joint Overview and Scrutiny Committee - Cheshire West and Chester (11th December 2018). The purpose of this session was to present the Case for Change (see Appendix 2) and to seek views to inform the options development. (<http://www.wirralurgentcare.co.uk/>)

1.4.4. This methodology was replicated with colleagues from primary, community and secondary care including Practice Managers, Dentists, Optometrists and Pharmacists. The results of the Listening Exercise were published on the NHS Wirral CCG website.

1.5. Location of the Urgent Treatment Centre

1.5.1. The recommendation to locate the Urgent Treatment Centre for Wirral at Arrowe Park Hospital by developing the existing Walk in Centre was approved by NHS Wirral CCG Governing Body in February 2018. (<https://www.wirralccg.nhs.uk/media/4218/govening-body-meeting-pack-060218.pdf>). The decision to co-locate the UTC at the Arrowe Park site means that patients who present themselves and deteriorate rapidly can be immediately transferred to A&E to receive emergency interventions.

1.6. Wider considerations informing options for consultation

1.6.1. It was acknowledged that the UTC needed to be complemented by additional lower acuity level Community Urgent Care services.

Dressings	<p>Planned dressing services account for 24% of Walk in Centre and Minor Injury Units activity. It was recognised that an element of this provision is for planned dressings for which there is a clear need.</p> <p>Commissioners therefore recommended in their final 2 options a bookable dressings service acknowledging that the majority of dressings were of a planned nature and should not be subject to typical walk in waiting times on a sometimes daily basis</p>
Location	<p>Locations were considered as part of the activity analysis, considering cost envelope and the ambition to ensure equity and consistency. The intention was to have a community urgent care hub in each of the 4 localities across Wirral, aiming to support the Neighbourhood model.</p>

<p>Care Seeking</p>	<p>Activity data evidences that almost 50% of people presenting to A&E, do so with a minor condition that could be treated elsewhere (http://www.wirralurgentcare.co.uk/wp-content/uploads/2018/09/case-for-change.pdf). Commissioners acknowledge the trend in how the public seek care and the need to embed cultural change over a period of time. Due consideration needs to be given to changing the public mindset of often defaulting to A&E as a trusted mechanism to receive urgent care.</p>
<p>Childrens (0-19) Service</p>	<p>Activity data shows that almost 50% of attendances to Children’s A&E present with minor issues that could be treated elsewhere and are discharged within 2 hours.</p> <p>26% of Walk in and Minor Injury presentations were from the 0-19 age range.</p>
<p>Arrowe Park Site Footfall</p>	<p>Due consideration of our proposals and the impact it would have on Arrowe Park footfall revealed in a worst case scenario the additional numbers would be 30 people day for a 24-hour UTC and an 8 hour community offer and 20 people per day for a 15 hour UTC with a 12-hour community offer. Detail of these assumptions is evidenced in Appendix 3.</p>
<p>Extended Access to Primary Care</p>	<p>Since the national development to extend access to primary care was announced this has been an important element of our considerations and how we improved access for same day, urgent appointments.</p> <p>As of 2018/19 38,654 additional GP appointments per year were made available via extended access. As part of our initial considerations, the proposal to remove adult walk-in access would be replaced by same day primary care access within the community. Further detail is located within Appendix 4.</p>
<p>Cheshire West and Chester Residents</p>	<p>As illustrated in the Case for Change, there is clear evidence of Cheshire West and Chester residents utilising urgent care services across Wirral, notably in the South Wirral area. The breakdown of this is attached in Appendix 5.</p> <p>The activity was taken into account with ongoing engagement with both West Cheshire Commissioners and Primary Care colleagues to ensure full consideration and minimal negative impact for Cheshire West resident when considering the options for consultation.</p> <p>There has been ongoing engagement with Cheshire West and Chester Council and NHS West Cheshire CCG throughout the consultation process.</p>

<p>Transport</p>	<p>As part of our ongoing considerations for the redesign of urgent care we have worked collaboratively with local Councillors, Council Transport officers and Transport providers to duly consider public transport access to both the Arrowe Park site and the community locations. The intention being to identify any specific transport issues and seek resolution/solutions. Please see Appendix 6 for heat maps used to inform discussion. Heat maps present a physical map of a locality highlighting the ‘hot’ areas that require attention or highlight a particular issue relating to travel times. The maps are colour-coded red, amber, green with red relating to areas of highest travel time/distance to/from certain areas outlined on the maps.</p> <p>This intelligence data has also been shared with our primary care colleagues for due consideration as part of the extended access rollout.</p>
<p>Estates</p>	<p>Consideration was given to suitable venues for the delivery of community urgent care offer. The decision was taken to seek views from the public during the formal consultation with regard to the factors that were most important to them. This would then be used to inform the most appropriate estate choices.</p>

1.7. Final Options for Consultation

1.7.1. In determining the final options for consultation, commissioners considered the positives and negatives of each of the 5 options. See Appendix 7 for discounted options. Sustainably, both financially and in terms of workforce and activity were key drivers in determining the recommendations.

Option 1

- **A&E** - 24 hours
- **Urgent Treatment Centre – 24 hours** at the Arrowe Park site. Walk-in and bookable appointments. Led by GPs with a team of healthcare professionals. Access to X-Ray. Access to A&E Consultant/ Service
- **Community:** In your local area, there will be **urgent bookable appointments via NHS 111/your GP:**
 - GP or nurse appointments - **within 24 hours (8am-8pm)**
 - Access to same day urgent care for children (0-19yrs) – **available up to 8 hours a day (walk in also available)**
 - Access to dressings (wound care) – **available up to 8 hours per day.**

Option 2

- **A&E** - 24 hours
- **Urgent Treatment Centre – 15 hours** at the Arrowe Park site. Walk-in and bookable appointments. Led by GPs with a team of healthcare professionals. Access to X-Ray. Access to A&E Consultant/ Service
- **Community:** In your local area, there will be **urgent bookable appointments via NHS 111/your GP:**
 - GP or nurse appointments - **within 24 hours (8am-8pm)**
 - Access to same day urgent care for children (0-19yrs) – **available up to 12 hours a day (walk in also available)**
 - Access to dressings (wound care) – **available up to 12 hours per day.**

- **Option 1** was based on a 24-hour UTC which would mean an 8 hour per day community offer
- **Option 2** presented a 15-hour UTC which would result in a 12 hour per day community offer.

The positives and negatives of each of these options were clearly articulated in our formal consultation document (Appendix 8 – Urgent Care consultation document).

1.8. NHS England Service Assurance Process

1.8.1. Commissioners have worked closely with NHS England to ensure due assurance throughout the process. The Service Change Assurance Process commenced on the 7th May 2018 and was inclusive of regular updates throughout the pre-consultation period until formal approval was obtained to consult on our proposals for urgent care by the NHSE Regional Management Team on 27th July 2018.

1.8.2. Assurance is required to secure consistency across the NHS commissioning system in respect of:

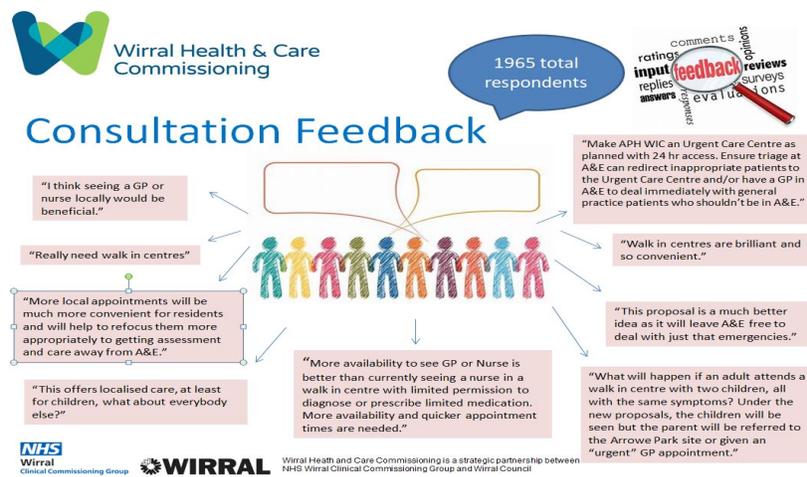
- The government and NHS England's key tests that should underpin service change proposals
- The strength of pre consultation business cases, clinical evidence and public involvement
- Proposals having regard to relevant national guidance and complying with legislation
- The programme management that underpins the planning and delivery of schemes
- Deliverability on the grounds of affordability.

2. CONSULTATION PROCESS

2.1. Public Consultation

- 2.1.1. A public consultation was undertaken from 20th September 2018 until 12th December 2018, with the issuing of notification letters to stakeholders and the launch of a dedicated website for the consultation materials. Informal briefings were held with principal stakeholders, including lead clinicians and local elected members, prior to the launch of the consultation. The consultation has been undertaken in accordance with the NHS Wirral CCG’s statutory duties for public and patient engagement.
- 2.1.2. During this consultation we engaged with the public at a range of events and roadshows (in excess of 80 individual events) across Wirral (See Appendix 9 - Engagement Timeline). These included focus groups, public meetings, stakeholder engagement meetings and visits to current urgent care locations. Local and regional media were utilised to highlight the consultation and a household postcard drop was also completed. Engagement activity has also included visits to shopping centres and social media posting on Facebook and Twitter.
- 2.1.3. There were 1,965 responders to the public consultation survey, 98% of whom identified themselves as residents of Wirral. Respondents were presented with the two options for urgent care (see below) with option 1 being the most popular option (66.5%) particularly for carers (77.1%).
- 2.1.4. We engaged an independent organisation to undertake external analysis of public feedback from the consultation (for a full breakdown of this analysis, please see Appendix 10 - HITCH Marketing report).

2.2. Key Messages from Consultation Analysis and Public Feedback



What respondents liked about the consulted options:

- UTC will provide greater diagnostics - WICs lack diagnostic tools so can only treat minor illness
- GP led UTC at the Arrowe Park Hospital site is good
- Extended access to bookable GP appointments
- Convenience associated with bookable appointments across different locations;
- A uniform, standardised approach to wound care and dressing

What respondents disliked about the consulted options:

- Closures of MIUs and WICs in local communities
- Access to UTC at the Arrowe Park Hospital site (travel; cost & parking)
- Resources at the Arrowe Park Hospital site already stretched; lack of belief that sufficient GPs appointments will be provided within the extended access in a time of GP shortage
- Pressure on the Arrowe Park Hospital site where not able to make appointments on the day for wound care and dressings and would therefore present at A&E

2.2.1. When considering where services may be located, we asked the public what their most important factors were ranked as follows:

- Distance from home (32.2%)
- Accessible by public transport (23%)
- Flexible and convenient appointments (23%)
- Parking
- Accessible for people with mobility requirements

2.2.2. Distance from home was the factor most often cited as the most important with access on public transport (23%) and convenient timing of appointments the next most common (23%).

2.2.3. Parking was most commonly ranked as 4th most important (by 26% of respondents) and only ranked as most important by 10%).

2.2.4. It was suggested by a number of participants that Walk-in Centre's should not be discounted but rather utilised in the implementation of the extended access service.

2.3. Children’s (0-19) Service

2.3.1. Whilst there was a lot of support for the proposed changes in urgent care for children, the public voice centred around concern over the adult walk-in provision:

“What will happen if an adult attends a walk in centre with two children, all with the same symptoms? Under the new proposals, the children will be seen but the parent will be referred to the Arrowe Park site or given an “urgent” GP appointment.”

“This offers localised care, at least for children, what about everybody else?”

2.3.2. This was considered prohibitive in that previously both patients could be treated locally at a Walk-in Centre, whereas the new services could result in either both needing to access Arrowe Park Hospital Site or making one journey to a walk-in service for children and another to Arrowe Park to the UTC. The proposal to change children’s urgent care services was supported (agreed with) by 52.8% of respondents (814/1543), with 33.1% disagreeing and 14.1% neither agreeing nor disagreeing (21.5% did not answer).

3. CLINICAL SENATE PROCESS

3.1. An Independent Review

3.1.1. We recognise that independent review is a key part of this process. On advice from NHS England we invited the Clinical Senate for Greater Manchester, Lancashire and South Cumbria to review our process and proposals and this took place in parallel with the consultation. The aim of this was to undertake an independent clinical review of the proposed plans for Urgent and Emergency Care services delivered in Wirral, in line with the NHS England Stage 2 Assurance Process. The Senate produced a detailed report and recommendations – please see Appendix 11 Clinical Senate Report and Recommendations.

3.1.2. Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent. As part of this process the senate reviewed a range of things including our approach to communications and engagement, key findings from engagement events, our overall process and approach, the design phase and discounted options. A site visit was conducted on Monday 26th November 2018 to the intended location of the UTC, Arrowe Park Hospital as well as visiting existing urgent care sites.

3.1.3. The panel were convinced that there is a compelling need for the current model of care to change. The main drivers for change being:

- A large number of services across a number of providers, each with a differing offer and differing / varying opening times. This has caused confusion amongst the local population as to where to go and when for their pertinent health needs

- The Arrowe Park Hospital A&E and Walk-in Centre front door is currently confusing, illogical and lacks robust documentation at first contact
- Confusing service landscape across Wirral for the public and patients which can lead to them defaulting to A&E when it is not always the most appropriate option

3.1.4. The Clinical Senate were of the opinion that the future UTC and community provision ought to be tackled as part of a bigger plan. If the workforce capacity allows it, the panel recommended a stepped approach to any changes rather than whole scale change at once. We have taken this advice into consideration when developing our overall implementation plan.

3.1.5. For a full list of all recommendations and mitigations, please see Appendix 12 Clinical Senate Recommendation Mitigations.

3.2. Options Appraisal Post Consultation

3.2.1. Following a review of the shortlisted options and taking into account public feedback surrounding the retention of walk-in facilities for all ages as well as more availability to see a GP or Nurse, we have explored and amended our final proposal.

3.2.2. A number of alternative proposals from providers were received as follows:

- General Practice Wirral Federation submitted multiple proposals of varying levels of service
- Wirral Community Health and Care NHS Foundation Trust submitted their feedback on the consultation via a letter; it was difficult to evaluate this information as detailed financial or workforce information was not provided
- Post consultation and Clinical Senate recommendations NHS Wirral CCG considered 25 options based on combination of opening hours and locations based on feedback from public, providers and clinical senate including some blended options of multiple proposals.

Commissioners used the following scoring matrix, which was developed with clinical input, to evaluate the proposals:

Criteria and Weightings					
Within Financial Envelope	Quality	Deprivation	Access and treatment close to home	Sustainability	Consistent Offer
25%	40%	10%	10%	10%	5%

KEY:

- **Within Financial Envelope** - Both the UTC and the supporting community urgent care offer, need to be delivered within the £4.2m financial cost envelope.
- **Quality** - The overall clinical offer and how it supports both the A&E and the local offer in line with clinical evidence based best practice.
- **Deprivation** - Does the offer meet the needs of deprived communities?
- **Access and Treatment Close to Home** - Does the offer provide local access to urgent care services?
- **Sustainability** - Can it be maintained in future years?
- **Consistent Offer** - Does the offer provide equitable and consistent access and provision across each of the constituencies?

Scoring

5	Fully Meets the criteria
4	Nearly meets the criteria
3	Goes some way to meet criteria
2	Meets some elements of the criteria
1	Meets little of the criteria
0	Meets none of the criteria

- 3.2.3. Consultation feedback showed strong opposition from the public to the loss of all age walk-in facilities across Wirral. Reviewing the alternative proposals in tandem with public feedback post consultation and considering the recommendations from clinical senate we have developed a number of further options, some of which fall into a ‘hybrid category’ utilising elements from a range of proposals (both our own and those of providers).
- 3.2.4. Taking this into consideration we have explored the potential to retain some element of all age walk in facilities (with caveats in place, such as same cost envelope) as part of the new model of urgent care.
- 3.2.5. Further work has also been undertaken with clinicians around the clinical model post consultation with regular updates and meetings. Stakeholders have had significant input into the proposed model of care.
- 3.2.6. From the proposals considered, consulted and submitted, the following options were shortlisted based on the criteria used for evaluation. Options that scored at least 4.2 out of 5 were then scrutinised.

Options	UTC Hrs	Detailed options	Score	Positives	Negatives
Option 1 - CCG	24hrs	4 constituency based sites. Open 8 hours. Available for planned dressing appointments. And walk in services for 0-19 year olds.	4.8	24hr offer provides continuity for A&E service. Equal access for each area.	Reduced hours in areas of higher deprivation. B'head/Wallasey
Option 2 - CCG	15hrs	15hr UTC supporting A&E. 4 constituency based sites. Open 12 hours. Available for planned dressing appointments. And walk in services for 0-19 year olds.	4.5	Equal access for each area. Greater community provision in areas of deprivation.	Would not provide a consistent urgent care offer for patients at the Arrowe Park site. Would not be supporting A&E when UTC is closed.
Option 3 - GPW FED	15hrs	15 hr UTC supporting A&E. 4 constituency based sites open 10 hours. Providing walk in services. 5 x 2hr dressings clinics (Moreton, Parkfield, Heswall, St Cath's, & N. Wallasey)	4.35	Equal access for each area. Greater community provision in areas of deprivation.	Would not provide a consistent urgent care offer for patients at the Arrowe Park site. Would not be supporting A&E when UTC is closed. 10 hour offer rather than 12 hour offer in areas of greater deprivation.
Option 4 - GPW FED	15hrs	15hr UTC supporting A&E. 5 constituency based sites (2 in Birkenhead & 3 in other constituencies) open 8 hours each. Providing all age walk in services. 5 x 2hr dressings clinics (Moreton, Parkfield, Heswall, St Cath's, N. Wallasey)	4.4	Equal access for each area. Greater community provision in areas of deprivation.	Would not provide a consistent urgent care offer for patients at the Arrowe Park site. Would not be supporting A&E when UTC is closed. Reduced community hour offer.
Option 5 - GPW FED	24hrs	24hr UTC supporting A&E. 4 constituency based sites open 8 hours each. Providing all age walk in services.	4.5	24hr offer provides continuity for A&E service. Equal access for each area.	Reduced hours in areas of higher deprivation. B'head/Wallasey
Option 6 - CCG	15hr	15hr UTC supporting A&E. Community offer providing walk in facilities and planned dressings: 2 constituency based sites (Wallasey & Birkenhead) open for 12 hours each. 1 constituency based site (Wirral South) open for 8 hours.	4.2	Greater community provision in areas of deprivation.	Would not provide a consistent urgent care offer for patients at the Arrowe Park site. Would not be supporting A&E when UTC is closed. West Wirral to use the UTC
Option 7 - CCG	15hrs	15hr UTC supporting A&E. Community offer providing walk in facilities and planned dressings: 3 constituency based sites (Wallasey, Birkenhead & Wirral South) open for 12 hours each.	4.3	Greater community provision in areas of deprivation.	Would not provide a consistent urgent care offer for patients at the Arrowe Park site. Would not be supporting A&E when UTC is closed. West Wirral to use the UTC
Option 8 - CCG	24hrs	24hr UTC supporting A&E. Community offer providing walk in facilities and planned dressings: 2 constituency based sites (Wallasey & Birkenhead) open for 12 hours each. 1 constituency based site (Wirral South) open for 8 hours.	4.8	24hr offer provides continuity for A&E service. Greater community provision in areas of deprivation.	West Wirral to use the UTC

3.3. Equality Impact Assessments

- 3.3.1. Equality Impact and Risk Assessments were carried out for the overall recommendation as well as for the proposed changes to Gladstone (formerly Parkfield) and Moreton Minor Injury Units (see Appendix 13 Equality and Risk Impact Assessments).

Assessment	CSU Approval
Equality Impact and Risk Assessment – Stage 1 & 2	30.05.19
Quality Impact Assessment	30.05.19
Equality Impact and Risk Assessment Gladstone (formerly Parkfield) MIU) – Stage 1 & 2	30.05.19
Quality Impact Assessment Gladstone (formerly Parkfield) MIU)	30.05.19
Equality Impact and Risk Assessment (Moreton MIU) – Stage 1 & 2	30.05.19
Quality Impact Assessment (Moreton MIU)	30.05.19

4. FINANCIAL ANALYSIS

4.1. Financial Envelope

- 4.1.1. The 2018/19 contractual values for each commissioned area within the scope of the review was identified. This is shown in the table below totaling £4.2million and includes Commissioning for Quality and Innovation (CQUIN) payments of £91,000.

Commissioning Envelope	£
Victoria Central and Eastham Walk in Centres	2,716,945
Arrowe Park Walk-in Centre	1,036,107
Minor Injuries Unit: Birkenhead/ Miriam Medical Centre	261,827
Minor Injuries Unit: Gladstone (formerly Parkfield) Medical Centre	83,000
Minor Injuries Unit: Moreton Health Clinic	100,000
Total	4,197,879

4.2. Summary of Costs

- 4.2.1. The cost of the redesigned services have been calculated by benchmarking against Hartlepool and Stockton on-Tees CCG, which is similar to the Wirral as they have a similar sized population have comparable levels of deprivation.
- 4.2.2. North Tees and Hartlepool NHS Foundation Trust implemented a UTC in April 2017 and provided staffing cost breakdowns. Our costings were benchmarked and calculated using their model and the capacity to meet the expected demand for appointments in Wirral.

4.2.3. It is expected that the cost of implementing the urgent care redesign will be cost neutral as summarised below:

Summary of costs	£
Urgent Treatment Centre	2,176,986
Community offer	1,608,001
Re-design costs	412,891
Total	4,197,878

4.3 Urgent Treatment Centre Costs

4.3.1. Using the University Hospital of North Tees and Hartlepool NHS Foundation Trust model and Wirral costs, we were able to determine the cost of the proposed UTC at the Arrowe Park site.

Spend Type	Band	WTE	Gross Cost per WTE £	Subtotal £	*Enhs. For unsocial hrs £	Total Gross Cost £
Pay						
GP		5.51	108,378	597,162		597,162
Advanced Nurse Practitioner	7	8.45	54,613	461,599	72,642	534,241
Nurse (8am-11pm)	6	3.48	46,428	161,584	17,888	179,472
Nurse (11pm-8am)	6	2.09	46,428	96,951	21,240	118,191
Healthcare Assistant	2	3.48	25,908	90,167	15,237	105,403
Reception	3	5.51	25,908	142,804	33,070	175,874
Non-Pay						
Consumables						158,638
Estates						180,822
Overheads						127,182
Total		28.52				2,176,986

*Enhancement payments for evening and weekend working

4.3.2. The UTC staffing costs have been modelled and costed to be able to deliver the capacity required to meet the expected demand for the number of patients currently attending the Arrowe Park WIC plus the patients attending A&E with minor illnesses and ailments. Staffing ratios have been flexed down to reflect reduced night time activity.

4.3.3. The capacity deliverable is shown in the table below and breaks down the appointments that are available by each staff type and shows that a total of 73,664 appointments could be delivered against expected activity of 69,000.

Appointments delivered by staff type	Between 11pm to 8am	Between 8am to 11pm	Total
GP	8,378	15,274	23,652
Band 7 Advanced Nurse Practitioner	0	30,549	30,549
Band 6 Nurse	4,189	7,637	11,826
Band 2 Healthcare Assistant	0	7,637	7,637
Total	12,566	61,098	73,664

Note: Triage built in

4.4 Community Offer Costs

4.4.1. There are two community sites that are being proposed to be open for 12 hours a day are at:

- Victoria Central and
- Birkenhead Medical Centre.

It is proposed that the third site, Eastham, would be open for 8 hours a day. The costs associated with delivering the activity required in the community for Wirral residents are detailed below:

2 Sites open, 12 hrs a day, 7 days a week	Band	WTE	Gross Cost per wte £	Subtotal £	Enh for unsocial hrs £	Total Gross Cost £
Pay						
Nursing	7	8.69	54,613	474,837	53,815	528,652
Nursing	5	6.77	37,513	253,831	36,957	290,788
Admin	3	5.80	25,908	150,171	18,558	168,729
Non-Pay						
Consumables						218,181
Estates & Overheads						151,495
Subtotal 2 Sites Open 12 Hrs 7 days a week						1,357,844
1 Site open, 8 hrs a day, 7 days a week	Band	WTE Required	Gross Cost per wte	Subtotal £	Enh for unsocial hrs £	Total Gross Cost £
Pay						
Nursing	7	1.29	54,613	70,614	6,778	77,393
Nursing	5	1.29	37,513	48,505	4,656	53,161
Admin	3	1.29	25,908	33,499	3,216	36,714
Non-Pay						
Consumables						20,522
Estate & overheads						62,367
Subtotal 1 Site Open 8 Hrs per day 7 days a week						250,157
Total Cost of the Community Offer		25.14				1,608,001

4.4.3. A total of 85,201 appointments could be delivered within the community based on each appointment being 20 minutes long (this is compared to the current demand of 77,715). This is broken down in the table below:

Appointments	1x 8 hour centre	2x 12hour centres	Total
Nursing Band 7	6,104	41,048	47,152
Nursing Band 5	6,104	31,945	38,049
Total appointments	12,208	72,993	85,201

4.5. Methodology for Calculating the Numbers of appointments

- 4.5.1. To ensure staffing levels and costs were reasonable (capacity sufficient to meet expected demand), the number of clinical hours for each site were calculated based on the staffing numbers in each location.
- 4.5.2. Based on the clinical hours the number of appointments deliverable were calculated on each appointment being approximately 20 minutes.
- 4.5.3. A 10% wastage ratio was added to reflect that demand for appointments would not be constant.

4.6. The Calculation of Whole Time Equivalent (WTE)

4.6.1. The number of WTEs required to support each role within the staffing model have been calculated using the following method:

$$\frac{\text{Numbers of hours that a facility (UTC/ Community facility) was open for}}{\text{Number of productive staffing hours}}$$

For example, Productive hours were calculated as follows:

Hub opening hrs 7 days per week, 52 weeks per year	Total hours open	Total productive hours	WTE to staff
Open 8 hours per day	2,922	1,574	1.86
Open 10 hours per day	3,653	1,574	2.32
Open 12 hours per day	4,383	1,574	2.78
Open 15 hours per day	5,479	1,574	3.48
Open 24 hours per day	8,766	1,574	5.57

Total productive hours	Hours
Hours per year (37.5x52.18 weeks)	1,957
Less Annual leave (7.5hours x 33 days)	(248)
less Bank Holidays (7.5hours x 8 days)	(60)
Less sickness (7.5hours x 10days average)	(75)
Total productive hours per annum	1,574

4.6.2. The sickness levels were taken from national averages and averages present in local provider trusts for staff working in urgent care settings.

4.7. The Calculation of Enhancements

4.7.1. To ensure full costs were accounted for under Agenda for Change, enhanced rates of pay were included for time worked for the following hours:

- Mon-Friday 8pm-10:30pm,
- Saturday 7am to 10:30pm,
- Sunday 7am to 10:30pm,
- Bank holidays-8 days

$\begin{aligned} &\text{Number of enhanced hours per year (x)} \\ &\text{hourly rate of staff working enhanced hours} \\ &\text{(x) enhanced rate} \end{aligned}$

4.8. Consumables

4.8.1. The cost of consumables have been calculated using existing costs for each facility. These costs were provided by the individual organisations managing those facilities.

4.9. Estates

4.9.1. The cost of each estate has been calculated using the actual cost provided by present providers. These are detailed below:

Site	Value £
Victoria Central Walk in Centre	105,409
Eastham Walk in Centre	66,437
Birkenhead Medical Building	37,652
Total	209,498

4.10. Staffing Implications

4.10.1 The WTEs calculated for the model were benchmarked against the information shared by providers. The redesigned models for the UTC and Community offers would require an additional 5.51 WTE GPs and 2.98 WTE fewer nursing staff than at present. Better Care funding and staffing have not been included in this business case as these are non-recurrent.

4.10.2. It is expected that the reduction in numbers of nursing roles would be absorbed by the Wirral health system.

4.11. 24-Hour versus 15-Hour UTC

4.11.1 To underpin the choice of whether a 24-hour or 15-hour UTC would be the most effective on a cost basis, we reviewed the difference in costs between the two options alongside the activity levels that the UTC would need to see from those that presently attend A&E.

A&E activity 2017-2018

Estimated delivery cost	£
24hr UTC	2,176,986
15hr UTC	1,684,566
Difference	492,420

HRGCostType	11pm to 8am	8am to 11pm	Grand Total
High Cost	1,459	6,394	7,853
Medium Cost	3,539	17,057	20,596
Lower Cost	9,900	47,830	57,730
(blank)	79	392	471
Grand Total	14,977	71,673	86,650

4.11.2. Total of 14,977 patients attended A&E between the hours 11pm to 8am in 2017-2018. Of this figure 9,311 were not admitted.

4.11.3. For the 24-hour UTC to be cost effective based on the present payment mechanism (payments by results) the UTC would need to see approximately 5,430 of the present lower to medium level A&E patients between the 11pm to 8pm (the additional funded 9 hours) within the year.

5. FINAL RECOMMENDATION OPTION

5.1. A 24-hour UTC on the Arrowe Park site (utilising current WIC footprint)

5.1.1 Our consultation set out the option for either a 15-hour or 24-hour UTC. Post consultation and learning from North Tees and Hartlepool (who have implemented a 24-hour UTC), it is our considered opinion that a 24/7 model would identify the following benefits:

- Provides full support to A&E
- Patients with minor illnesses/injuries only being seen in the UTC and not A&E
- Creation of a true 'single front door' - provides a consistent and clear offer to patients
- Improves system resilience

5.1.2. The 24/7 model would allow for effective staffing in terms of workforce cross cover and skill mix.

5.1.3. North Tees and Hartlepool learning has evidenced that the single most important factor in the success of this model was 24-hour access to Primary Care GPs.

5.2. All age walk-in access within the community (including bookable dressing services based at:

- **Wallasey** – Victoria Central Hospital (8am-8pm) - 2 hours from current provision
- **Birkenhead** - Birkenhead Medical Centre (8am-8pm) + 2 hours from current provision
- **South Wirral** - Eastham Clinic (12pm-8pm) no change from current provision
- **West Wirral** - UTC at the Arrowe Park site (24-hours) + 10 hours from current provision

5.2.1. The all age walk in provision will be carried out from local 'community Hubs' which will be based in Birkenhead, Wallasey and Eastham localities. It is anticipated that patients within West Wirral will be able to access parallel services within the UTC at the Arrowe Park Hospital site and the proposed dressings clinics.

5.2.2. All community hubs will meet the criteria that we consulted with the public over in the form of being accessible by public transport, distance from home, accessible for people with mobility requirements, parking and flexible and convenient appointments.

5.2.3. We know that currently, the public are confused about which services to access due to the variation in opening hours and services provided. The new community hubs will have consistent names and consistent clinical pathways. Commissioners will continue to work with all providers to develop and appropriate and equitable community urgent care offer. The proposed model of care aims to create a more consistent and standardised pathway which will ensure a safe and sustainable workforce. Whilst it is acknowledged there remains an inconsistency in that Wallasey Hub will provide x-ray services, this is due to the feedback from the public during the consultation to continue with this.

5.3. Changes to Minor Injuries and Illness Units

5.3.1. We recommend that the current minor injuries and illness units at the below sites, are replaced with access to urgent GP/Nurse appointments in local GP practices as part of the GP extended access scheme. This will be further supported by an enhanced NHS 111 service and a planned/bookable dressing service in the Moreton area.

- Gladstone (formerly Parkfield) Minor Injury Unit, New Ferry
- Moreton Minor Injury Unit, Moreton Health Clinic, Moreton

The rationale for this recommendation is as follows:

5.3.2. The attendances in 2018/19 (pro-rata from month 9 onwards) demonstrate that both MIUs witnessed the least number of attendances across all minor injury and walk-in centre sites.

5.3.3. On review of the current number of people attending Gladstone (formerly Parkfield), this activity can now be provided by additional GP appointments. The Extended Access appointments within the Gladstone (formerly Parkfield) locality equate to an additional 104 appointments per week from April 2019. There are approximately 75 attendances per week currently in the Gladstone (formerly Parkfield) MIU. The majority of additional extended access appointments (82 per week) will be still be delivered from the immediate locality.

5.3.4. Within the Moreton locality the Extended Access appointments will equate to an additional 64 appointments per week from April 2019. There are approximately 90 attendances per week currently in the Moreton MIU. However; a high proportion of this activity (74%) is delivered to patients based in practices close to Moreton Health Clinic (practices located less than half a mile from Moreton Health Clinic) – these patients may be encouraged to use their own GP instead (as well as other services such as NHS 111, self-care or utilise local pharmacies). Further services for these patients are also outlined in 5.4 below.

5.3.5. In terms of local pharmacies within the vicinity, there are 3 located less than half a mile from Moreton Health Clinic (with one being on-site). For Gladstone (formerly Parkfield), there are 5 local pharmacies within the locality.

5.3.6. Residents currently using Moreton and Gladstone (formerly Parkfield) will be able to access the Community hubs, located in Birkenhead, Wallasey and Eastham as well as the 24/7 UTC. Distances to alternate urgent care walk in facilities are given below:

- Gladstone (formerly Parkfield) is 3.6 miles to Birkenhead Medical Centre, 4.1 miles to Eastham and 5.1 miles to the UTC at the Arrowe Park site
- Moreton is 2.4 miles to the UTC at the Arrowe Park site and 3.7 miles to Victoria Central

5.4. Dressing Services

5.4.1. We acknowledge the high proportion of dressings activity (46%) delivered from Moreton Minor Injury Unit and are working with the Primary Care Networks to develop a specific planned/bookable dressing service within the West Wirral/Moreton area to ensure continuity of service for residents.

5.4.2. Commissioners recommend activity warrants a 4 hour per day x 3 days per week planned dressing service at a cost of £19,474. This would ensure delivery of approximately 3000 dressings per year which equates to 58 per week.

5.5. Areas of High Deprivation

5.5.1. Patients from deprived communities have been considered and whilst we have identified that they may find it more difficult to access services further afield due to increased travel time/ potential inability to walk to required service, we have mitigated this by proposing a number of alternative services/methods of treatment:

- Community Hubs offering same day (within 24-hours) access to nurse appointments.
- All age walk-in access delivered from the community hubs
- GP extended access appointments delivered across Wirral including from the locality of Moreton and Gladstone (formerly Parkfield) Minor Injury Units
- A 24-hour UTC located at the Arrowe Park Hospital site
- Pharmacy/NHS 111
- Dressing clinic in Moreton/West Wirral

6. RISKS

6.1. If Governing Body do not agree to the recommendation to transform the urgent care pathway, the risk will be the continuation of an inconsistent offer in the community. The risk of not implementing an Urgent Treatment Centre (UTC) would mean not meeting the national mandate set out by NHS England to implement a UTC to address key elements of urgent and emergency care which would have a number of negative implications:

- 6.1.1. Not meeting the Accident & Emergency (A&E) 4 hour standard (95% of patients should be admitted, transferred or discharged within 4 hours of arrival to A&E)

- 6.1.2. Overcrowded A&E departments which many people attending inappropriately when they could be treated in a more appropriate setting
 - 6.1.3. Ambulance turnaround delays increasing delays for patients in the community awaiting an ambulance
 - 6.1.4. Variation in the local offer supporting the delivery of urgent care
 - 6.1.5. The current service provision does not provide a consistent offer of urgent care
- 6.2. If Governing Body approve the recommendations the risk associated with implementation will be managed as per the Programme Management approach. This includes the mitigating actions.

7. CONCLUSION

7.1. Based on the evidence from pre and post consultation, commissioners are recommending a blended urgent care delivery model. This incorporates a blend of both views and feedback from the public, alternative proposals received from providers and sustainability considerations.

7.2. Next Steps

The following table outlines our next steps and key milestones.

1.	Implementation, Communication and Engagement Strategy	<p>Commissioners are proposing a phased approach to implementation following Governing Body final decision. The intention being that the new contract arrangements for the community hubs will begin April 2020 meaning any contractual notice periods will be from September 2019.</p> <p>It may be possible to defer the date of the delivery of the UTC. Work is ongoing with NHS England around these timeframes.</p> <p>Part of the overall communication and engagement strategy is the immediate post decision actions and longer-term plan:</p> <p>Immediate Post Decision Actions</p> <ul style="list-style-type: none"> • Managing the rationale for the decision • What this means in terms of the immediate changes aligned to the introduction of the UTC <p>Longer Term Communication Plan</p> <ul style="list-style-type: none"> • Wider communication campaign including how urgent care promotes self-care and aligns with place based care
-----------	--	---

		<ul style="list-style-type: none"> • A clear and active communication plan to promote and educate the public regarding the urgent care offer and where to go to access urgent care.
2.	Clinical Model/ Estates	<p>Parallel estates/capital development and clinical pathways redesign work is ongoing via the Clinical Modelling Working Group to explore and design the final clinical model.</p> <p>Capital funding will continue to be explored.</p>
3.	Contractual and Workforce Implications	<p>The collaboration between the various providers of urgent care in the new proposed pathway is critical to ensure a seamless and consistent pathway for patients. The contract model for the provision of the UTC will require collaboration of the providers and ensure a single governance framework.</p> <p>This should be developed and agreed by the beginning of April 2020.</p> <p>Commissioners intend to work with providers to enable a blended approach to workforce. There are no intended redundancies. Commissioners believe the small shortfall of posts needed to provide the 24-hour UTC and recommended community urgent care offer will be recruited to in time for a gradual implementation from April 2021.</p>
4.	Overview Scrutiny Committee post NHS Wirral CCG Governing Body Decision	<p>Scrutiny of the decisions and recommendations made by NHS Wirral Clinical Commissioning Group Governing Body decision on the 9th of July 2019.</p>

7.3. In conclusion, NHS Wirral CCG Governing Body are asked to:

- Note the process undertaken
- Formally agree to the recommendations
- Note the next steps

8. SUPPORTING DOCUMENTATION

The following supporting documentation can be located on the NHS Wirral CCG website:

<https://www.wirralccg.nhs.uk/get-involved/public-consultations/urgent-care-consultation-update/>

1. Urgent Care Transformation Operational Plan
2. Urgent Care Transformation Case for Change
3. Arrowe Park Hospital Footfall Worst Case Scenario Assumptions
4. Extended Access to Primary Care 2018-2019
5. Cheshire West and Chester Utilisation
6. Transport Heat Maps
7. Discounted Options
8. Urgent Care Consultation Document
9. Communication and Engagement Timeline
10. Hitch Marketing Report
11. Clinical Senate Report and Recommendations
12. Clinical Senate Recommendations and Mitigation Strategy
13. Equality Impact and Risk Assessments



HEALTH AND WELLBEING BOARD

17 JULY 2019

REPORT TITLE	<i>Wirral BCF update and recommendations for 19/20</i>
REPORT OF	<i>Jacqui Evans, BCF lead for WHCC</i>

REPORT SUMMARY

- The following report provides Wirral Health and Wellbeing Board with an update on progress and developments regarding BCF, and recommendations for approach and priorities for our 19/20 submission; in line with mandated guidance
- The following pledges are linked and supported:
 - Older People Live Well
 - People with disabilities live independently
 - Workforce skills meet business needs

RECOMMENDATION/S

- Health and Wellbeing Board to note the contents of the report and draft priorities for 19/20
- Health and well Being Board members to support the recommendation to delegate authority to the Director of Care and Health with the chair of H&WBB to formally approve the final BCF submission, in order to comply with mandated timescales for formal submission to NHSE.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

- 1.1 Systems are required to agree and submit a Better Care Fund plan with agreed pooled fund, (section 75 agreement), in line with national guidance and legislation
- 1.2 The local Better Care Fund continues to support integration and the delivery of Healthy Wirral priorities.

2.0 OTHER OPTIONS CONSIDERED

- 2.1 N/A

3.0 BACKGROUND INFORMATION

- 3.1 Wirral continues to build upon developments, achievements and learning from the past couple of years. As a system, we are committed to ensuring we work collaboratively to achieve the best outcomes for Wirral residents, maximise the use of resources and ensure value for money for Wirral £.
- 3.2 NHSE requested systems develop, agree and deliver a 2- year plan for 17/18 and 18/19.
- 3.3 That pooled fund value was approximately £52.2m and was approved with no conditions by NHSE. £2m was the improved BCF (IBCF) element.
- 3.4 The BCF scheme priorities and outcomes were reviewed in February/March 2019, to inform priorities for 19/20. These were shared and agreed at Healthy Wirral Partners Board and the Pooled Fund Executive Group in April.
- 3.5 The overview of review intentions and related elements of work is attached in appendix 2. Key stakeholder representation was agreed and referenced in the attachment.

- 3.6 Schemes 'in scope' for review are outlined in appendix 3, recognising that elements of the BCF are mandated minimum requirements, intending to protect adult social care and out of hospital commissioned services.
- 3.7 The current BCF is year 2 of a 2-year plan. The improved BCF (iBCF) funding was introduced for 2017–19 plans. Wirral's approach was to use iBCF element (£2m) as an innovation fund. Due to a variation in implementation timescales, in part due to recruitment delays, there was agreement to carry forward funds from 2017/18 to 2018/19, to enable some schemes to be fully implemented and evaluated.
- 3.8 Wirral's BCF has invested to support 7-day services across three key areas;
- Admission avoidance
 - Internal flow within the acute trust
 - Community services to support timely discharge

Recommendations and decisions for future funding of the BCF schemes is not only linked to the deliverability against commissioning priorities included in the 2019/20 Healthy Wirral Plan but also consideration of the following related pieces of work:

- Current and future capacity and demand modelling, including bed-based review
 - Ability of schemes to demonstrate effective scale up to effectively meet system demand requirements
 - Recognising new 19/20 operational planning requirements eg Same Day Emergency Care model and reducing long stay patients.
 - 19/20 BCF framework and planning requirements
- 3.9 Providers were involved in the decision-making process and agreed the following priorities would need to be included when analysing the evidence of performance in 2018/19;
- Are there opportunities to improve productivity and efficiency?
 - Is the service providing value for money / ROI?
 - Is there confidence in deliverability?
 - Is there a QIA impact if decommissioned?

The review team also agreed 4 potential recommendations against BCF schemes:

- Continue with current services (maintain)
- Redesign to optimise the model

- Invest
- Decommission

3.10 Overall there has been evidenced improvement in achievement of the following BCF priorities during 2018/19;

- 4.8% reduction in type 1 ED attendances compared to 2017/18
- 2.7% reduction of non-elective admissions for 65+ compared to 2017/18. Although NEL as a whole remains relatively static.
- Walk in Centres and MIU's achieving 99/100% against the 4-hour standard
- Consistent achievement of a maximum 2.67% DToC target
- Consistent and effective outcomes for reablement supporting people to remain at home
- Significant improvement in domiciliary capacity evidenced in a reduced waiting list and significantly reduced waiting times, compared to 2017/18
- Consistent delivery of streaming since Q3
- Delivery of High impact change model requirements including evidenced delivery of;
 - Trusted Assessor
 - Triage
 - Implementation of new 111 requirements
 - Support to care homes

3.11 Key challenges for the system to focus attention for 2019/20 are;

- Continuing focus on further reducing ED attendances and NEL
- Achievement of the 4-hour standard
- Improving internal hospital flow from the point of admission to discharge with particular focus on reducing long stay patients
- Improving LOS in both acute and community settings whilst reducing bed dependency and particularly improving our integrated commissioning approach and requirements within the community home first and T2A model
- Rapidly improving the 7-day home first pathway and community model to meet system demand requirements, optimising the future model
- Full implementation of the newly commissioned domiciliary care contract
- Maximising 7 day working by reviewing roles and responsibilities to improve efficiency supporting current and future workforce challenges
- Ensuring BCF remains aligned to Healthy Wirral planning priorities including new requirements for 2019/20 i.e. same day emergency care
- Further adapting the Integrated Discharge approach to really achieve a 'shift left'

3.12 Recommendations for funding in 19/20:

3.12.1 Continue with current funding: (Maintain)

The following schemes have shown effective ROI and positive patient outcomes supporting Healthy Wirral and BCF priorities, including delivery against the High Impact Change Model.

Continue / Maintain						
Scheme / initiative	Provider	Current allocation	Recommendation	Additional funding	Saving	Funding Required.
Care Homes Scheme - Nurse	CCG	40.000	Continue with funding	5,000	0	45,000
Trusted Assessor - Care Homes	WCT	71.000	Continue with funding	0	0	71,000
Administration	WCT /WUTH	12.000	Continue with funding	0	0	12,000
Mobilisation Officer/transformation capacity for T2A Model	WUTH	29.100	Continue with funding	0	0	29.100
Acute Visiting Service (AVS)	Primary care	709.920	Continue with reduced funding	0	65,000	644,920
Homeless Service	3rd Sector	93.279	Continue with funding	0	0	93,279
Street triage	CWP	152.000	Continue with funding	0	0	152.000
Dementia LES	Primary care	71.400	Continue with funding	0	0	71.400
Early onset Dementia	CWP	146.000	Continue with funding	0	0	146.000
Complex Needs Service	CWP	250.000	Continue with funding	0	0	250.000
Crisis Response (dementia nurse)	CWP	150.576	Continue with funding	0	0	150.576
Dementia Nurse	CWP	150.580	Continue with funding	0	75,139	75,290
Whole System Modelling Senior Performance Analyst (VENN-CDM)	Whole System	40.000	Continue with funding	0	0	40.000
Street Triage - enhanced hours of operation	CWP	112.668	Continue with funding	0	0	112.668
Mental Health detention transport	CWP	70.000	Continue with funding	0	0	70.000
Communication and Engagement Lead	Healthwatch	30.000	Continue with reduced funding	0	10,000	20.000
Ward Discharge Coordinators	WUTH	155.000	Continue with funding	0	0	155.000
Primary Care Bid - Clinical Streaming at Front Door	WUTH / WCT	300.000	Continue with reduced funding	0	150.000	150.000
Winter Capacity	System	279.814	Continue with funding	10,713	0	290,527
Specialist Commissioning	Varied	200.000	Continue with funding	0	0	200.000

3.12.2 Redesign to optimise the model:

The review has identified areas which whilst critical elements of effective system delivery, have not been able to mobilise to the optimum level to be able to support system demand. Therefore, the following areas require significant system wide transformational redesign Q1 into Q2:

Redesign to Optimise						
Scheme / initiative	Provider	Current allocation	Recommendation	Additional funding	Saving	Funding Required.
Home First - MDT (Enhanced Rapid Response Service)	WCT	399.657	Redesign to optimise	0	0	399,657

Home First - Clinical Support/Discharge capacity	WCT	540.808	Redesign to optimise	0	0	540.808
86 x T2A Nursing Beds - core funding	Independent Sector	3,471.472	Redesign to optimise	0	0	3,471.472
Primary Care & Therapies for T2A Beds	Primary care/WCT	967.428	Redesign to optimise	0	0	967,428
Growth in T2A Beds	Independent Sector	219.625	Redesign to optimise	0	137,473	82,152
T2A - 10 beds - Cover for Pressure Periods	Independent Sector	223.812	Redesign to optimise	0	168,000	55,812
Additional MDT support, including clinical cover for extra beds (10)	WCT	106.343	Redesign to optimise	0	0	106.343
Carers Service	Independent sector	818.512	Redesign to optimise	0	78,520	739,992
IV Antibiotics	WUTH/WCT	627.300	Redesign to optimise	0	0	627.300

3.12.3 We recommend investing in the following schemes, for which there is evidence to increase investment to support Healthy Wirral and BCF priorities and evidence of effective ROI.

- Teletriage: Increase the tele triage offer to support the roll out of additional technologies for health care monitoring across the care sector. Supports broader Telehealth model and approach.
 - Links with redesign of SPA as a fit for purpose clinical triage model, maximising technology solutions. Update DOS and associated pathways in line with changes
- New priorities-Same Day emergency care (SDEC) and acute frailty service:
 - Invest in transformation capacity and support to develop and fully implement SDEC and acute frailty services

Systems are required to increase the number of people discharged same day from ED and assessment areas, improving access to required diagnostics, clinical support and follow up if appropriate as an 'out-patient'

Invest						
Scheme / initiative	Provider	Current allocation	Recommendation	Additional funding	Saving	Funding Required.
Tele-triage costs. Expand as part of Telehealth development.	WCT	207.812	Invest to redesign to optimise	120,210	0	328,022
Supporting 2019/20 planning priorities (patient flow). SDEC and acute frailty service development	WUTH	N/A	Invest	100,000	0	100,000

3.12.4 Decommission

The following schemes have not been able to evidence current or potential ROI. There will also be partial decommission in some schemes where a more cost-effective model should be the priority e.g. reduction in residential T2A beds.

Decommission						
Scheme / initiative	Provider	Current allocation	Recommendation	Additional funding	Saving	Funding Required.
Wirral Independence Service (falls element IBCF)	Independent sector	220.000	Decommission/redesign to optimise.	0	220,000	0
Adapted Flats	Independent Sector	35.643	Redesign to optimise/ Decommission	0	27,000	8,643
Trusted Assessor - Dom Care	Independent Sector	110.000	Future funding not required. Business as usual.	0	110.000	0
BCF Scheme Lead/ROI Evaluation	LA Staff	35.000	Decommission	0	35,000	0
Home First Capacity - dom care, reablement, mobile nights	Independent Sector	78.955	Future funding not required. New model will provide capacity. Absorbed.	0	78.955	0
10 x T2A Residential Beds - core funding	Independent Sector	273.520	Decommission residential beds and GP contract from end of Sept 2019 (contract end) Low occupancy and will be supported by the home first pathway.	0	149,562	123,958
Transformation Programme Manager Role	Independent Sector	60.000	Decommission	0	60,000	0
Street Triage for NWAS	NWAS	174.752	Decommission. Unable to recruit.	0	174,752	0

3.12.5 A full summary of review outcomes and recommendation is attached in appendix 4, This includes full BCF priority funding, including mandated elements not in scope.

3.13 19/20 planning guidance:

3.13.1 Final guidance for 19/20 has yet to be circulated from NHSE. This is expected early July, following publication of the requirements and templates, there will be 42 days for systems to finalise, agree and submit plans, following final sign off at Health and Wellbeing Board.

3.13.2 Following submission, there will then be scrutiny at a regional and national level, as part of the overall assurance and approach process. Final timescales are yet to be outlined.

3.13.3 Better Care Fund anticipated policy and planning requirements 2019-20:

Plans are to be developed for a single year 2019-20. The BCF is currently being reviewed and a new national approach to integration is expected to be in place from 2020.

The **four national conditions** set by the Government remain unchanged:

- i. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the HWB, and by the constituent LAs and CCGs;
- ii. A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund
- iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
- iv. A clear plan on Managing Transfers of Care, including implementation of the High Impact Change Model for Managing Transfers of Care.

The **four national metrics** remain unchanged:

- i. Non-elective admissions (Specific acute);
- ii. Admissions to residential and care homes;
- iii. Effectiveness of reablement; and
- iv. Delayed transfers of care;

All BCF plans must include trajectories for each of these four metrics and plans for achieving these.

Expectations for reducing Delayed Transfers of Care (DToC) will continue to be set for each Health and Wellbeing Board. The national ambition is for the average daily DToC number to be fewer than 4000 by September 2019. For Wirral the target remains at a maximum 2.67%.

Grant funding to local government (iBCF and winter pressures funding) is to be pooled in BCF plans. The BCF plan will include the following mandatory funding sources:

- Minimum NHS ring-fenced from CCG allocation
- Disabled Facilities Grant (DFG)
- Improved Better Care Fund Grant (iBCF)
- Winter Pressures Grant

A single plan template that will include short narrative sections, covering:

- the local approach to integration,
- plans to achieve metrics
- plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care.

3.13.4 As the 19/20 BCF framework and planning guidance is awaited, in order to meet the mandated submission timescales indicated above, it is recommended that the Care

and Health Director is nominated to approve the final recommendations with the chair of H&WBB board. The final recommendations, ensuring framework compliance, will be circulated to members in advance for comment and approval from organisational Chief Executives.

4.0 FINANCIAL IMPLICATIONS

4.1 The BCF will be supported by a Section 75 pooled fund arrangement.

4.2 Official guidance on the BCF allocation for 2019/20 has not yet been received. Consequently, the apportionment of the BCF financial resources as described below is still subject to change.

4.3 The 2019/20 budget for the Better Care Fund is £56.1m. This comes from the following sources:

• CCG Minimum Allocation	£26.3m
• IBCF	£16.8m
• Public Health	£6.8m
• Disabled Facilities Grant	£4.2m
• Adult Care & Health Contribution	<u>£2.0m</u>
	£56.1m

4.4 The budget of £56.1m is budgeted to be spent across the following commissioning areas:

• Integrated Services	£20.6m
• Adult Social Care Services	£28.3m
• Disabled Facilities Grant	£4.1m
• CCG Services	£2.0m
• Other Services	<u>£1.1m</u>
	£56.1m

4.5 A breakdown of the constituent parts of each area is included as Appendix 1 to this report.

5.0 LEGAL IMPLICATIONS

The BCF will be supported by a Section 75 pooled fund agreement and the relevant legal implications will be identified within that document.

6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

There are no adverse staffing implications resulting from 19/20 priorities. There may be a small number of staff who change focus/roles, due to decommission and redesign of schemes. However, there are no intended redundancies.

7.0 RELEVANT RISKS

There are no specific risks, other than the need to comply with submission deadlines, following publication of guidance outlined within the report

8.0 ENGAGEMENT/CONSULTATION

Formal engagement and consultation N/A.

Engagement with system leads across organisations and via Healthy Wirral Partners has taken place.

9.0 EQUALITY IMPLICATIONS

(a) Yes, and impacts and mitigations are attached within appendix 4, against specific schemes.

REPORT AUTHOR: *Jacqui Evans*
Assistant Director, Unplanned Care and Community Care Market commissioning
telephone: 0151 666 3938
email: jacquievans@wirral.gov.uk

APPENDICES

Appendix 1 – Scheme by scheme financial breakdown



APPENDIX 1.docx

Appendix 2 – Overview of review intentions



APPENDIX 2.pptx

Appendix 3 – Overview of schemes in scope for review



APPENDIX 3.xlsx

Appendix 4 – Full review of scheme outcomes and proposals, with Quality Impact assessments



APPENDIX 4.pdf

REFERENCE MATERIAL

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Wellbeing Board	18/07/18
Health and Wellbeing Board	14/03/18
Health and Wellbeing Board	15/11/17
Health and Wellbeing Board	19/07/17
Health and Wellbeing Board	15/03/17

This page is intentionally left blank

APPENDIX 1
SCHEME BY SCHEME FINANCIAL BREAKDOWN

Scheme Title	2019/20 Budget (£)
Integrated Services	
Wirral Independence Services	3,985,000
Care Homes Scheme - Nurse	45,000
Tele-Triage Recurrent Costs	328,022
Adapted Flats	8,643
Trusted Assessor – Care Homes	71,000
Home First – MDT (Enhanced Rapid Response Service)	399,657
Home First – Clinical Support/Discharge Capacity	540,808
Home First – Administration	12,000
Mobilisation Officer for T2A Model	29,100
Acute Visiting Service (AVS)	644,920
10 x T2A Residential Beds – Core Funding	123,958
86 x T2A Residential Beds – Core Funding	3,471,472
Primary Care & Therapies for T2A Beds	967,428
T2A – 10 Beds – Cover for Pressure Periods	55,812
Additional MDT Support, inc. Clinical Cover for Extra Beds	106,343
Community Offer (ASC)	3,972,292
Community Offer (CCG)	854,011
Reablement – Commissioned Care	1,231,249
Dom Care (Stabilising the Market 15 min & 7 day Retainer)	412,000
Enhanced Dom Care (Dom Care Plus)	143,000
Joint Posts – Mental Health	474,587
Homeless Service	93,279
Existing Schemes	2,213,779
ICCT – Existing Contract	426,236
Comms – Home First	3,000
Total Integrated Services	20,612,596
Adult Social Care Services	
Early Intervention & Prevention	1,199,000
Carers Service	739,992
Mobile Night Service	703,394
Care & Support Bill Implementation	497,180
Drugs & Alcohol	6,835,600
Protection of Social Care	18,280,901
Brokerage	27,000
Total Adult Social Care Services	28,283,067

Scheme Title	2019/20 Budget (£)
CCG Services	
CCG Third Sector	485,378
IV Antibiotics	627,300
Street Triage	152,000
Dementia LES	71,400
Early Onset Dementia	146,000
Complex Needs Service	250,000
Crisis Response	150,576
Dementia Nurse	75,290
Total CCG Services	1,957,944
Disabled Facilities Grant	4,163,057
Other Schemes	
Communication & Engagement Lead Role	20,000
Whole System Modelling – Senior Performance Analyst	40,000
Mental Health Detention Transport	70,000
Ward Discharge Co-Ordinators	155,000
Supporting 2019/20 Planning Priorities (Patient Flow)	100,000
Clinical Streaming at Front Door	150,000
Winter Planning	372,679
Complex/Specialist Commissioning Support	200,000
Total Other Schemes	1,107,679
Grand Total	56,124,343

Better Care Fund (BCF) – Desktop Review Q4 18/19

SYSTEM LEAD REVIEW TEAM;

Jacqui Evans WHCC, Assistant Director – Unplanned Care and Community care market
Tracey Dakin, WHCC, Commissioning Manager.
Natalie Armes WCFT, Assistant Director Transformation
Jenny Dodd WCFT, Associate Director Transformation

TIMESCALES;

COMPLETED – February/March 19
RECOMMENDATIONS – PFEG (March)

FOCUS & OUTCOMES;

System wide desktop review of BCF outcomes and priorities:

- Do we have the right comprehensive range of services?
- Do the comprehensive range of services need to include 'sub acute' type provision?
- Recommendations for BCF priorities and spend 2019/20 to PFEG and Health & Wellbeing Board.

CONTEXT;

BCF 19/20 priorities need to ensure the following:

- Align with NHS long term plan
- Align with 19/20 operational guidance
- Ensure we continue to meet broader BCF planning requirements, including mandated spend and performance priorities.
- Support Healthy Wirral priorities

AGREED ELEMENTS OF WORK;

The following need to be considered as part of the BCF review to inform recommendations.

- System wide capacity and demand modelling
- Bed based review (reviewing T2A provision)
- Point prevalence recommendations (system wide rehab patients, inc Acute, Clatterbridge and T2A-January 19)
- Review of clinical support to community beds
- Individual scheme reviews, evidencing ROI and performance against KPI's and intended outcomes.

SCOPE;

- Given the nationally mandated requirements for BCF, it is proposed the schemes on the attached appendix 2 are 'in scope' for this review.

This page is intentionally left blank

Better Care Fund Schemes 2018-19				
Better Care Fund Scheme Title	Provider	Allocation £,000	In Scope?	Out of Scope?
Wirral Independence Service	Falls	220		x
Care Homes Scheme - Nurse	CCG Staff	40	✓	
Tele-triage recurrent costs	WCT	208	✓	
Adapted Flats	Indep Sector	36	✓	
Trusted Assessor - Dom Care	ind sector	110		x
Trusted Assessor - Care Homes	WCT	71		x
BCF Scheme Lead/ROI Evaluation	LA Staff	35	Decommissioned	
Home First Capacity - dom care, reablement, mobile nights	Indep Sector	79	✓	
Home First - MDT (Enhanced Rapid Response Service)	TBC	400	✓	
Home First - Clinical Support/Discharge capacity	WCT	541	✓	
Administration	WCT	12	✓	
Mobilisation Officer for TZA Model	WUTH	29		x
Acute Visiting Service (AVS)	GPs	710		x
10 x TZA Residential Beds - core funding	Indep Sector	274	✓	
86 x TZA Nursing Beds - core funding	Indep Sector	3,471	✓	
Primary Care & Therapies for TZA Beds	GP	967	✓	
Growth in TZA Beds	Indep Sector	220	✓	
TZA - 10 beds - Cover for Pressure Periods	Indep Sector	224	✓	
Additional MDT support, including clinical cover for extra beds (10)	WCT	106	✓	
Community Offer (ASC)	WCT	3,972		x
Community Offer (CCG)	Various	854		x
Reablement - Commissioned Care	Indep Sector	1,231		x
Dom Care	Indep Sector	412		x
Enhanced Dom Care (Dom Care Plus)	Indep Sector	143		x
Joint Posts - Mental Health	CWP	475		x
Homeless Service	3rd Sector	93	✓	
Existing Schemes	Various	1,270		x
ICCT - CCG Contract	WCT	426		x
Comms - Home First	Other	12		x
Total Integrated Services		20,625		
Early Intervention & Prevention	3rd Sector	1,199		x
Carers Service	Various	819		x
Mobile Night Service	Indep Sector	694		x
Care & Support Bill Implementation	LA Staff	497		x
Drugs & Alcohol	Public Health	7,094		x
Protection of Social Care	Indep Sector	14,881		x
Brokerage	Other	27		x
Total ASC Services		25,211		
CCG Third Sector	3rd Sector	485		x
IV Antibiotics	WUTH/WCT	627	✓	
Street triage	CWP	152	✓	
Dementia LES	GPs	71	✓	
Early onset Dementia	CWP	146		x
Complex Needs Service	CWP	250		x
Crisis Response	CWP	151		x
Dementia Nurse	CWP	151		x
Total CCG Services		2,033		
DFG	Housing	3,858		x
Total Other		3,858		
Transformation Programme Manager Role	Indep Sector	60		
Whole System Modelling Senior Performance Analyst	whole system	40		x
Mental Health detention transport	CWP	70	✓	
Street Triage - enhanced hours of operation	CWP	113	✓	
Street Triage for NWS	NWAS	175	✓	
Ward Discharge Coordinators	WUTH	155	✓	
Integrated Assessments Training & Implementation	Other	8		
Primary Care Bid - Clinical Streaming at Front Door	WUTH / WCT	300	✓	
		921		x
Winter Planning	system	280		x
specialist commissioning	varied	200		x
Known Development Pressures		128		x
Allocation of increase in CCG minimum allocation		482		x
		1,090		x
Total BCF		53,738		x

2018-19 Funding

52,215

Current Shortfall

#REF!

This page is intentionally left blank

BCF Metric	Scheme / Initiative	Scheme Information				Recommendations & Ongoing Funding				Commissioner Report/Recommendations	EIA	QIA	Comments
DTOC Non-elective admissions Admissions to res & care homes Effectiveness of reablement	Scheme / Initiative	Provider	Previous Allocation £,000	In Scope	Out of Scope	Comments	Recommendation	Additional Funding Required	Saving	Funding Required 2019/20			
DTOC	Wirral Independence Service	Medequip	3,985.000		x	Not included in the review as ROI evidenced and monitored in as part of Contract	Continue with funding	0	0	3,985,000			This funding needs to be broken down on what is provided to identify costs for OT provided by WCFT and also the permanent admin staff funding
	Wirral Independence Service	Falls	220.000		x	This was initial set up funding. Falls app license costs are covered until 2020. Ongoing review for inclusion in wider technology strategy	Future funding not required	0	220,000	0			BCF Review Falls - email inc papers
	Care Homes Scheme - Nurse	CCG Staff	40.000	✓		Nurse employed by WHCC quality improvement team - This will require a review during 2019/20 to identify how this post can support a wider care home strategy	Continue with funding	0	0	45,000			
Non-elective admissions	Tele-triage recurrent costs	WCT	207.812	✓		Report from Sara Shaikh - ROI evidenced with current resource, recommends additional £10,780 for ongoing full year costs and £109,430 for service expansion as part of the wider Home First Pathway redesign and capacity and demand modelling in May 2019	Invest to redesign to optimise	120,210		328,022			Teletriage ROI March 2019 v2 paper
To be decommissioned	Adapted Flats	Indep Sector	35.643	✓		A review of these flats will be undertaken in Q1 as they are currently not optimised to their full potential. This will be included as part of the Home First Pathway redesign and capacity and demand modelling in May 2019	Redesign to optimise/Decommission	0	27,000	8,643			Paper to follow review to be undertaken in early May 2019
	Trusted Assessor - Dom Care	ind sector	110.000		x	Although this is mandated, this review confirms this has become business as usual as part of the new dom care commission April 2019	Future funding not required	0	110,000	0			Dom Care Trusted Assessor - email
	Trusted Assessor - Care Homes	WCT	71.000		x	Mandated HICM. Review to evidence costs for 19-20 and impact will be included as part of the wider care home strategy development	Continue with funding	0	0	71,000			
Page 119	BCF Scheme Lead/ROI Evaluation	LA Staff	35.000		Decommissioned	Post vacant - depriorised due to financial pressure. To be absorbed from existing resource	Decommission	0	35,000	0			N/A
	Home First Capacity - dom care, reablement, mobile nights	Indep Sector	78.955	✓	Decommissioned	Although this is not included in the integrated dom care and reablement commission going live in April 2019 capacity for this funding will be picked up within the new commission and cost envelope.	Future funding not required	0	78,955	0			N/A
	Home First - MDT (Enhanced Rapid Response Service)	WCT	399.657	✓		Report from Tracey Dakin - recommends redesign of the Home First Pathway linking with the capacity and demand modelling in May 2019.	Redesign to optimise	0	0	399,657			BCF Review 14 04 19
	Home First - Clinical Support/Discharge capacity	WCT	540.808	✓		Report from Tracey Dakin - recommends redesign of the Home First Pathway linking with the capacity and demand modelling in May 2019.	Redesign to optimise	0	0	540,808			See paper included in line 12 (BCF Review 14 04 19)
	Administration	WCT	12.000	✓		IDT Admin to support with timely discharge into T2A	Continue with funding		0	12,000			IDT Admin - email
	Mobilisation Officer for T2A Model	WUTH	29.100		x	Capacity required within WUTH to embed transformational change - AB post 50% cost share with WUTH	Continue with funding	0	0	29,100			This post will need to be reviewed as part of the IDT review to inform future funding intentions.
Non-elective admissions	Acute Visiting Service (AVS)	GPs	709.920		x	Report from Sara Shaikh - Although ROI is evidenced there are few home visits undertaken. Recommendation to remove driver and associated costs. There will be a separate review linked to Home First Pathway redesign and UTC design. Recommendations will align with BCF- review to include removal of mileage allowance and include mileage payment	Continue with reduced funding	0	65,000	644,920			AVS Return on Investment March 2019v2
	10 x T2A Residential Beds - core funding	Indep Sector	273.520	✓		Decommission 10x res beds (contract ends Sept 2019) demand absorbed in respite beds & community provision following Home First redesign. MDT to continue to support community provision.	Decommission residential beds and GP contract from end of Sept 2019 (contract end)	0	149,562	123,958			See paper included in line 12 (BCF Review 14 04 19)
	86 x T2A Nursing Beds - core funding	Indep Sector	3,471.472	✓		Commission will be reviewed as part of the Home First Pathway redesign and capacity and demand modelling in May 2019	Redesign to optimise	0	0	3,471,472			Recommendations from a bed based review will inform future commissioning intentions for the T2A beds.
	Primary Care & Therapies for T2A Beds	GP	967.428	✓		Commission will be reviewed as part of the Home First Pathway redesign and capacity and demand modelling in May 2019	Redesign to optimise	0	0	967,428			Recommendations from a bed based review will inform future commissioning intentions for the T2A beds.

					Report from Tracey Dakin - Recommends redesign of the Home First Pathway linking with the capacity and demand modelling in May 2019. 3 x EMI nursing to be spot not block to maximise ROI.	Redesign to optimise	0	137,473	82,152	See paper included in line 12 (BCF Review 14 04 19)		Recommendations from a bed based review will inform future commissioning intentions for the T2A beds. Any spot purchase beds will be authorised by the commissioning lead for T2A to allow for monitoring for this cohort of patients
	Growth in T2A Beds	Indep Sector	219.625	✓								
	T2A - 10 beds - Cover for Pressure Periods	Indep Sector	223.812	✓	Winter funding element ring fenced. Capacity & demand model will inform prioritisation, impementation Q2	Redesign to optimise	0	168,000	55,812	 Point of Prevlance - paper & see paper included in line 12 (BCF review)		Recommendations from a bed based review will inform future commissioning intentions for the T2A beds.
	Additional MDT support, including clinical cover for extra beds (10)	WCT	106.343	✓	Winter funding element ring fenced. Capacity & demand model will inform prioritisation, impementation Q2	Redesign to optimise	0	0	106,343			Recommendations from a bed based review will inform future commissioning intentions for the T2A beds.
	Community Offer (ASC)	WCT	3,972.292		Mandated / Protection of Social Care - reviewed as part of the core contract arrangements	Continue with funding	0	0	3,972,292			
	Community Offer (CCG)	Various	854.011		Mandated / Protection of Social Care - reviewed as part of the core contract arrangements	Continue with funding	0	0	854,011			
	Reablement - Commissioned Care	Indep Sector	1,231.249		Mandated - review complete - new commission from 01/04/19	Continue with funding	0	0	1,231,249			
	Dom Care	Indep Sector	412.000		Mandated - review complete - new commission from 01/04/19	Continue with funding	0	0	412,000			
	Enhanced Dom Care (Dom Care Plus)	Indep Sector	143.000		Core Contract - review complete - new commission from 01/04/19	Continue with funding	0	0	143,000			
	Joint Posts - Mental Health	CWP	474.587		Core Contract. Protection of social care - reviewed as part of the core contract arrangements	Continue with funding	0	0	474,587	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
	Homeless Service	3rd Sector	93.279	✓	Awaiting review report, anticipate ongoing funding required	Continue with funding	0	0	93,279	Need to check if this is the same as the CWP homeless service at £70k speak to Jo Watts & Hannah Ward		
	Existing Schemes	Various	1,269.526		Core Contract CCG - reviewed as part of the core contract arrangements now includes the increase in CCG allocation (WCT)	Continue with funding	482,000	0	1,751,526			
	ICCT - CCG Contract	WCT	426.236		Core contract-therapies, part of bed base review and 7 day working - reviewed as part of the core contract arrangements	Continue with funding	0	0	426,236			
	Comms - Home First	Other	12.000		Continue to refine winter comms locally	Continue with limited funding	0	9,000	3,000	 Comms support from BCF for winter - email  		
	Total Integrated Services	N/A	20,625.475									
Page 120	Early Intervention & Prevention	3rd Sector	1,199.000		In Contract, ROI demonstrated - reviewed as part of the core contract arrangements	Continue with funding	0	0	1,199,000			
	Carers Service	Various	818.512		Mandated, in contract-review required - decommission 1 x nursing bed & 2 res EMI	Redesign to optimise	0	78,520	739,992	 Carers respite BCF review - paper		
	Mobile Night Service	Indep Sector	694.394		Core Requirement	Continue with funding	9,000	0	703,394			
	Care & Support Bill Implementation	LA Staff	497.180		Statutory Requirement	Continue with funding	0	0	497,180			
	Drugs & Alcohol	Public Health	7,093.526		Reviewed via PH-recommission	Continue with funding	0	0	7,093,526			
	Protection of Social Care	Indep Sector	14,880.901		Commissioning Independent Community Provision	Continue with funding	0	0	14,880,901			
	Brokerage	Other	27.000		Forms part of review of function Q3 19/20 following new commission	Continue with funding	0	0	27,000			
	Total ASC Services	N/A	25,210.513									
	CCG Third Sector	3rd Sector	485.378		Core contracts - Reviewed as part of the core contract arrangements	Continue with funding	0	0	485,378			
	IV Antibiotics	WUTH/WCT	627.300	✓	Performance continues to exceed anticipated targets. - continue with a view to review and improve where recommended	Redesign to optimise	0	0	627,300			
	Street triage	CWP	152.000	✓	Continue within contract now part of core contract	Continue with funding	0	0	152,000	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
	Dementia LES	GPs	71.400	✓	Continue within contract - full review 2019/20 as part of wider CWP contract performance	Continue with funding	0	0	71,400			
	Early onset Dementia	CWP	146.000		Core Contract - Reviewed as part of the core contract arrangements	Continue with funding	0	0	146,000	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
	Complex Needs Service	CWP	250.000		Core Contract - Reviewed as part of the core contract arrangements	Continue with funding	0	0	250,000	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
	Crisis Response (dementia nurse)	CWP	150.576		Core Contract - Reviewed as part of the core contract arrangements	Continue with funding	0	0	150,576	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
	Dementia Nurse	CWP	150.580		Core Contract - Reviewed as part of the core contract arrangements as it has not delivered on antipated activity (330 referrals against estimated 840). Only recruited 1 nurse - £75,290 now part of core contract	Continue with funding	0	75,139	75,290	 BCF Review 2018 19 - Jo Watts BCF overview 13 03 19		Jo Watts monitors performance - get regular updates as part of BCF report
	Total CCG Services	N/A	2,033.234									
	DFG	Housing	3,858.041		Statutory / Mandated - New SLA with housing in place	Continue with funding	0	0	3,858,041			
	Total Other	N/A	3,858.041									
	Communication and Engagement Lead	Healthwatch	30.000		£20k salary plus promotional material	Continue with reduced funding	0	10,000	20,000	 		
	Transformation Programme Manager Role	Indep Sector	60.000		Depriorised due to financial pressure. To be absorbed from existing resource	Decommission	0	60,000	0	 		

Whole System Modelling Senior Performance Analyst	whole system	40.000		x	CDM as a system approved at HWEDG 40K	Continue with funding	0	0	40,000			
Mental Health detention transport	CWP	70.000	✓		Report from Jo Watts - Recommend ongoing funding based on activity and ROI	Continue with funding	0	0	70,000	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
Street Triage - enhanced hours of operation	CWP	112.668	✓		iBCF was for shortterm funding. Inyear funding to be carried forward into 2019/20 financial year due to late recruitment. Expected ROI - future funding to be sourced as part of core CWP contract.	No future funding required	0	112,668	0	See paper included in line 49 (BCF Review 2018 19 - Jo Watts BCF overview 13 03 19)		
Street Triage for NWAS	NWAS	174.752	✓		Unable to recruit to posts	Decommission	0	174,752	0	Agreed with lead commissioner		
Ward Discharge Coordinators	WUTH	155.000	✓		Critical part of internal redesign pathway at WUTH to manage flow and reduce LOS		0	0	155,000			
Integrated Assessments Training & Implementation	Other	8.250			This was a one off payment for 18/19	No future funding funding	0	8,250	0	N/A	N/A	N/A
Supporting 2019/20 planning priorities (patient flow)	WUTH	N/A			Long stay patient is the single biggest challenge across the system, impacting upon performance across the board		100,000		100,000	New 2019/20 Operational Planning Requirements - systems must develop and implement SDEC model and Acute Frailty Service by Sept 2019. Target to discharge same day 1/3 of patients attending for emergency care.		
Primary Care Bid - Clinical Streaming at Front Door	WUTH / WCT	300.000	✓		Mandated-Separate Review- linked to UTC implementation timescales.		0	150,000	150,000	Streaming model now in place and delivering. BCF supporting funding of additional clinical staff.		
	N/A	920.670		x								
Winter Capacity	system	279.814		x	Capacity and demand modelling in May will inform system requirements and winter commission. This will be used to inform priority spend for winter		10,713	0	290,527	SARA MORRIS CAN THIS BE INCLUDED? - This will need to include the 82k funding above (line 20) giving a total of £372,679 for winter		
Specialist Commissioning	varied	200.000		x	LD CHC funding		0	0	200,000			
Known Development Pressures		128.387		x	Absorbed within current contract developments (QIPP)		0	128,387	0	QIPP requirement?? - Jacqui to speak to Graham as saving £1.5m		
							£721,923	£1,797,706	£52,215,000			
							Allocated 2019/20 Budget		£52,215,000			

FALLS PREVENTION SERVICE– Funding Bid 2019-20

Wirral Falls Prevention Service (WFPS) has always had the remit of providing early intervention to Wirral residents. The main interventions provided by the Falls Prevention Service have been:

- Multi-factorial assessment according to nice 161 guidelines - delivered mainly within clinic settings.
- Health and wellbeing advice with referral on to other specialist services as necessary.
- Community based exercise programmes to improve strength and balance called postural stability instruction (PSI).

July 2015 The Wirral Falls Prevention Service was included in the Wirral Independence Service contract and the commission was awarded to Medequip UK LTD. With the change of provider, anyone at risk of falling was automatically referred to The Falls Prevention Team. The Service very quickly became overwhelmed with a very high volume of referrals including housebound clients with complex –co-morbidities and severe frailty which is outside of service specification

Contracted referral activity 2015 -2016 was 900 to increase by 10% per year.

- 2015 / 16 contracted referrals 900 , actual referrals were 2151
- 2016/17 contracted referrals 990 actual referrals were 2225
- April 18 –March 19 contracted 1197 actual referrals to date (Jan 19) 2668

Through a flexible, accommodating and solution focussed approach the service worked collaboratively with commissioners agreeing to take clients outside of scope whilst supporting the development and understanding of a “Wirral Wide Falls System”

Despite the team’s best efforts the volume and complexity of clients referred into the service caused waiting lists to dramatically increase.

October 17 the waiting list stood at 582 with maximum wait 34 weeks. Such a long wait for initial assessment increases the risk of further falls and possible injurious falls with hospital admission for those with the highest risk. Investment of £15,000 per month from the Better Care Fund enabled the service to invest significantly in locum staff and develop new initiatives to manage the workload i.e. commissioning of 3 x training videos, development of the “Taking Positive Steps” booklet, which has been extremely well received.

March 18, 62% reduction in the waiting list (582 down to 224) with waiting times down from 34 weeks to 8 weeks. Although this was a significant improvement, 8 weeks wait remained too long and repeat falls remained a concern. A high volume of referrals continued to be received by the service. End of October 17 to end March 18, the contracted volume of referrals to be managed within KPIs was 454 referrals. Actual number of referrals received was 1,926.

April 18 – March 19 Investment was revised to £6,600 per month which was invested in Locum staffing levels to further reduce and manage the waiting lists in line with the contract KPI’s. By October 2018, with the increased staffing level the waiting list reduced to 80 with a maximum waiting time of 4 weeks and this is currently being sustained as of January 2019. Referrals April 18 – January 19 stand at 2668 which remains significantly above the contracted volume to be managed within KPIs. Average monthly referral rate remains at 260+ referrals.

Recent Initiative Jan 2019

Medequip have engaged the software house “CSS” to develop an IT platform to manage all our falls referrals, measuring our activity, outcomes whilst producing KPI reporting in line with the contractual PMF and to ensure that we fully comply with the GDPR requirements.

Interventions provided outside the contract are

Assessment and provision of low-level equipment –October 2017 to January 2019, 751 people assessed for equipment resulting in 1,403 pieces of equipment provided by the service, which is not specified within the contract.

Assessment referrals to other services for such interventions as home adaptations or outside walking practice.

None of these interventions are measured within the Performance Management Framework (PMF). This is essential work, without these interventions clients will remain at high risk of falling, become increasingly housebound, frailty and dependency levels will increase; further increasing the risk of falling.

OUTCOME - The age of clients being referred into the service is increasing many of these are too frail to access the PSI programme in the first instance. A lower impact chair based programme has been introduced. 153 clients have completed this programme to date, 90% have improved balance (4 step balance test). Some clients have now progressed to the PSI programme. This improvement in balance reduces frailty, improves independence, reducing the risk of further falls.

OUTCOME Housebound clients, too frail for community programmes, are being supported with a home exercise programme developed as a joint venture with Age UK known as “The exercise buddy programme” 35 referrals to date, of those who have completed the programme 66% have not had any further falls. 6 have progressed to community chair based exercises reversing their risk of becoming increasingly housebound, risk of falling is reduced.

OUTCOME – Of 518 clients able to engage with 6 week review 79% have not had any further falls.

OUTCOME 35 care homes and 6 domiciliary care providers have engaged with the falls prevention training programme. Since attending this training 19 homes have taken up the safe steps screening tool.

Nice guidelines show that a previous fall is a strong indicator of further falls. From reportable service data, a sample of 341 clients reported a total of 1450 falls in the 12 months prior to referral to the Wirral Falls Prevention Service.

Pre intervention $1450/52\text{weeks} = 27$ falls per week x 6 weeks = 167 falls

Post intervention 259 (76%) clients reported no further falls at 6 week;

Of those remaining at risk of falling, average number of falls reduced by 3 per week.

OUTCOME -a potential annual reduction of 1,102 falls for this sample group.

Therefore if 75% of all clients referred to the Falls Prevention Service 2019/20 engage with the service there is potential to reduce falls on Wirral by 3,363. Not all of these falls will be injurious however research shows that 10 -15% of falls in older people result in hospital admission therefore the cost to the local economy or potential savings could be in the region of £1,902,500- £2,854,000.

Base contract = £32,565 per month for 1197 referrals = £27.20 per referral

With added funding = £39,231 per month for 2,668 referrals = £14.70 per referral

The volume of referrals remains significantly above the contracted level that can be managed within KPIs. Service outcomes are proving to be effective in preventing further falls for older people on Wirral. Reduction of Better Care Funding will result in reduced staffing levels, causing waiting times to increase

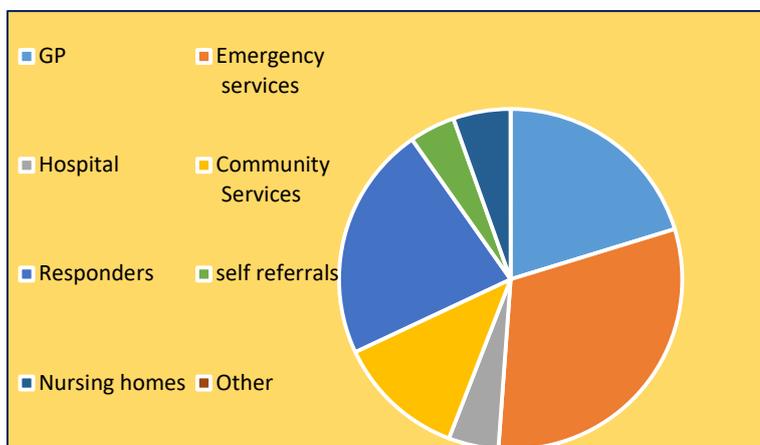
again, increasing the risk of further falls and hospital admissions; increasing frailty and dependency whilst waiting for assessment and interventions from the Falls Prevention service.

MAKING A DIFFERENCE WITH FALLS PREVENTION – Medequip continue to make a difference and bring about improved outcomes as part of the Early Intervention Falls Prevention Service on Wirral October 17 – Jan 19



Referrals sources

449 Older People recruited to exercise programmes



7,664 Advice booklets issued

90% Improved balance

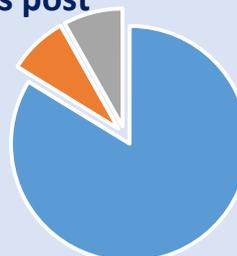
OUTCOMES -Post intervention

71% had improved confidence in Activities of Daily Living (from reported outcomes)



No further falls at 6 weeks post intervention (79%)

(from 776 reported outcomes)



0 falls 1 fall 2+ falls

2019-20 –Manage extra activity within KPIs. Improve competency within other services to identify and manage falls risks.

- Affirm service position within falls pathway as “early intervention” and share referral criteria
- Increase awareness sessions delivered to recruit suitable clients to exercise programmes
- Increase number of exercise sessions delivered to accommodate extra clients and improve access.
- Develop partnership working to enable continued activity post exercise intervention.
- Broaden scope of providers to whom falls awareness is delivered to include professional health and social care teams.

EQUALITY IMPACT & RISK ASSESSMENT STAGE 1 SCREENING TOOL



Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to decommission: Group 1 - No change in service (just funding stream) Wirral Independence Service: Falls App, Trusted Assessors, Integrated
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)

Falls app was introduced as part of the Wirral Independence Service Falls Prevention service with funding provided to support set up costs. License fees have been funded until at least 2020 and ongoing support will be considered within the technology strategy. Free licenses have been agreed with provider as Wirral funded development work which is now being rolled out to other systems. Trusted Assessors are a mandated element of BCF and will continue to be commissioned however they are now funded within the new dom care commission (from 1 April 2019). Integrated Assessments Training and Implementation was a one off payment for one off training 18/19 which has now been delivered. No further funding required.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) Although it is listed as a decommission, it is withdrawal of funding source from BCF but service will continue unchanged/ no additional funding required
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	Section N/A as no change to service, just funding mechanism
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	No change to current model
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 1 - No change in service (just funding stream) Wirral Independence Service: Falls App, Trusted Assessors, Integrated Assessments Training and Implementation

Brief description of scheme:

Falls app was introduced as part of the Wirral Independence Service Falls Prevention service with funding provided to support set up costs. License fees have been funded until at least 2020 and ongoing support will be considered within the technology strategy. Free licenses have been agreed with provider as Wirral funded development work which is now being rolled out to other systems.

Trusted Assessors are a mandated element of BCF and will continue to be commissioned however they are now funded within the new dom care commission (from 1 April 2019)

Integrated Assessments Training and Implementation was a one off payment for one off training 18/19 which has now been delivered. No further funding required.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A				0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N/A				0	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A				0	

Please describe your rationale for any positive impacts here:

NA - there will be no change to service delivery, funding will continue.

Signature:	Designation:	Date:
-------------------	---------------------	--------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT EXPERIENCE	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?				0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?				0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?				0	
	What is the impact on strategic partnerships and shared risk?				0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?				0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?				0	
	Will this impact on the organisation's duty to protect children, young people and adults?				0	
	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)				0	
How will it impact on choice?				0		

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?				0	
	How will it impact on preventable harm?				0	
	Will it maximise reliability of safety systems?				0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?				0	
	What is the impact on clinical workforce capability care and skills?				0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?				0	
	How will it impact on clinical leadership?				0	
	Does it support the full adoption of Better care, Better Value metrics?				0	
	Does it reduce/impact on variations in care?				0	
	Are systems for monitoring clinical quality supported by good information?				0	
	Does it impact on clinical engagement?				0	
PREVENTION	Does it support people to stay well?				0	
	Does it promote self-care for people with long term conditions?				0	
	Does it tackle health inequalities, focusing resources where they are needed most?				0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?				0	
	Does it eliminate inefficiency and waste?				0	
	Does it support low carbon pathways?				0	
	Will the service innovation achieve large gains in performance?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT	Does the proposal involve reducing staff posts? If so describe the impact this will have				0	
	Is the loss of posts likely to impact on remaining staff morale?				0	
	Can arrangements be made to prioritise and manage workload effectively?				0	
	Are vacancies likely to impact on patient experience?				0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?				0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates				0	
	IT Resource				0	
	Funding streams/income				0	
	Other providers (specify how/what)					
	Social care/voluntary/third sector				0	

Signature:	Designation:	Date:
-------------------	---------------------	--------------

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour
Minimal or no impact on the environment
Likelihood score
Rare
This will probably never happen/recur

		2
Minor (Green)	Moderate (Yellow)	
Formal complaint (stage 1)	Formal complaint	
Local resolution	Local resolution go to independent	
Single failure to meet internal standards	Repeated failure to meet standards	
Minor implications for patient safety if unresolved	Major patient safety findings are	
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality	Late delivery of service due to	
	Unsafe staff competence	
	Low staff morale	
	Poor staff attendance mandatory/	
Breach of statutory legislation	Single breach of legislation	
Reduced performance rating if unresolved	Challenging recommendation notice	
Local media coverage –	Local media coverage	
short-term reduction in public confidence	long-term reduction in public confidence	
Elements of public expectation not being met		
<5 per cent over project budget	5–10 per cent over project budget	
Schedule slippage	Schedule slippage	
Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	2 Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
	3	4
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Teletriage – Return on Investment

Executive Summary

Teletriage is a nurse and GP led 24 hr service that provides remote clinical assessment for care home residents in order to reduce 111 calls, ambulance conveyances and non-elective admissions.

Cost of service 2018/19: £207,000

Estimated Return on investment 2018/19 using 2017/18 baseline: **£632,167**

Funding requested for 2019/20: £319,000 (increase of £112,000)

Additional Return on investment 2019/20 compared to 2018/19: **£789,391**

Background

Teletriage is available 24 hours per day, 7 days a week, and is delivered by Wirral Community NHS Foundation Trust (WCFT). Nurse practitioners staff the service 8am-8pm, 7 days per week, with GP OOH providing the service overnight. In the in-hours period, the AVS GP (also BCF Funded) provided by PCW Federation provides GP support to the nurses.

The teletriage service started in June 2017, with the first months of the service spent engaging with Care Homes and installing equipment. The service was then rolled out to Care Homes in a phased approach, with full roll-out to 76 older people's residential and nursing homes completed in July 2018. The service started with two nurse practitioners, with a third nurse practitioner starting in June 2018.

Care home staff can use teletriage to skype with a nurse practitioner when a resident becomes unwell. Using the observations taken by care home staff, and a visual assessment of the patient via skype on a high definition screen, the teletriage nurse is able to provide clinical advice and management for patients without the patient needing to leave the care home. This may include advice, prescribing medications, arranging a same day GP visit, ongoing monitoring for a number of hours, and supporting end of life care.

Following the consultation, a letter is sent to both the Care Home, and the patient's GP with the details of the clinical assessment, and the advice given.

The Teletriage nurses are developing the service by integrating with existing community services and Wirral University Teaching Hospital (WUTH) to enhance communication between the primary and secondary interface. The nurses promote advance planning for patients who are at the end of life to improve the care experience for this client group; promoting choice and facilitating proactive pragmatic care for complex patients with chronic health conditions to meet their needs in the care home setting.

Service Aims

- Reduce avoidable ambulance calls and conveyances from care homes
- Reduce A&E attendances and admissions from care homes
- Reduce NHS 111 calls from care homes
- Provide care in patient's place of residence and improve patient experience

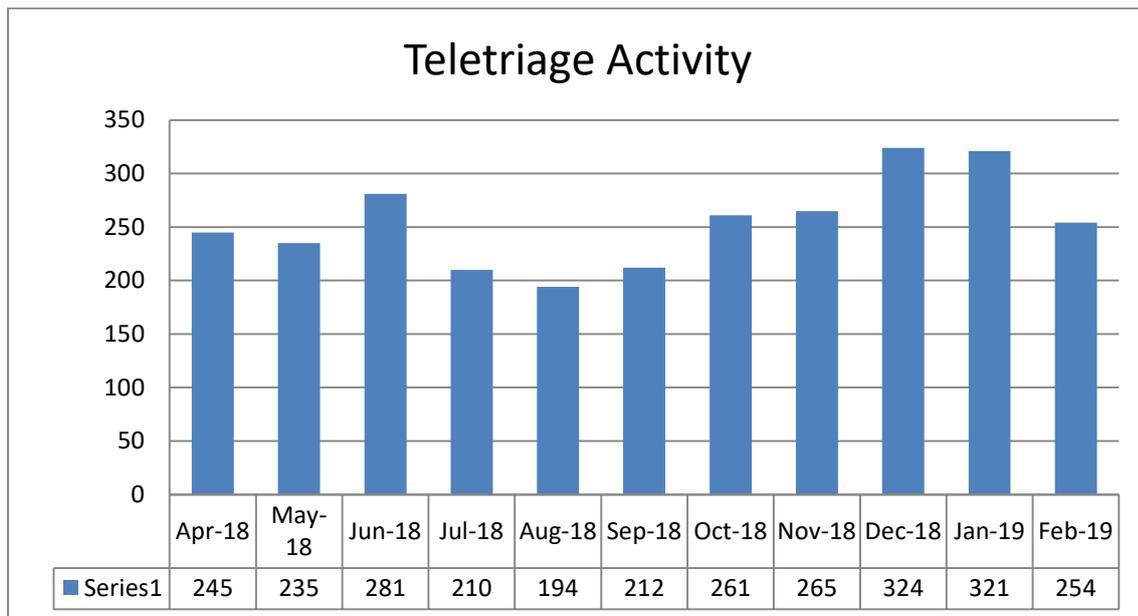
Cost of Service

Teletriage service cost for 2018/19 was £207,000, consisting of:

- £168,000 staffing cost of three Nurse Practitioners
- Remainder in software, licencing costs and IT support to the care homes.

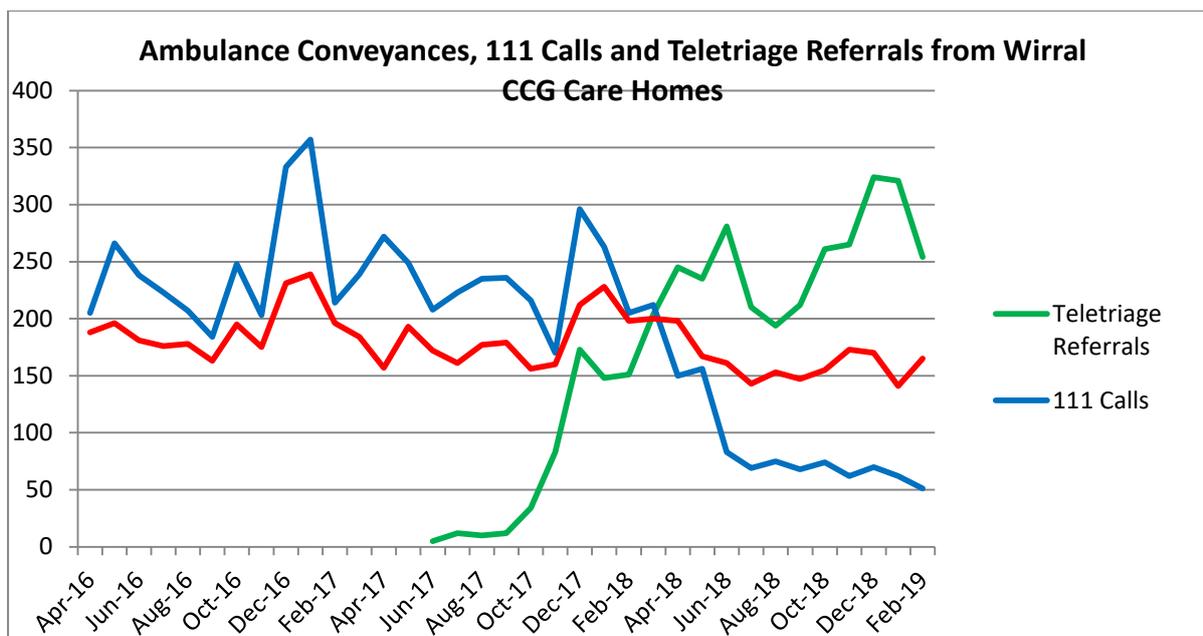
Teletriage Activity

The graph below shows numbers of referrals to teletriage in 2018/19



The graph below shows monthly referrals to teletriage, calls to NHS 111 and Ambulance Conveyances from Care Homes to Arrowse Park Hospital. As teletriage referrals have increased, 111 calls have decreased and ambulance conveyances have decreased.

Ambulance Conveyances in November 2018 – January 2019 did not follow the same pattern as the previous two years, where there was a large increase over winter.



Teletriage Outcomes

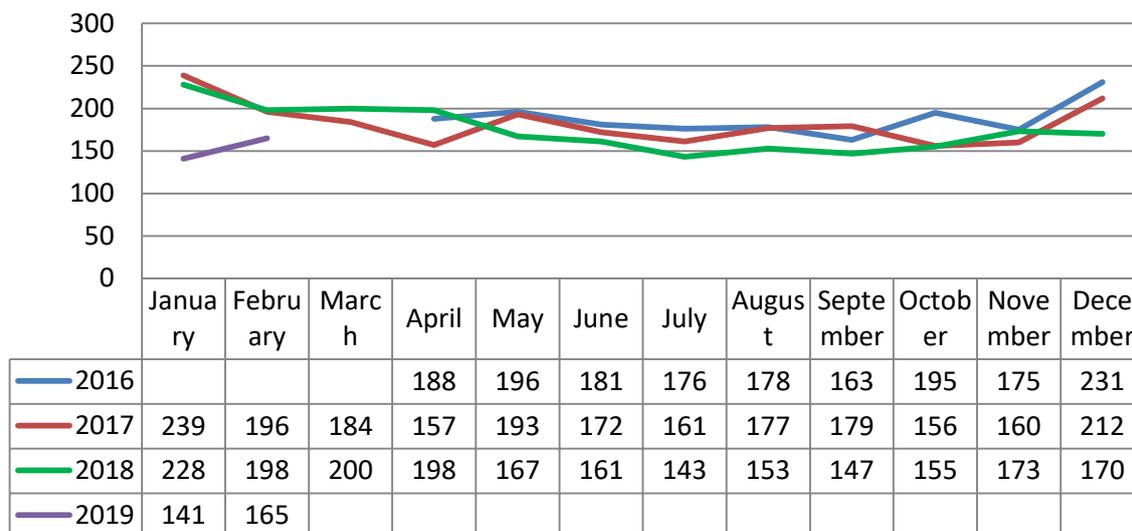
The table below shows the outcome of referrals to teletriage. Approximately 85% of referrals are managed in the patient's place of residence and do not result in the patient going to hospital.

Outcome	%
Home Management/ Advice from Teletriage/No follow up	25.0%
Contact own GP if necessary	24.4%
GP to follow up please	23.4%
Ambulance	10.7%
Referred to District Nurse	5.7%
Patient Deceased (expected)	3.4%
Referred to ACU/SAU/Other Assessment Area	2.9%
Referred to A&E	2.8%
Other	1.6%

Ambulance Conveyances

The graph below shows ambulance calls resulting in conveyance to hospital from Wirral care homes reduced by 12% in 2018/19 (forecast from 11 months data). There is no financial saving attributable to reducing conveyances, as it is a block contract – however it has been used here as a proxy for Non-elective admissions, as that data is not currently available from WUTH.

Ambulance Conveyances from teletriage care homes to Arrowe Park Hospital



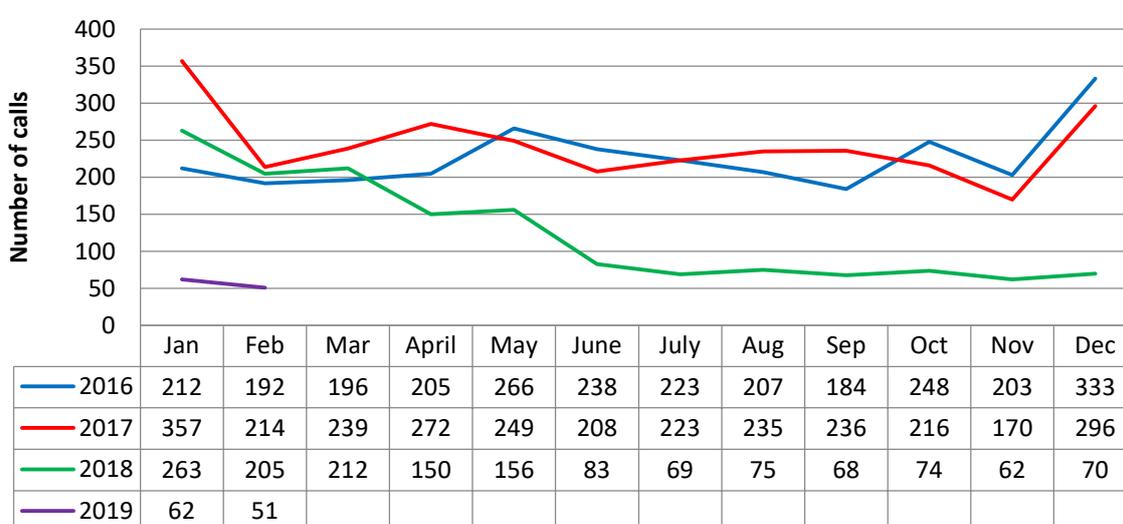
NHS 111 Calls

A key aim of teletriage is to reduce care home calls to NHS 111, because the risk-averse nature of the NHS 111 pathways algorithm can result in an ambulance being dispatched and the patient being conveyed to hospital. Teletriage offers care home staff quicker access to a specialist local service.

The graph below shows calls from Wirral Care Homes to NHS 111 from 2016 onwards. Calls have reduced dramatically from April 2018 onwards, stabilising from June onwards at a much lower level.

NHS 111 calls from Care Homes from June 2018- February 2019 showed a reduction of 70% compared to the same period in 2017-18.

Calls to NHS 111 from Wirral Care Homes



There is a small financial saving achieved by reducing NHS 111 calls, however the main benefit of reduction in NHS 111 calls is improved patient and staff experience from quicker access to clinical input.

Return on Investment 2018/19

Description	Unit cost	Forecast reduction from 2017/18	Forecast Number avoided 18/19 compared to 17/18	Estimated Cost Avoided 18/19 compared to 17/18
A&E attendance	£119	12%	263	£31,297
NEL admission	£3000	12%	263	£789,000
NHS 111 Calls	£10.46	70%	1804	£18,870
<i>Teletriage Cost</i>				<i>-£207,000</i>
			<i>Net saving</i>	<i>£632,167</i>

Investment for 2019/20

Additional Funding is requested for 2019/20: £207,000 plus additional £112,000 (Total cost £319,000)

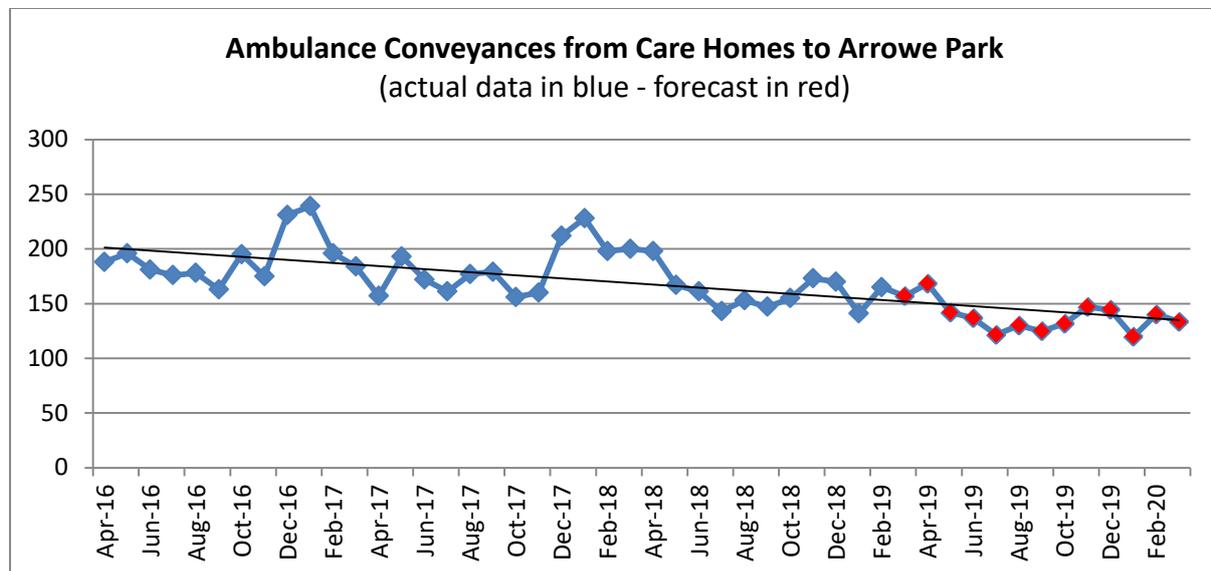
Forecast Return on Investment 2019/20

The table below shows *further* reductions in A&E attendances and NEL admissions from 2018/19, which has significantly reduced from 2017/18 levels. 111 calls are not forecasted to reduce further as they have already reached low levels.

Description	Unit cost	Forecast reduction from 18/19	Forecast number avoided 2019/20 compared to 18/19	Estimated cost avoided in 2019/20 compared to 18/19
A&E attendance	£119	15%	289	£34,391
NEL admission	£3000	15%	289	£867,000
NHS 111 Calls	£10.46	Not forecasted to reduce further		
<i>Cost increase from 18/19</i>				<i>-£112,000</i>
			<i>Net Saving</i>	<i>£789,391</i>

Ambulance Conveyances

The graph below shows the reduction in ambulance conveyances in 2018/19, and the forecasted further reduction in ambulance conveyances (in red), that will be possible with increased funding.



Benefits of increased investment:

This investment will expand the team from three WTE nurses to five WTE nurses. The service already covers 24 hours, with nurses covering 8am-8pm, 7 days per week, and GP OOH covering overnight. The additional staffing will mean that there are always two nurses on duty from 8am-8pm. This will increase capacity and mean that the quick response time (approximately 15 minutes) is maintained as referrals continue to increase. One nurse will remain at base to take skype calls, and one nurse can be out visiting care homes to visit patients, and proactively target care homes that have high levels of admissions.

Further reduction of 999 conveyances and non-elective admissions will be delivered through:

- Proactively targeting care homes that frequently call 999
- Continue to expand on delivering education and training to care home staff (joint work with end of life team and community geriatricians)
 - End of Life care
 - Anticipatory care planning
 - Management of specific conditions
 - Frailty and falls management
- Provide proactive support for T2A patients when they first arrive at the home
- Attending MDTs for T2A homes
- Management of simple chest infections/urinary tract infections/cellulitis/pain management within the place of residence this could be done with either the use of PGDs or non medical prescribing.
- Roll-out of teletriage to new care homes that have opened since teletriage launch or will open in future (service is currently covering all the homes it has been commissioned to cover).

- Manage minor injuries in the patients place of residence
- Verification of deaths within care homes
- Cannulation and point of care testing
- Collaborative working with the SALT team to provide swallow assessments in care homes

Recommendations

- It is recommended that the funding for teletriage is continued and increased in 2019/20
- It is recommended that opportunities for joint working are explored around AVS and T2A clinical oversight.

EQUALITY IMPACT & RISK ASSESSMENT STAGE 1 SCREENING TOOL



Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BGF Schemes - Decision to decommission: Group 3 - Adapted flats and T2A Residential Beds x 10
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 The decision to decommission Adapted flats and 10 residential T2A beds is based on demand for the services both of which being significantly under utilised. Therefore it is a more cost effective option to spot purchase beds / flats as patient needs determines rather than a block funding agreement that is not utilised. There are also alternative beds/services available for these cohorts of patients such as respite beds and home first. There will be no change to service users as they will still have access to the same facilities or an improved option more suited to their needs. There may be some impact on providers however adequate notice has been given re decision not to continue funding.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) Please note, although services are to be decommissioned due to low demand, they can still be accessed via spot purchase
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	
EQUALITY RISK			Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	N	Analysis of use demonstrates that both services are underutilised with demand focusing on nursing homes or residential EMIL. A proportion of the residential patients will be better placed under new dom care / home first pathway where care can be received at home.
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	Y	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	N	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	Y	Services continue to be available via spot purchase therefore there are no public sector equality duty considerations to be aware of
15	Do you plan to publish your information? Include any "Decision Reports"	N	Spot purchase of this type of service if required
16	Can you minimise any negative effect? Please state how.	Y	Activity Dashboards
17	Do you have any supporting evidence? If YES please list the documents.	Y	Yes a discussion will take place with providers regarding decision made
18	Have you/will you engage with affected staff and users on these proposals?	Y	

IMPACT There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK There is a high risk

HUMAN RIGHTS IMPACT			Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	N	
20	Will the policy/decision lead to degrading or inhuman treatment?	N	
21	Will the policy/decision limit a person's liberty?	N	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	N	
23	Will the policy/decision result in unlawful discrimination?	N	
24	Will the policy/decision limit a person's right to security?	N	
25	Will the policy/decision breach the positive obligation to protect human rights?	N	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	N	
27	Will the policy/decision interfere with a persons right to participate in life?	N	

RISK There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT			Comments (provide example)
28	Will the project involve the collection of new information about individuals?	N	
29	Will the project compel individuals to provide information about themselves?	N	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	N	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	N	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	N	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	N	
34	Is the information to be used about individuals' health and/or social wellbeing?	N	
35	Will the project require you to contact individuals in ways which they may find intrusive?	N	

RISK There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@nhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	MOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 3 - Adapted flats and T2A Residential Beds

Brief description of scheme:

The decision to decommission Adapted flats and T2A beds is based on demand for the services both of which being significantly under utilised. Therefore it is a more cost effective option to spot purchase beds / flats as patient needs determines rather than a block funding agreement that is not utilised. There are also alternative beds/services available for these cohorts of patients such as respite beds and home first. There will be no change to service users as they will still have access to the same facilities or an improved option more suited to their needs. There may be some impact on providers however adequate notice has been given re decision not to continue funding.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A			0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N	2	2	4	Note, beds will revert back to being available for long term care
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A			0	

Please describe your rationale for any positive impacts here:

NA

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
LITLITND Page 152 QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	
	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
PREVENTION	Does it impact on clinical engagement?		0	0	0	
	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2
Minor (Green)	Moderate (
Formal complaint (stage 1)	Formal complaint	
Local resolution	Local resolution go to independent	
Single failure to meet internal standards	Repeated failure to meet standards	
Minor implications for patient safety if unresolved	Major patient safety findings are	
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality	Late delivery of service due to	
	Unsafe staff competence	
	Low staff morale	
	Poor staff attendance mandatory/	
Breach of statutory legislation	Single breach of	
Reduced performance rating if unresolved	Challenging recommendation notice	
Local media coverage –	Local media coverage	
short-term reduction in public confidence	long-term reduction in public confidence	
Elements of public expectation not being met		
<5 per cent over project budget	5–10 per cent over project budget	
Schedule slippage	Schedule slippage	
Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1		2
	Unlikely	Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
	3	4
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

EQUALITY IMPACT & RISK ASSESSMENT STAGE 1 SCREENING TOOL



Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to decommission: Group 1 - No change in service (just funding stream) Wirral Independence Service: Falls App, Trusted Assessors, Integrated
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)

Falls app was introduced as part of the Wirral Independence Service Falls Prevention service with funding provided to support set up costs. License fees have been funded until at least 2020 and ongoing support will be considered within the technology strategy. Free licenses have been agreed with provider as Wirral funded development work which is now being rolled out to other systems. Trusted Assessors are a mandated element of BCF and will continue to be commissioned however they are now funded within the new dom care commission (from 1 April 2019). Integrated Assessments Training and Implementation was a one off payment for one off training 18/19 which has now been delivered. No further funding required.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) Although it is listed as a decommission, it is withdrawal of funding source from BCF but service will continue unchanged/ no additional funding required
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	Section N/A as no change to service, just funding mechanism
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT ● There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK ● There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	No change to current model
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK ● There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 1 - No change in service (just funding stream) Wirral Independence Service: Falls App, Trusted Assessors, Integrated Assessments Training and Implementation

Brief description of scheme:

Falls app was introduced as part of the Wirral Independence Service Falls Prevention service with funding provided to support set up costs. License fees have been funded until at least 2020 and ongoing support will be considered within the technology strategy. Free licenses have been agreed with provider as Wirral funded development work which is now being rolled out to other systems.

Trusted Assessors are a mandated element of BCF and will continue to be commissioned however they are now funded within the new dom care commission (from 1 April 2019)

Integrated Assessments Training and Implementation was a one off payment for one off training 18/19 which has now been delivered. No further funding required.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
163						
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A				0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N/A				0	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A				0	

Please describe your rationale for any positive impacts here:

NA - there will be no change to service delivery, funding will continue.

Page 164

Signature:	Designation:	Date:
-------------------	---------------------	--------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
QUALITY Page 165	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?				0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?				0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?				0	
	What is the impact on strategic partnerships and shared risk?				0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?				0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?				0	
	Will this impact on the organisation's duty to protect children, young people and adults?				0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)				0	
	How will it impact on choice?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?				0	
	How will it impact on preventable harm?				0	
	Will it maximise reliability of safety systems?				0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?				0	
	What is the impact on clinical workforce capability care and skills?				0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?				0	
	How will it impact on clinical leadership?				0	
	Does it support the full adoption of Better care, Better Value metrics?				0	
	Does it reduce/impact on variations in care?				0	
	Are systems for monitoring clinical quality supported by good information?				0	
	Does it impact on clinical engagement?				0	
PREVENTION	Does it support people to stay well?				0	
	Does it promote self-care for people with long term conditions?				0	
	Does it tackle health inequalities, focusing resources where they are needed most?				0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?				0	
	Does it eliminate inefficiency and waste?				0	
	Does it support low carbon pathways?				0	
	Will the service innovation achieve large gains in performance?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?				0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT	Does the proposal involve reducing staff posts? If so describe the impact this will have				0	
	Is the loss of posts likely to impact on remaining staff morale?				0	
	Can arrangements be made to prioritise and manage workload effectively?				0	
	Are vacancies likely to impact on patient experience?				0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?				0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates				0	
	IT Resource				0	
	Funding streams/income				0	
	Other providers (specify how/what)					
	Social care/voluntary/third sector				0	

Signature:	Designation:	Date:
-------------------	---------------------	--------------

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2	
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint	
Local resolution		Local resolution go to independent	
Single failure to meet internal standards		Repeated failure to meet standards	
Minor implications for patient safety if unresolved		Major patient safety findings are	
Reduced performance rating if unresolved			
Low staffing level that reduces the service quality		Late delivery of service due to	
		Unsafe staff competence	
		Low staff morale	
		Poor staff attendance/mandatory/	
Breach of statutory legislation		Single breach	
Reduced performance rating if unresolved		Challenging recommendation notice	
Local media coverage –		Local media	
short-term reduction in public confidence		long-term reduction in public confidence	
Elements of public expectation not being met			
<5 per cent over project budget		5–10 per cent over project budget	
Schedule slippage		Schedule slippage	
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget	

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
3	4	5
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

EQUALITY IMPACT & RISK ASSESSMENT STAGE 1 SCREENING TOOL



Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to decommission: Group 2 - project management capacity - BCF Scheme Lead/ROI Evaluation and Transformation Programme Manager
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 Funding was previously utilised to fund a dedicated BCF scheme lead and transformation manager. These have now been absorbed within existing resource. Note, this decommission has not involved any redundancies.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples)
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	Section N/A
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 2 - project management capacity - BCF Scheme Lead/ROI Evaluation and Transformation Programme Manager

Brief description of scheme:

Funding was previously utilised to fund a dedicated BCF scheme lead and transformation manager. These have now been absorbed within existing resource. Note, this decision has not involved any redundancies.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A				0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N/A				0	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A				0	

Please describe your rationale for any positive impacts here:

NA

Page 179

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DIVERSITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
NT EXPERIENCE	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT	Does the proposal involve reducing staff posts? If so describe the impact this will have		0	0	0	
	Is the loss of posts likely to impact on remaining staff morale?		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?		0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income	Contribute to BCF savings	4	2	8	Positive impact
	Other providers (specify how/what)		0	0		
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____ Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour
Minimal or no impact on the environment
Likelihood score
Rare
This will probably never happen/recur

		2
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint
Local resolution		Local resolution go to independent
Single failure to meet internal standards		Repeated failure to meet standards
Minor implications for patient safety if unresolved		Major patient safety findings are
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality		Late delivery of service due to
		Unsafe staff competence
		Low staff morale
		Poor staff attendance mandatory/
Breach of statutory legislation		Single breach of legislation
Reduced performance rating if unresolved		Challenging recommendation notice
Local media coverage –		Local media coverage
short-term reduction in public confidence		long-term reduction in public confidence
Elements of public expectation not being met		
<5 per cent over project budget		5–10 per cent over project budget
Schedule slippage		Schedule slippage
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	2 Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
	3	4
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BGF Schemes - Decision to decommission: Group 4 Home First - dom care, reablement, mobile nights
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 The above is a proportion of home first funding, other funding stream will be retained and used to remodel the service. This element of the service - dom care, reablement and mobile nights will continue to be available from a service user perspective however there will be a change in provider to align to the new dom care commission which already includes dom care, reablement and mobile nights. The commission includes more than one provider.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) There will be an impact for the HCA currently delivering the service, they may be redeployed within team, be on temporary contracts and not renewed or could potentially move to new provider
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	Y	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	NA as service will continue to be delivered by new provider who already delivers this level of care Services continue to be available therefore there are no public sector equality duty considerations to be aware of
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT ● There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK ● There is a high risk

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	NA as service will continue to be delivered by new provider who already delivers this level of care Services continue to be available therefore there are no public sector equality duty considerations to be aware of
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK ● There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	NA as service will continue to be delivered by new provider who already delivers this level of care Services continue to be available therefore there are no public sector equality duty considerations to be aware of
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK ● There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

LIKELIHOOD	IMPACT				
	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 4 Home First - dom care, reablement, mobile nights

Brief description of scheme:

The above is a proportion of home first funding, other funding stream will be retained and used to remodel the service. This element of the service - dom care, reablement and mobile nights will continue to be available from a service user perspective however there will be a change in provider to align to the new dom care commission which already includes dom care, reablement and mobile nights. The commission includes more than one provider.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	P	2	3	6	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A			0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N	3	3	9	Y
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A			0	

Please describe your rationale for any positive impacts here:

Inclusion within the new dom care contract provided a more joined up specialist service and is more cost effective also.

Page 194

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
QUALITY 105	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT	Does the proposal involve reducing staff posts? If so describe the impact this will have	This involves moving funding from one provider to another and therefore there is potential for some HCA roles to be reduced. However, the roles may be absorbed within other contracts/services e.g. community nursing and funding was only agreed on a temporary basis	3	3	9	The new provider will have vacancies with additional demand through service and therefore could employ existing workforce
	Is the loss of posts likely to impact on remaining staff		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?	It is not anticipated that there will be an impact on patient experience.	0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income		0	0	0	
	Other providers (specify how/what)		0	0	0	
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____

Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour
Minimal or no impact on the environment
Likelihood score
Rare
This will probably never happen/recur

		2	
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint	
Local resolution		Local resolution go to independent	
Single failure to meet internal standards		Repeated failure to meet standards	
Minor implications for patient safety if unresolved		Major patient safety findings are	
Reduced performance rating if unresolved			
Low staffing level that reduces the service quality		Late delivery of service due to	
		Unsafe staff competence	
		Low staff morale	
		Poor staff attendance/mandatory/	
Breach of statutory legislation		Single breach	
Reduced performance rating if unresolved		Challenging recommendation notice	
Local media coverage –		Local media	
short-term reduction in public confidence		long-term reduction in public confidence	
Elements of public expectation not being met			
<5 per cent over project budget		5–10 per cent over project budget	
Schedule slippage		Schedule slippage	
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget	

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	2 Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
	3	4
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Better Care Fund Review

March 2018

This report provides a review of Better Care Funded (BCF) schemes commissioned during the 2018/19 financial year with recommendations for future commissioning based on outcomes and value for money. This report particularly focuses on the following services provided by Wirral Community Foundation Trust;

- Home First
- Transfer to Assess
- Rapid Community Response

The purpose of these schemes is to provide discharge pathway or a temporary 'step-up' provision for people who may need short-term or urgent support and do not require intervention within an acute setting.

All activity included in this report is based on information sent from the Community Trust. Unfortunately the data did not include details on the support provided by Social Workers for the services included in this report due to IT system constraints.

Home First

Home First provides an opportunity to assess a person's short or long term needs within their own home and also provide short term support until ongoing needs can be met by alternative services. This service is accessed via the Single Point of Access and is operational 7 days per week. As the Community Trust was being funded via BCF for a Rapid Community Response (RCR) service the additional funding to provide a Home First provision was used to enhance the service is part of the Rapid Community Response service the funding provided by BCF was used to enhance RCR with the following staff;

- 5 WTE x Occupational Therapists (OT) - The 5 OT posts provide a total of 187.5 staff hours per week to cover 76 service hours per week (12 hours per day 5 days per week and 8 hours per day 2 days per week).
- 5 WTE x Physiotherapists - The 5 physio posts provide a total of 187.5 staff hours per week to cover 76 service hours per week (12 hours per day 5 days per week and 8 hours per day 2 days per week).
- 15 WTE x Health Care Assistants (HCA) - The 15 HCA posts provide a total of 562.5 staff hours per week to cover 98 service hours per week (14 hours per day 7 days per week).

The BCF funding allocated to Home First service is £940,465

Referrals – Feb 2018 – Jan 2019 = 944

Cost of the service per patient (funding/referrals) = £996.26

£158.14 per patient per day (based on average LOS 6.3 days)

Referrals

According to the data provided there were 944 referrals to Home First between February 2018 and January 2019. The average number of patients on the caseload for this period was 11.5 per day with a peak of 16.5 in August 2018. The average number of days for patients on the caseload was 6.3 days with the longest being 9.4 days in Feb 2019.

The data provided a breakdown on how the service was delivered for these referrals. It resulted in the service providing 2,139 face to face visits in patient homes for this period totalling 1,365.68 hours (81,941 minutes). In addition to the visits there were 770 hours for administration (46,195 minutes) which gives a total of 2,135.68 hours (128,136 minutes) attributed to Home First. The average length of stay (LOS) for this period was 6.3 days. The table below shows a breakdown of the proportion of visits carried out by each staff role/discipline, however this does not take into account if these were carried out as joint visits with more than one discipline;

Role + funded posts (weekly WTE hours)	Hours of Operation	Percentage of Contacts/Visits (overall service hours)	Average time spent on each visit	Hours Face to Face patient contacts	Hours Admin time	Annual Total Hours
HCA x 15 (562.5 hours per week)	8 am – 10 pm 7 days per week	34% of the visits	32.3 mins	388.5 hours (23,311 minutes)	240.7 hours (14,442 minutes)	629.2 hours (37,753 minutes)
Technical Instructor	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	25% of the visits	33.8 mins	262 hours (15,720 minutes)	214.4 hours (12,865 minutes)	476.4 hours (28,585 minutes)
OT x 5 (187.5 hours per week)	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	17% of the visits	47.8 mins	282.8 hours (16,971 minutes)	180.5 hours (10,831 minutes)	463.3 hours (27,802 minutes)
Physio x 5 (187.5 hours per week)	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	16% of the visits	51 mins	369.5 hours (22,168 minutes)	85.6 hours (5,135 minutes)	455.1 hours (27,303 minutes)
Nurse	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	8% of the visits	27.9 mins	62.8 hours (3,771 minutes)	48.7 hours (2,922 minutes)	111.5 hours (6,693 minutes)

The care provided by each of the roles/disciplines in the table above is summarised as follows;

HCA

- Provides delegated care to patients in their own homes. Supports in the planning of day to day work, working mainly alone and in a service which is responsive to patient's needs.
- Assists patients with personal care, if required assists with meals and drink preparation.
- To assist registered nurses when they are implementing assessed care needs. Helps to maintain progress in rehabilitation.
- Liaises with voluntary and statutory agencies within the home setting.

TI

The technical instructor supports patients with any rehabilitation goals following assessment from the OT or Physio.

Physio

- A full subjective assessment- obtaining social history, past medical history, drug history, family history.
- Functional assessment including assessment of mobility, transfers and upper and lower limb range of movement and strength.
- Refer patients on and sign post to various other services including rehabilitation at home, SALT, DNs etc.

OT

To be responsible for the assessment, implementation and evaluation of Specialist Occupational Therapy interventions including assessments for;

- Montreal Cognitive Assessment (MOCA) of cognition as a standardised screen of cognition
- Functional assessments, including personal care, meal preparation, mobility and transfers.
Goal
- Environmental Visits and Home Visits as appropriate to help inform discharge decisions. This would include assessment and provision of equipment after assessment, education and advice to families and carers regarding use of equipment.
- Manual handling risk assessments to inform care staff of safest transfers and mobility

Social Worker

They are responsible for having an initial meeting with patients and their relatives providing further details;

- They provide a holistic and person-centred assessment of need and determine eligibility in accordance with statutory requirements of the Care Act 2014.
- Take the lead in liaising with both Right Time, Right Place Coordinators and with the Trusted Assessor to engage their intervention and support for patients seeking 24 hour care placements.
- Creating the reablement support plan
- Maintaining records of patients within the LiquidLogic system ensuring that plans are closed down in timely manner on discharge which supports improved data for length of stay reporting and bed occupancy levels.

Referral Source & Outcomes

The data includes the referral source, which shows the proportion of referrals from the community and acute hospital, see table below. The majority of referrals are captured on SystemOne as being from allied health professionals who, according to the Community Trust BI team, is mainly due to referrals being made via the Single Point of Access service. This is apparently due to the staff who are entering the referral onto the system however, these referrals, in the majority will have been made from WUTH. This shows that the service is providing support to reducing delays in discharge and therefore reducing patient length of stay within the hospital. The table also shows that small numbers are being referred from the community which is supporting a reduction in hospital attendances and therefore avoidable non-elective admissions to hospital.

Referral Source	Numbers of referrals	Percentage of referrals
Allied Health Professional	577	61.12%
Physiotherapist	194	20.55%
GP (National code: 3)	89	9.43%
Discharge to assess / Home First team	27	2.86%
T2A - Home First	24	2.54%
Other	11	1.17%
Accident And Emergency Department	9	0.95%
Integrated Discharge Team	5	0.53%
Social Services (National code: 19)	3	0.32%
Community Nurse	2	0.21%
T2A - Bed Base	1	0.11%
Rehabilitation at Home	1	0.11%
North West Ambulance Service	1	0.11%

The outcomes, included in the data, for patients referred to Home First shows that this pathway provides positive support for people in their own home. Unfortunately the outcome data, as shown below, does not provide a breakdown of patients requiring domiciliary care within their own home on discharge. The data also does not show if those patients requiring an admission to hospital were community referrals or failed discharges (readmissions are being looked at separately to this report).

Location after discharge	Numbers of discharges	Percentage based on numbers referrals
Patient's own home	795	85%
Hospital	119	13%
Residential Home	9	1%
Intermediate Care	9	1%
Care Home	7	1%
Patient's home (including relative's or carer's home)	1	0%

Summary & Recommendations

It is evident from the outcome data that Home First is providing support for people within their own home and therefore supporting the reduction in non-elective admissions, which is a cheaper alternative to a hospital admission.

Unfortunately the data is also showing that the numbers of patients being managed by this service is not supporting the numbers required to meet the demands of the system. The referral numbers and daily caseload figures show that this is a high cost service providing a small return on investment.

It is therefore recommended that the funding for this service be used to redesign the Home First Pathway to be able to meet system demands and show a greater return on investment from both a financial and patient outcomes basis. This may require part of the service to be decommissioned from the CT, however it is proposed that this will be determined in quarter 1 of the 2019/20 fiscal year for implementation in quarter 2.

Rapid Community Response

Rapid Community Response service provides a urgent response to people in need of health and/or social care support and do not require an acute hospital bed. The service accepts referrals from the community, to avoid hospital admission, and also from the hospital, to facilitate a reduction in LOS for people no longer in need of acute care. As noted above this team expanded following additional investment to provide the Home First service, however the Rapid Response element of the team comprises of;

- Nurses
- Social workers
- Therapists

The cost of Rapid Community Response is £730,543

Referrals – Feb 2018 – Jan 2019 = 1,351

Cost of the service per patient = £540.74

£115.05 per day (based on average LOS 4.7 days)

Rapid Community Response Referrals

According to the data provided there were 1,351 referrals to Rapid Response between February 2018 and January 2019. The average number of patients on the caseload per day for this period was 14.9 with a peak of 18.5 in July 2018. The average number of days for patients on the caseload was 4.7 days with the longest being 7.5 days in February 2019.

The data provides a breakdown on how the service was delivered for these referrals. The results show that the service provided 4,494 face to face visits in patient homes for the period between February 2018 and January 2019 totalling 2,765 hours (165,917 minutes). In addition to the visits there were 835 hours for administration (50,094 minutes) which gives a total of 3,600 hours (216,011 minutes). A breakdown of who provided the visits shows the proportion of calls each professional role made visits to support patients in their own home, as follows;

Role	Hours of Operation	Percentage of Contacts/Visits (overall service hours)	Hours Face to Face patient contacts	Hours Admin time	Hours Total
HCA	8 am – 10 pm 7 days per week	46% of the visits	1,134 hours (68,060 minutes)	209 hours (12,562 minutes)	1,343 hours (80,622 minutes)
Physio	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	16% of the visits	580 hours (34,818 minutes)	320 hours (19,156 minutes)	900 hours (53,974 minutes)
OT	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	13% of the visits	479 hours (28,766 minutes)	81 hours (4,845 minutes)	560 hours (33,611 minutes)
Nurse	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	13% of the visits	294 hours (17,640 minutes)	100 hours (6,025 minutes)	394 hours (23,665 minutes)
Technical Instructor	8 am – 8 pm Mon – Fri and 9 am – 5 pm Weekends and Bank Holidays	12% of the visits	277 hours (16,633 minutes)	125 hours (7,506 minutes)	402 hours (24,139 minutes)

The care provided by each of the roles/disciplines in the table above is the same as listed under the Home First service with the addition of the nurse role which provides;

RCR Nurse

A health assessment, which indicates the level of care required and make any necessary referrals for ongoing support and/or recovery and promote well-being and independence. The assessment will result in a structured goal-orientated care plan that places the emphasis on supporting the person to return to their normal functionality, or if this is not possible, to maximise their independence.

Referral Source & Outcomes

The data includes the referral source, which shows the proportion of referrals from the community and acute hospital, see table below. The majority of referrals are captured on SytemOne as being from GP's which shows the service is receiving the majority of referrals from the community providing a positive influence on reducing unplanned hospital attendances and therefore avoidable non-elective admissions. The referrals made from the hospital front door (Emergency Department) are extremely low at 0.89% of the overall referral numbers.

Referral Source	Numbers of Referrals	Percentage of referrals
GP (National code: 3)	895	66.25%
Community Nurse	95	7.03%
Allied Health Professional	86	6.37%

Social Services (National code: 19)	63	4.66%
Physiotherapist	44	3.26%
Other	43	3.18%
North West Ambulance Service	30	2.22%
Integrated Care Coordination Team	27	2.00%
T2A - Bed Base	24	1.78%
Rehabilitation at Home	18	1.33%
Accident And Emergency Department	12	0.89%
Other (Green Car, IDT, Home First, Admission Prevention, Discharge to assess)	14	1.04%

The outcomes, included in the data, for patients referred to Rapid Community Response shows that this pathway provides positive intervention to keep people in their own home with the support needed. Unfortunately the data doesn't provide a breakdown of services providing the support to patients, i.e. community nursing, domiciliary package of care, following discharge.

Location after discharge	Number of discharges	Percentage based on numbers referred
Patient's own home	1024	77%
Hospital	157	12%
Intermediate Care	85	6%
Care Home	48	4%
Residential Home	17	1%
Other	2	0%

Summary & Recommendations

As this service links closely with the Home First service looking at the overall referrals and outcomes should be considered as part of any changes to the service pathways and objectives. However, it is evident that the Rapid Community Response service is providing an 'Urgent Response' service for Wirral by reducing ED attendances and non-elective admissions. However, the low numbers of patients referred from the front door at WUTH indicates that there is a potential to increase RCR support at the front door to further support a reduction in non-elective admissions. This will also provide better outcomes for people who do not need intervention in an acute setting whilst providing initial assessment and support to identify long term needs.

Based on the data provided for this report it is recommended to review how this service is currently delivered and how increased support can be provided at the front door in WUTH whilst maintaining direct referrals from GP's and the community. There will also need to be additional information on which services RCR refer patients to for ongoing support to help identify the numbers of patients that could be 'turned around' prior to admission with support from these services. This would provide Wirral with a more robust 'Urgent Response' service which would also provide part of the 'Home First Pathway'.

Transfer to Assess

Transfer to Assess (T2A) provides ongoing support and assessment for people who are clinically optimised and do not require an acute hospital bed, but may still require bed based care services. This support is provided in a care home setting where a plan for future care can be determined. Individuals in a T2A care bed will be supported by a Multi-Disciplinary Team (MDT) who work with care home providers until the person can be discharged to their usual place of residence with support if required. The MDT comprises of;

- Occupational Therapists
- Physiotherapists
- Social Workers
- Primary Care GP's
- Care Home Providers

There are currently 104 core T2A beds commissioned within the community to provide the following level of support;

- 86 Nursing Care Beds
- 10 Residential Care Beds
- 5 Residential EMI Beds
- 3 Nursing EMI Beds

The funding for T2A is paid as a block contract for the care homes and the MDT support with the relevant providers; however the GP costs are paid on actual activity.

The cost of T2A is £5,262,000 (excluding winter beds)

Cost of the service (inc MDT costs) = £5,262,000 - £365,539 (GP budget)

£4,896,461 / 104 beds
= £47,081 per bed per year
£47,081 / 52 weeks
= £905 per bed per week
£905 / 7 days
= **£129 per bed per day excluding GP costs**

Referrals – Feb 2018 – Jan 2019 = 836

Cost of the service per patient = £6,294.26 (£5,262,000 / 836)

£983.48 per week (based on average 6.4 weeks)
£140.50 per patient per day (inc GP costs)

T2A Activity & Referrals

There were 836 referrals, according to the data provided, between February 2018 and January 2019. The occupancy level within T2A for the same period was 74.97% overall, this can be broken down by home type;

Nursing beds – 85.2%
 Residential beds – 71.6%
 Residential EMI – 94.7%
 Nursing EMI – 17.6%

The 836 patient referrals resulted in the therapy element of the MDT service, Community Trust staff, providing 5,858 face to face contacts within the T2A care home for the period between February 2018 and January 2019 totalling 2,290 hours (137,380 minutes). These hours include time to complete administrative tasks. A breakdown of the proportion of each professional role made to support patients whilst in T2A is as follows;

Role	Hours of Operation	Percentage of Contacts/Visits (overall service hours)	Hours Total
Physio	9 am – 5 pm Mon – Fri	56% of the visits (3,268 contacts)	1,247 hours (74,800 minutes)
OT	9 am – 5 pm Mon – Fri	21% of the visits (1,247 contacts)	535 hours (31,124 minutes)
Technical Instructor	9 am – 5 pm Mon – Fri	23% of the visits (1,343 contacts)	508 hours (30,456 minutes)

The MDT provided by the Community Trust provide a 7 day service, however this is significantly limited at weekends, with only therapists available to complete initial assessments in line with the service specification requirements. In addition to the therapy staff social workers also provide input to support the patients throughout their stay in T2A which includes discharge planning. The care provided by each of the roles/disciplines in the table above is the same as listed under the Home First service. The average length of stay for this period was 6.3 weeks.

Patients are managed on a day to day basis by the care home staff and they work with the MDT to provide the relevant support to each patient in preparation for their discharge. As there are 7 core care providers the care provided varies depending on each organisations corporate mandates. The main aspect to this variance is due to varying staffing levels per home as there is no stipulation within the service specification on required staffing levels. CQC require each home to have a staffing tool in place, which they do, however each home use different tools so the outcome on staffing numbers is different in each home.

GP's provide the clinical support as required but there is no consistency on how this is provided across all of the care home providers. T2A also refers patients to the RCR nurses for any patients requiring a health assessment as part of discharge planning.

Referral Source & Outcomes

The data includes the referral source, which shows the majority of referrals are from WUTH with 85.17% of referrals. Additional acute referrals from out of area acute trusts total 4.43% of referrals and community referrals totalling 10.41%. These figures show that the T2A bed based service is primarily supporting people being discharged from hospital with small numbers being referred from the community to avoid hospital admissions.

Referral Source	Numbers of referrals	Percentage based on total referrals
Arrowe Park Hospital	712	85.17%
Rapid Response (CRT)	68	8.13%
Countess of Chester Hospital: Ward 53	18	2.15%
Community Nursing	9	1.08%
Admission Prevention Service	7	0.84%
Clatterbridge Hospital	5	0.60%
Royal Liverpool University Hospital	4	0.48%
Liverpool Heart and Chest Hospital	3	0.36%
Other / Out of area	3	0.36%
Walton Centre	3	0.36%
Social services (National code: 94)	1	0.12%
Integrated Care Coordination Team	1	0.12%
Aintree University Hospital	1	0.12%
Rehabilitation at Home	1	0.12%

The data also provides the average number of patients seen per day which is 28.6 for T2A with a peak of 31.7 in Nov 2018. This can be broken down to staff role;

- Physio – average of 10.8 patients per day with a peak of 12.5 in January 2019
- OT – average of 6.5 patients per day with a peak of 8.7 in November 2018
- TI – average of 8.1 patients per day with a peak of 9.7 in November 2018

Although the data includes the reason for the referral, it is somewhat limited with the majority stating 'for further assessment'. To understand what support is required for these patients during their stay in T2A additional information would need to be obtained to inform what services are required to support an earlier discharge and reduce the length of stay.

The outcomes, included in the data, provide limited information as shown in the table below. Although the service is providing a positive outcome for the majority of people who are able to return to their usual place of residence further understanding of why people are admitted to hospital from T2A is required if the service is to continue to provide the level of support to the patients being referred. The patients listed as being discharged to 'other' also require further investigation so that understanding can be gained as to what support is required for discharges following a stay in T2A.

Location after discharge	Numbers of discharges	Percentage based on total referrals
Usual Place Of Residence	385	53%
Hospital	188	26%
Other	146	20%
Acute Hospital	1	0%

Summary & Recommendations

It is evident that T2A is providing positive outcomes for people who require ongoing bed based support following discharge from hospital; however the activity levels, length of stay and occupancy levels could be significantly improved. Alternately the number of beds commissioned could be reduced.

In parallel to this report there has been a Point of Prevalence (PoP) review and subsequent report which includes recommendations for future development and modelling of this service. It is therefore recommended that the PoP be reviewed along with this report for final recommendations to be made on how this service is to be commissioned which will also need to link closely with the review and redesign of community services.

The capacity and demand modelling work due to be undertaken in May 2019 will indicate future service requirements and modelling which will also inform what will be required for the T2A service.

Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BGF Schemes - Decision to decommission: Group 4 Home First - dom care, reablement, mobile nights
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 The above is a proportion of home first funding, other funding stream will be retained and used to remodel the service. This element of the service - dom care, reablement and mobile nights will continue to be available from a service user perspective however there will be a change in provider to align to the new dom care commission which already includes dom care, reablement and mobile nights. The commission includes more than one provider.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) There will be an impact for the HCA currently delivering the service, they may be redeployed within team, be on temporary contracts and not renewed or could potentially move to new provider
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	Y	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	
EQUALITY RISK			Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	N	NA as service will continue to be delivered by new provider who already delivers this level of care Services continue to be available therefore there are no public sector equality duty considerations to be aware of
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	N	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	N	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	Y	
15	Do you plan to publish your information? Include any "Decision Reports"	N	
16	Can you minimise any negative effect? Please state how.	N	
17	Do you have any supporting evidence? If YES please list the documents.	N	
18	Have you/will you engage with affected staff and users on these proposals?	N	

IMPACT ● There should be little or no impact. There is no requirement to carry out a Stage 2 assessment
RISK ● There is a high risk

HUMAN RIGHTS IMPACT			Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	N	
20	Will the policy/decision lead to degrading or inhuman treatment?	N	
21	Will the policy/decision limit a person's liberty?	N	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	N	
23	Will the policy/decision result in unlawful discrimination?	N	
24	Will the policy/decision limit a person's right to security?	N	
25	Will the policy/decision breach the positive obligation to protect human rights?	N	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	N	
27	Will the policy/decision interfere with a persons right to participate in life?	N	
RISK ● There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment			

PRIVACY IMPACT			Comments (provide example)
28	Will the project involve the collection of new information about individuals?	N	
29	Will the project compel individuals to provide information about themselves?	N	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	N	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	N	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	N	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	N	
34	Is the information to be used about individuals' health and/or social wellbeing?	N	
35	Will the project require you to contact individuals in ways which they may find intrusive?	N	
RISK ● There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment			

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

LIKELIHOOD	IMPACT				
	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 4 Home First - dom care, reablement, mobile nights

Brief description of scheme:

The above is a proportion of home first funding, other funding stream will be retained and used to remodel the service. This element of the service - dom care, reablement and mobile nights will continue to be available from a service user perspective however there will be a change in provider to align to the new dom care commission which already includes dom care, reablement and mobile nights. The commission includes more than one provider.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	P	2	3	6	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

219

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A			0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N	3	3	9	Y
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A			0	

Please describe your rationale for any positive impacts here:

Inclusion within the new dom care contract provided a more joined up specialist service and is more cost effective also.

Page 20

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
ALTYN B 2018 21	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
NT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT Page 225	Does the proposal involve reducing staff posts? If so describe the impact this will have	This involves moving funding from one provider to another and therefore there is potential for some HCA roles to be reduced. However, the roles may be absorbed within other contracts/services e.g. community nursing and funding was only agreed on a temporary basis	3	3	9	The new provider will have vacancies with additional demand through service and therefore could employ existing workforce
	Is the loss of posts likely to impact on remaining staff		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?	It is not anticipated that there will be an impact on patient experience.	0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income		0	0	0	
	Other providers (specify how/what)		0	0	0	
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____ Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour
Minimal or no impact on the environment
Likelihood score
Rare
This will probably never happen/recur

		2	
Minor (Green)		Moderate (Yellow)	
Formal complaint (stage 1)		Formal complaint	
Local resolution		Local resolution go to independent	
Single failure to meet internal standards		Repeated failure to meet standards	
Minor implications for patient safety if unresolved		Major patient safety findings are	
Reduced performance rating if unresolved			
Low staffing level that reduces the service quality		Late delivery of service due to	
		Unsafe staff competence	
		Low staff morale	
		Poor staff attendance/mandatory/	
Breach of statutory legislation		Single breach	
Reduced performance rating if unresolved		Challenging recommendation notice	
Local media coverage –		Local media coverage	
short-term reduction in public confidence		long-term reduction in public confidence	
Elements of public expectation not being met			
<5 per cent over project budget		5–10 per cent over project budget	
Schedule slippage		Schedule slippage	
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget	

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/ slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
3	4	5
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Acute Visiting Service (AVS) – Return on Investment

Background

Acute Visiting Service (AVS) provides GP cover to provide the following services:

- AVS
- 111 APAS
- 999 APAS (not yet implemented)
- GP support to teletriage service

A Dedicated AVS GP is funded 8am-Midnight Sunday-Thursday; and 8am-2am Friday-Saturday. Outside of these hours, activity is low and AVS is provided as part of GP OOH. AVS is based at Arrowe Park Walk in Centre, and provided by PCW Fed (in-hours), and WCT (out-of-hours).

AVS

Acute Visiting Service (AVS) provides GP advice, appointments and home visits to patients who have called 999 but do not need to be conveyed to hospital if NWAS has fast access to a GP for clinical advice. NWAS accesses AVS through the Wirral Community NHS Foundation Trust (WCT) Single Point of Access (SPA).

111 APAS

In 2018/19, AVS GP also started providing 111 APAS (Acute Patient Assessment Service). This is urgent access to a GP from NHS 111, for patients who would otherwise be directed to A&E. This has been provided by GP OOH across the North West for over a year, but Wirral has now been able to provide this 24 hours per day, ensuring a consistent service offer, and maximum deflection from A&E. Wirral is the only Cheshire/Warrington/Wirral CCG to provide this.

999 APAS

A future development is to provide 999 APAS (Acute Patient Assessment Service). This pathway will provide urgent GP access to the NWAS control centre, which will mean that some low-acuity 999 calls can be passed to AVS without needing to dispatch an ambulance first. This is likely to be patients who would have come through to AVS anyway once the ambulance crew had arrived, but the new pathway will mean more efficient use of NWAS resources.

GP Support to Teletriage Service

Teletriage is a nurse-led service in the day (and provided by GP OOH overnight) Care homes are equipped with iPads and can skype nurses when residents are unwell. AVS GP can support the teletriage nurses with GP advice.

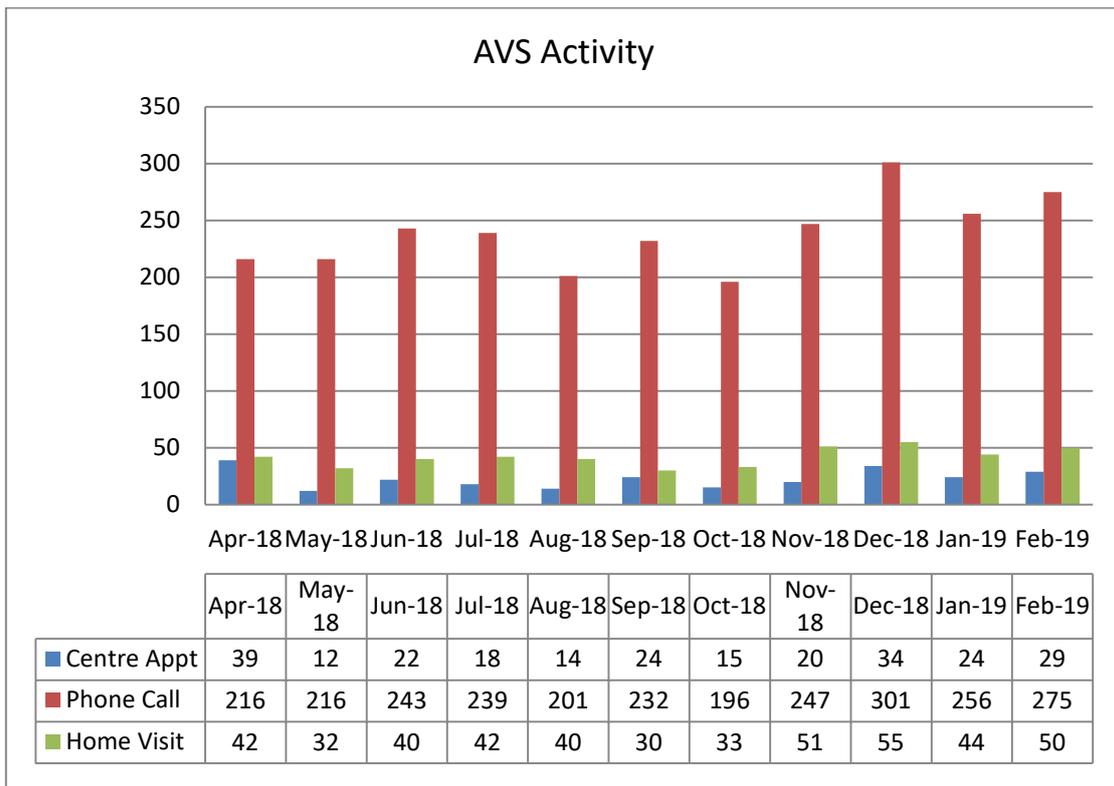
Cost of Service

Cost of Service 2018/19: £710,000

This includes GP, car and driver for home visits.

AVS Activity

The graph below shows AVS Activity for 2018/19, including breakdown of advice calls, appointments, and home visits. This includes in-hours and out of hours



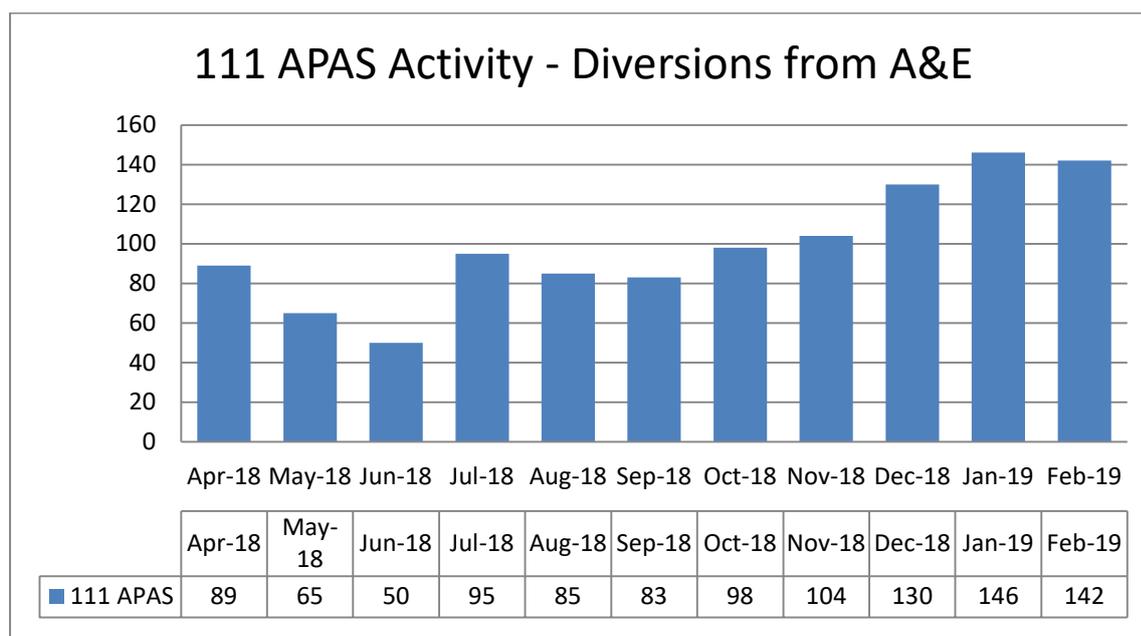
AVS Outcomes

Of the patients referred to AVS, approximately 85% remain at home, with the remaining patients admitted to ACU, SAU or A&E

111 APAS Activity

The Table below shows 111 APAS activity. This is the number of patients who have been given an urgent GP call back by the AVS GP instead of being referred to A&E. On average, this is 34% of the total "ED dispositions" from NHS 111.

It is not possible to track what patients do following their GP advice call. For the purposes of the return on investment, it has been assumed that a small percentage (10%) may decide to attend A&E anyway.



Return on Investment

Scheme	Description	Unit cost	Percentage	Estimated Number Avoided 2018/19	Estimated Cost Avoided
AVS	A&E attendance	£119	85% avoided	2431	£274,703
AVS	NEL admission	£3000	50% of number of A&E attendances avoided	1215	£3,646,500
111 APAS	A&E Attendance	£119	90% avoided	978	£116,418
	<i>Service Cost</i>				<i>-£710,000</i>
				Total	£3,327,621

Impact on Ambulance Service

There is no cost reduction associated with reducing ambulance conveyance as it is a block contract, however a significant number of conveyances have been avoided. The reduction in unnecessary conveyances ensures that NWAS can make best use of their resources and reach patients quickly.

Funding 2018/19

Option 1 – Continue Same Funding £710,000

This option includes retaining GP, car and driver as per current service model.

Option 2 – Reduce Funding to cover GP and mileage payments only (cease funding car and driver)d driver) - £640,000

The number of home visits carried out by AVS is very low – approximately 1.4 per day, with the vast majority of calls being dealt with over the phone. This option would remove the car and driver and retain an allowance for mileage payments. This follows the model in general practice, where GPs use their own cars for visits.

Recommendation

Due to funding pressures, option 2 is recommended to ensure most efficient use of investment.

Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to reduce funding - AVS (Acute Visiting Service)
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 The AVS funding included funding for a driver to enable to AVS GP to undertake home visits. Review of activity has demonstrated that there are limited home visits undertaken and therefore the service does not require a dedicated car and driver. Alternatives include GP drive own car to undertake visits as they would in general practice, request to patients own GP to do home visit or where possible, patient attends walk in centre to see GP.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example click for examples No impact on service users as the very small proportion of patients that require a GP home visit will continue to receive one. Driver will experience change in working pattern. Drivers are not contracted to this specific role so will be reallocated to GP CCH.
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	Y	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	NA
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT  There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK  There is a high risk

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	NA
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK  There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	NA
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK  There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@nhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:


Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to reduce funding - AVS (Acute Visiting Service)

Brief description of scheme:

The AVS funding included funding for a driver to enable to AVS GP to undertake home visits. Review of activity has demonstrated that there are limited home visits undertaken and therefore the service does not require a dedicated car and driver. Alternatives include GP drive own car to undertake visits as they would in general practice, request to patients own GP to do home visit or where possible, patient attends walk in centre to see GP.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A			0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N	2	4	8	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A			0	

Please describe your rationale for any positive impacts here:

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
ALTERNATIVE RANGE	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
LCP/MI/NC/VC/RY Page 244	Does the proposal involve reducing staff posts? If so describe the impact this will have	The driver post will be removed from this service however the driver is not dedicated to service currently and will revert back to another WCT service e.g. GPOOH	2	4	8	Alternative
	Is the loss of posts likely to impact on remaining staff		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?		0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income		0	0	0	
	Other providers (specify how/what)		0	0	0	
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____ Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint
Local resolution		Local resolution go to independent
Single failure to meet internal standards		Repeated failure to meet standards
Minor implications for patient safety if unresolved		Major patient safety findings are
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality		Late delivery of service due to
		Unsafe staff competence
		Low staff morale
		Poor staff attendance/mandatory/
Breach of statutory legislation		Single breach of legislation
Reduced performance rating if unresolved		Challenging recommendation notice
Local media coverage –		Local media coverage
short-term reduction in public confidence		long-term reduction in public confidence
Elements of public expectation not being met		
<5 per cent over project budget		5–10 per cent over project budget
Schedule slippage		Schedule slippage
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale	No staff attending mandatory training /key training on an ongoing basis
	No staff attending mandatory/ key training	
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external tations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage	Schedule slippage
	Key objectives not met	Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
3	4	5
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BGF Schemes - Decision to decommission: Group 3 - Adapted flats and T2A Residential Beds x 10
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 The decision to decommission Adapted flats and 10 residential T2A beds is based on demand for the services both of which being significantly under utilised. Therefore it is a more cost effective option to spot purchase beds/ flats as patient needs determines rather than a block funding agreement that is not utilised. There are also alternative beds/services available for these cohorts of patients such as respite beds and home first. There will be no change to service users as they will still have access to the same facilities or an improved option more suited to their needs. There may be some impact on providers however adequate notice has been given re decision not to continue funding.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) Please note, although services are to be decommissioned due to low demand, they can still be accessed via spot purchase
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	
EQUALITY RISK			Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	N	Analysis of use demonstrates that both services are underutilised with demand focusing on nursing homes or residential EMIL. A proportion of the residential patients will be better placed under new dom care / home first pathway where care can be received at home.
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	Y	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	N	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	Y	Services continue to be available via spot purchase therefore there are no public sector equality duty considerations to be aware of
15	Do you plan to publish your information? Include any "Decision Reports"	N	Spot purchase of this type of service if required
16	Can you minimise any negative effect? Please state how.	Y	Activity Dashboards
17	Do you have any supporting evidence? If YES please list the documents.	Y	Yes a discussion will take place with providers regarding decision made
18	Have you/will you engage with affected staff and users on these proposals?	Y	

IMPACT ● There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK ● There is a high risk

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	N
20	Will the policy/decision lead to degrading or inhuman treatment?	N
21	Will the policy/decision limit a person's liberty?	N
22	Will the policy/decision interfere with a person's right to respect for private and family life?	N
23	Will the policy/decision result in unlawful discrimination?	N
24	Will the policy/decision limit a person's right to security?	N
25	Will the policy/decision breach the positive obligation to protect human rights?	N
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	N
27	Will the policy/decision interfere with a persons right to participate in life?	N

RISK ● There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	N
29	Will the project compel individuals to provide information about themselves?	N
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	N
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	N
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	N
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	N
34	Is the information to be used about individuals' health and/or social wellbeing?	N
35	Will the project require you to contact individuals in ways which they may find intrusive?	N

RISK ● There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@nhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Page 252

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 3 - Adapted flats and T2A Residential Beds

Brief description of scheme:

The decision to decommission Adapted flats and T2A beds is based on demand for the services both of which being significantly under utilised. Therefore it is a more cost effective option to spot purchase beds / flats as patient needs determines rather than a block funding agreement that is not utilised. There are also alternative beds/services available for these cohorts of patients such as respite beds and home first. There will be no change to service users as they will still have access to the same facilities or an improved option more suited to their needs. There may be some impact on providers however adequate notice has been given re decision not to continue funding.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A			0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N	2	2	4	Note, beds will revert back to being available for long term care
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A			0	

Please describe your rationale for any positive impacts here:

NA

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	
	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint
Local resolution		Local resolution go to independent
Single failure to meet internal standards		Repeated failure to meet standards
Minor implications for patient safety if unresolved		Major patient safety findings are
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality		Late delivery of service due to
		Unsafe staff competence
		Low staff morale
		Poor staff attendance/mandatory/
Breach of statutory legislation		Single breach of legislation
Reduced performance rating if unresolved		Challenging regulatory notice
Local media coverage –		Local media coverage
short-term reduction in public confidence		long-term reduction in public confidence
Elements of public expectation not being met		
<5 per cent over project budget		5–10 per cent over project budget
Schedule slippage		Schedule slippage
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	2 Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
3	4	5
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Point Of Prevalence (POP) Review

Summary Report

April 2019

WUTH Contract Meeting

Service	Transfer to Assess (T2A), Rehabilitation, Network, Respite & Re-ablement bed-based provision
Commissioner Lead	Wirral Health & Care Commissioning Phil Forrester
Provider Leads	
Period	Winter Period - 2018-2019
Date of Review	January & February 2019

1. Point Of Prevalence Executive Summary

This paper will provide an overview of the Point of Prevalence (POP) review, the key findings and a number of recommendations.

The recommendations will be approved at Urgent Care Executive Group (UCEX), Urgent Care Operational Group (UCOG), A&E Delivery Board and will be aligned within a robust Action Plan (s), supporting delivery of Service Deliver Improvement Plans (SDIPs) and the NHS Operating Guidance (2019/20)

Operational monitoring and delivery of the key recommendations and associated action plans will be supported by both UCOG & UCEX.

The report and key actions will be shared system-wide and also with NHSI & NHSE Leads.

2. Introduction

There was a requirement (From Wirral system leaders & NHSI) for an evidence-based review of the systems, processes, individuals, outcomes and the acuity of patients who are referred to and access all T2A, Rehabilitation, and Re-ablement-type settings within the Wirral system.

This would enable us, as a system, to

- Better identify and evidence, key themes within T2A & Rehabilitation Pathways
- Understand key issues and blocks
- To support any required improvements in overarching systems, process, information and reporting.

It was also a key priority to understand the impact of the current systems & processes, related services & teams upon the T2A pathway & indeed the overarching Transfer of Care Pathway

Executive Summary

Introduction

All Acute hospitals face growing demand for services and are looking for ways to reduce length of stay for patients who do not require “Acute Level Care”.

Ensuring that patients don’t stay in hospital for any longer than is clinically necessary frees up capacity in the system but also improves quality of care for patients. (NHSI)

NHSI also advocate that It is equally important to ensure that we have robust systems in place to support patients in the community setting, reduce the number of inappropriate (Acute) attendances, and signpost patients into the most appropriate non-acute settings

Wirral System- Summary of Key Findings.

The Wirral system has significant resources already in place to support patient flow and appropriate “Transfers of Care”. Despite this resource, the panel confirmed that this was not being realised in terms of overall performance, effectiveness, patient experience and underpinning processes.

A lack of egress (from the acute setting) is often cited as a key factor in the non-delivery of urgent care related performance and metrics. The panel has however confirmed that the reported “Lack of Egress” is due to a number of issues and factors from within both the Acute & Community settings.

The panel identified that the current systems, policies and processes which support the Wirral system with discharge planning in the Acute setting, supporting Transfers of Care from the acute and then accessing community services are far too complex.

There are multiple entry and exit points, duplication of assessment, a lack of understanding regarding proactive discharge planning and complex processes supporting transfers of care to both community services and consultant led rehabilitation beds.

Activity & Discharges

The panel accepted that there is reduced “Elective Surgery” at weekends, which does influence the level of weekend discharges. However the number of NEL attendances and admissions remains relatively consistent, whilst the level of (NEL) discharges drops significantly at weekends.

The panel agreed that there is an urgent priority to review, confirm and improve the impact of 7-day services, across both community & Acute settings, including reduced staffing at weekends, and address the significant reduction in NEL discharges and transfers of care at weekends.

National best practice – Home-First Approach

(ECIST & NHSI) promotes the principles of “Home-First” services as a priority for the significant majority of all complex Patients and “Bed-based services” as much less of a priority. This enables patients to be more appropriately assessed within their own home, by the right team member and prevents inappropriate delays within acute hospital beds.

Currently, too many patients in the Wirral system are being assessed within an acute hospital bed for a domiciliary care POC or a T2A bed-based option.

The emphasis needs to shift-left with people being assessed in their own home, for the right service for their needs, and not the easiest pathway on a particular day.

The panel acknowledge that specific cohorts of patients will require a bed-based service, however the system needs to move away from an over-reliance of bed-based capacity as the key currency within Wirral and instead adopt a “Home-First” offer which is both comprehensive, is able to flex, has capacity, is timely and provides a better patient experience.

Transfer of Care Services

Central to addressing these key issues for the Wirral system are the current overarching “Transfer of Care Services”, systems & processes and resources currently commissioned to support effective transfer of care from both the acute setting & also into and from the community (i.e. admission avoidance)

NHSI have identified that across the UK there are wide variations in length of stay, (LOS) even for patients with similar conditions.

This strongly suggests that improvements can be made to the way that care is organised and delivered, particularly to ensure that patients are discharged as soon as they no longer need acute care and discharged as soon as they become “Medically Optimised”.

Front-Door

Primary Care Clinical Streaming.

WCFT adopted the “Primary Care Clinical Streaming Model” (November 5th 2018) and have significantly improved the number of patients being streamed away from the front door of the Emergency Department (ED).

Although there was a dip in activity (February 2019) WCFT now regularly stream 20-30 (39 on 7th March 2019) patients away from the front door of the ED per day.

Current Services Front-Door

The panel recognised that there are services already in place, with a remit to support the front door and manage specific cohorts of patients, i.e. The Specialist Nurse for Older People (SNOP) service. The (SNOP) service was highlighted as an area of good practice however it was not clear to the panel, as to the volume of patients who are “turned around” at the front door. The (SNOP) service, is however, not responsible for turning other cohorts of patients around at the front door.

Evidence (from the current BCF review) confirmed that between February 2018 and January 2019 a total of 12 patients only were referred to the “Rapid Community Response Service” (RCR) from the Emergency Department (WUTH).

This current level of activity (to RCR) is a missed opportunity to potentially “turn around” patients at the front door of the Emergency Department (ED) and requires urgent focus.

Escalation & Ambulatory Emergency Care Unit (AECU)

There are reports (including From the daily-tele-conference) that the Ambulatory Care Unit (AECU & SAU) are frequently used to facilitate acute (NEL) admissions into hospital overnight. Using the ACU as additional acute capacity significantly reduces the opportunity of utilising the ACU for its intended purpose (i.e. to rapidly assess and treat and discharge – same-day- a cohort of non-elective patients who are at risk of acute admission and who were historically admitted into the Acute bed-base).

The ACU aims to turn these patients around the same day during hours of operation, whilst supporting the 2019/2020 operating plan and guidance for Same Day Emergency Care (SDECs) and in increasing appropriate ZERO LOS for (NEL) patients.

Preventing the use of the ACU as “escalation capacity” and addressing the current short-fall in “Acute Medical Consultants” is an absolute priority for WUTH.

- A fully functioning AECU would allow cohorts of (NEL) patients to be seen, assessed, receive appropriate diagnostics, treated and discharged on the same day, rather than being admitted into the acute bed-base

- The Royal College of Physicians (RCP) completed a comprehensive review into both the Emergency Department & Assessment areas, and the report is to be shared widely with the system leaders. WUTH have committed to implementing the key recommendations from the (RCP) report and have devised a robust action plan to support.
- The implementation of (SDECS) is a key priority within the NHS operating plan (2019/20) and is currently being reflected in the local (Wirral) plans , including the Service Development Improvement Plans (SDIPS)

Integrated Discharge Team (IDT), SAFER & Board Rounds.

The Integrated Discharge Team (IDT) is a significant and valuable resource commissioned to support the care of patients (with currently 60-80 patients on an active daily list) with additional or complex Transfer of Care Requirements.

The IDT is currently “jointly-hosted” by WCFT & WUTH and includes nursing, social work, discharge trackers and community nursing resources within its comprehensive establishment.

Function of the IDT

One of the key aims of the IDT is to support effective transfers of care, for patients with complex transfer of care requirements. This includes supporting the acute wards in transferring patients from the acute setting, into the menu of community beds and services currently available within Wirral.

The current “Transfer of Care policy”, which includes information regarding the IDT, requires updating. This is however an opportunity to update this as part of a comprehensive suite of recommendations

Because of the current volume of “blanket” referrals from the ward staff into IDT, the panel was informed that the team has to trawl through every (IDT) referral to try and prioritise those patients who may or may not require IDT support.

In addition a significant amount of time is spent (by IDT Nurses) in supporting a Daily MDT and a twice-weekly stranded review meeting.

These stranded meetings are valuable, however much of this time is currently spent coordinating information and lists, which could and should be collected at “Ward Level”. Information could be collected on each acute ward as part of the daily board rounds and by appropriately using the electronic white-boards and CERNA and populating this information in real-time.

The Panel concluded that the IDT is an extremely valuable resource in supporting the wards with proactive discharge planning and managing the transfers of care of “complex” patients.

The IDT are currently spread too thinly, and the panel has identified key areas that must be adopted urgently, and which would make the function and productivity of the IDT much more effective.

SAFER & Board Rounds

There is an absolute requirement to embed standardised board rounds (Inc. SAFER & SHOP) on each and every acute ward.

- This must include a directive for the ward staff (including the Board Round MDT) to update CERNA & The electronic white-boards in “real-time”
- The Acute Ward staff need to understand the value of supporting this directive as it will clearly “release time to care” for both Ward Staff & supporting staff (including the IDT).
- Real-time completion of CERNA/Whiteboards will prevent the need for Matrons, On-Call Managers & Patient Flow staff telephoning each individual ward for an update regarding the number of empty beds, the number of actual & potential discharges, the reasons why patients remain in hospital, etc.
- The panel was informed that the Ward Staff can be contacted many times throughout the day, from various sources, requesting the above information. This can be via telephone or in person and removes staff from patient care, (including from Ward Rounds & Board Rounds) leading to delays in treatment and ward-based care.

Transfer of Care Systems & Processes

Coordination (Rehabilitation & T2A bed-base)

- The panel found that there are many separate and confusing points of entry and coordination, in accessing the T2A & Rehabilitation beds for patients in Wirral.
- This current process included access via individual specialist teams (i.e. CVA), via Acute Therapists i.e. in accessing Ward M1, Via IDT, Via SPA, via Patient Flow, and even via Matrons. As a result there is a lack of a coordinated approach to transfer, oversight and discharge planning for the body of bed-based rehabilitation related and T2A beds.

Non-Acute Bed-Based Provision

- There are currently 249 (non-acute) beds within the Wirral system; divided into the following services (**this excludes any spot-purchased beds or CHC fast-track beds.)
- This bed-based capacity is significantly greater than the majority of neighboring and national systems, when bench-marked with other systems.

- Examples of comprehensive “Home-First” options, combined with a reduced bed-based (non-acute care) model are cited as best- practice. East Lancashire has front-loaded their “Home-First” model into a single coordinated approach, whilst reducing the non-acute bed base by circa 50%.

Transfer to Assess (T2A) Community Bed-Based Provision

Transfer to Assess (T2A) provides ongoing support and assessment for people who are Medically optimised and do not require an acute hospital bed, but may still require care services. This support is provided in a care home setting where a plan for future care can be determined.

Non-Acute (T2A) Bed-Based Split

There are currently 104 T2A beds commissioned within the community to provide the following level of support;

- 86 T2A Nursing Care Beds = LOS = 5.5 weeks (from April 2018 to YTD)
- 10 Residential Care Beds = LOS = 4.9 weeks
- 5 Residential EMI Beds = LOS = 6.5
- 3 Nursing EMI Beds = LOS = 4.2
- *GDU 30 Nursing beds = LOS = 4.9 (Since November 2018 to YTD)

There are an additional 70 Consultant-Supported Rehabilitation Beds on the Clatterbridge site

- Clatterbridge Rehabilitation Centre (CRC) CVA 20 Beds LOS = ALOS 105 (Days)
- Clatterbridge Rehabilitation Centre (Network ABI) 10 beds LOS = ALOS 94 (DAYS) 72**
- Ward M1 (Rehabilitation) 40 Beds LOS = ALOS 57 (DAYS)

Clatterbridge Rehabilitation Centre (CRC)

The panel reviewed the capacity within the CRC, which consists of 20 beds dedicated to “Stroke Rehabilitation” and another 10 beds dedicated to “Acquired Brain Injury” under the governance of both WUTH & the Merseyside and Cheshire network.

The panel concluded the following key areas & focused on the 10 ABI (Network) beds.

- There were examples of patients, within the acute trust, with significant LOS, who were delayed awaiting a bed within the CRC (Network Beds)
- There is currently minimal support to the existing rehabilitation Consultant role, which results in delays in assessment and transfer of potential patients.
- There appears to be an inequity in the overarching support provided (from the network), in comparison to other regional spoke units. This requires clarification from specialist commissioning, CCG and the network leads.

The panel recommended that additional capacity is required to meet the needs of Wirral patients. The 10 (Network) beds should form part of a broader review of the Clatterbridge site, to increase capacity for this cohort of patients.

This may require additional investment, but this would be off-set somewhat by the reduction in delayed transfers of care from the acute setting and would support improved quality and patient experience.

This will be picked up as part of the bed-based review into the wider non-acute bed base.

Non-Bed-Based community services

There are significant (Non-Bed-Based) services provided in the community & within patients own homes including.

- Home First
- Rapid Community Response
- STARS & Re-Ablement
- Rehabilitation at Home
- Domiciliary Care Packages of Care
- CHC “Fast Track” Beds
- CHC Fast-track District Nurse provision

Domiciliary Packages of Care (DPOC)

The panel observed that Patients are still being assessed within the acute hospital setting for domiciliary packages of care (DPOC).

On a particular day & snapshot, the panel observed that there were 15 patients (in hospital) awaiting a DPOC.

It is clearly evidenced that the number of delays (or stranded patients) who are awaiting a DPOC has reduced significantly over the last 12 months due to improved access. In fact the number of patients awaiting a DPOC in December ranged from 2-5 in January 2019 and 6 on 2nd April 2019, however, this was due to a better response from the domiciliary care providers, not due to a change in process.

Cohorts of patients awaiting Dom Care POC

The panel was provided with a breakdown of the level of DPOC that individual patients were waiting in hospital for.

Surprisingly this included relatively low-level DPOCS, and the question must be asked as to why these patients were not considered for a “Home-First” option.

Home-First findings

It was reported to the panel that the current non-bed-based community provision, including the various “home-first” options is fragmented; too complex for professionals to understand and the current processes lead to delays.

There are also reported capacity issues within the current home-first offers, which can lead to delays. This can include reduced therapy or carer support at various times or days and is reported via the daily tele-conference. There have been offers (from WCFT Operational Staff) to move resources across the “home-first options” to support discharges from hospital. This is currently discussed on a daily basis, is subject to capacity, and is an informal process currently.

Community Services Redesign

The panel acknowledged that WCFT have proposed a paper (Community Services Redesign) to both UCEX & UCOG. This proposal includes an overarching implementation plan which includes a plan to streamline the current home-first options into a single “Home-First pathway. At the time of the (POP) review, the implementation of a single streamlined home-first model has not yet been implemented.

Notification to Assess

WCCG have recently coordinated a system-wide “Home-first” working group to review the current service and adopt a streamlined electronic process to improve the current “notification to assess” process and simplify the “home-First” offer.

The current position regarding the Wirral home-first options requires urgent review and implementation at pace to ensure that ALL patients are considered for a “Home- First” model, That the home-first service can meet actual demand, and is supported by a process which is streamlined, widely understood and is responsive.

Discharge Planning

The review team wanted to confirm and evidence whether effective and proactive discharge planning was happening in parallel to the medical plan of care, rather than waiting until patients were medically optimised.

The panel directly observed board rounds within the Acute setting, have observed MDT & stranded meetings and concluded that “Proactive Discharge Planning” was not currently happening from Day 1 of the patient journey or pathway on all acute wards.

SAFER & SHOP

The Acute Trust has attempted to adopt the “SAFER” methodology over a number of years, with varying levels of success.

WUTH have recently moved towards adopting a SHOP model across the ward areas and adopting a standardised board round approach.

This key intervention (SHOP) has not yet been embedded, and the panel reviewed progress during a visit to the Acute Wards.

The panel observed that currently there was no standardised board round model and checklist in place, the electronic whiteboards were in place but not actually used and no updates, including requests for diagnostics or medication were made in real-time.

The Board Round & Ward Round

The panel observed that although there is on-going work to address “Board Round Practice” (Via PFIG) that this is clearly not yet embedded.

Embedding a standardized board round model, and actively using the already available technology (i.e. electronic whiteboards) is an absolute priority.

The Board round is the starting point for effective discharge planning (Which must start from Day 1 of each patients pathway)

The Acute Trust must commit to implementing these key recommendations as a matter of urgency, and this must be supported by the Ward leaders (Both Nursing & Consultants) and delivered together with effective IDT support.

This single intervention would actively support the smooth management of a patient’s acute care, support patient flow and result in timely discharge.

In addition, any blocks (i.e. in community services & capacity) could be evidenced at the board round and escalated appropriately & immediately.

Technology

The Acute Trust already has electronic whiteboards (supported by CERNA) available on every single acute ward, however they are not currently utilised

The Acute Trust leaders' must commit to the use and updating of the electronic whiteboards within each and every ward as part of a standardised daily board round and checklist.

This single intervention alone, will also significantly support the hospital to plan and understand its capacity at all times and importantly understand the "Actual Number of Discharges", "Potential Discharges" and importantly have an understanding of the potential discharges over the following few days.

Stranded (Long Stay) Patients

WUTH leads & WCCG have implemented a new process to support and understand the stranded patient metrics within the Acute setting.

Weekly "Stranded Patient Length of stay reviews" has been implemented to ensure that the teams can potentially respond to identified delays to discharge through appropriate action planning. The new process now evidences the causes and themes for why patients may be stranded in hospital

There is now an urgent requirement to identify the executive and operational leads to tackle each of the "themes" and report this mitigation into the AEDB.

Point of Prevalence (POP) Review, Key Recommendations

1 Urgent Care Executive (UCEX)

- The Urgent Care Executive leads to utilise the POP (Final Report), the BCF review and the planned "Bed-Based Review" to rapidly drive the key recommendations and improvements required across the Wirral system

2 Home-First

- The current Home-First model and offer (including Dom Care, Stars, Re-ablement, and Rehabilitation at home, rapid community response) is complex, fragmented and requires urgent redesign supported by a single overarching offer, systems & processes and a clear and transparent governance structure.

- Best practice (East Lancashire) demonstrates that a robust, “Front-Loaded” single co-ordinated Home-First offer is effective and is urgently required for the Wirral system. This model would also support our key priorities by significantly reducing delays, support egress within the acute setting and support the potential reduction in T2A bed based capacity.
- The panel does accept that the “Community Services Redesign Proposal” is in its implementation phase; (Led by WCFT) however the review recommends that increased pace is urgently required in terms of developing a robust, single home-first offer for Wirral.
- The panel recognises the whole-system work in supporting the new digital “Notification to Assess (NTA)” and “Notification to Discharge NTD” project and process from the acute setting. This new proposal is timely, and requires full cooperation and engagement from all partners in improving the overarching Transfer of Care processes, supporting proactive discharge planning in the acute setting, home-first process & offer.

Adopting the comprehensive “Notification to Assess” model, must be mandated as part of a new standardised board round model and checklist, supported by fully implementing CERNA/Whiteboards

- As part of a comprehensive (BCF) review we, as a system, need to ensure that the Home-First model demonstrates ROI. From the review and other sources, the executive leads must to consider whether the current model is fit for purpose or to support the recommendations for a new & preferred home-first model going forward.

We need to consider whether the current model is fully optimised, and if not, make the significant changes required from a complex service into a single and coordinated offer.

3 Transfer To Assess Bed-Base

- This review has identified that there is overprovision of bed-based offer, but due to lack of optimisation, ineffective pathways, reduced patient flow, this capacity is currently being used inappropriately & inefficiently.
- Bench-marking has clearly identified that there is significantly more non-acute bed capacity and resources within the Wirral system than in comparable systems. The current “Transfer to Assess” bed-based model is not however delivering what we need for patients in Wirral.

- Given the recent expansion of T2A Bed-Based provision (E.g. GDU at Clatterbridge), there is an urgent need to review & streamline the current bed-based model, optimising patient outcomes & resource
- As part of the bed-based review, the feasibility of a single or dual site “Sub Acute Bed-based model” should be considered to integrate with the new and proposed “Front-Loaded” Home-First offer and would replace the current Transfer to Assess (T2A) bed-based model.
- In addition the current T2A workforce (including the T2A MDT) is reportedly spread too thinly, particularly at weekends. A review of the combined IDT and T2A workforce is required to ensure that the associated resources support the new vision for Wirral
- The panel have advised that over a 12 month period we should aim to reduce the number of beds by re-investing resource within the community services (Non bed based) and radically improving the Home-First offer
- This new initiative, supported by proactive discharge planning (within the Acute Setting) would also, improve the current level of stranded patients within the acute setting, who are experiencing long stays whilst waiting for T2A bed-based care, Home of Choice, a home-first option, and for Dom Care POCs.

4 Ward Based Processes & Egress (WUTH)

- The Transfer of Care system & process will not function until proactive discharge planning from day 1 of admission is adopted fully across the WUTH acute bed-base.
- Evidence clearly confirms that although a number of long-stay patients are “stranded” within an acute bed whilst waiting for a non-acute option, the majority of stranded patients remain in an acute bed due to factors within the control of the Acute Hospital.
- The current Transfer of Care Process requires urgent focus at Acute & Ward-Level to ensure that the transfer of care processes is embedded from Day 1 of the patients’ admission.

There is an urgent requirement for the acute setting, WUTH to grip and deliver on a number of key factors, including the following.

- Urgent delivery of Standardised Board and Ward Rounds on each acute ward, across the full 7 days
- Each Daily Board round must be represented by the key decision makers (Within the MDT) & the process led by the Consultant and Ward manager
- There must be standardisation of processes across each and every acute ward (Including a Checklist or Action Cards), which support staff with the management of an effective and timely board round process
- Each ward must evidence the Full implementation of SAFER and SHOP as a matter of urgency, as part of a standardised board round.
- A priority for WUTH is the Full utilisation of the electronic whiteboard system as a template (to support a standardised checklist and approach) and as a data collection tool. Adopting this key recommendation will support the following.
 - Support a standardised Board Round (Right time every time)
 - Ensure discharge planning starts on DAY 1 of admission.
 - Confirms key data (i.e. reason for admission, TDD, Plans etc.)
 - Real-Time completion of the Cerna-Whiteboard will result in significantly improved patient flow related data.
- This improved data will remove the current practice of multiple “Patient Flow Related” lists being collected by IDT, Matrons, Managers, and Patient Flow.
- This will remove the need for the current practice of senior staff calling or visiting each ward (several times per day) seeking information (i.e. number of possible discharges, number of definite discharges, any internal blocks (i.e. awaiting an echo, external blocks i.e. waiting for a T2A bed)

5. The Integrated Discharge Team (IDT)

- There is an urgent requirement to undertake a comprehensive review and redesign for the current function and structure of Integrated Transfer Team (IDT) (currently Hosted by WCFT & WUTH).
- As part of the review, executive leads to agree the overarching hosting structure for the IDT. The management functions are currently hosted by WUTH (although 2/3 funded by WCFT & 1/3 WUTH)

- The Acute Wards have not supported the principles of shift left and standardised board rounds have not yet been adopted across the acute wards. This has to be a key priority for the IDT, in supporting the Acute Wards.
- The panel concluded that an urgent review into the governance, culture, structure, function and priorities of the IDT is required.
- There is a real opportunity to better understand this valuable resource, determine the current and proposed priorities and support a more collaborative approach with other teams & services utilising best practice. (examples of good-practice include East Lancashire model)

6. Technology, policies & Documentation

- Significant time and effort is spent compiling various pieces of information and paper-based lists together, which directly impacts on the productivity of the IDT.
- Better use of the already “Existing” technology and improved board round structure would enable the IDT to adequately support each ward area and associated board rounds.
- In addition the current “Discharge or Transfer of Care Policy” is out of date, and there is an opportunity to align the recommendations with this new policy.
- The use of technology will be explored to support the redesign of Board Rounds, the function of the IDT and the redesign of the Single Point Access (SPA)

7 Transfer to Assess Beds (MDT), IDT & SPA.

- The panel identified that there is a resource based in the acute setting (IDT), whose primary function is to support transfers of care from the Acute setting into community services.
There is another resource (SPA) based at St Catherine’s, whose primary responsibility is to support access (from the community setting) into both the Acute & Primary Care or Community services.
There is also a resource which supports the multi-disciplinary care of patients residing within the T2A bed provision.
- The executive leads to confirm whether the review of the IDT should be combined with the review of the T2A MDT. There is the potential opportunity to combine these resources under a single structure which could then support both the Acute Setting & T2A settings, which roles, functions and priorities clearly identified as part of this review

(and proposal).

- The executive leads to also confirm whether the scope for the redesign of the “Single Point Access” (SPA) sits outside the review of both IDT & T2A (MDT) or could be considered as part of a phased approach.
- There is an urgent requirement to undertake a comprehensive staffing review for the current T2A (MDT) workforce to include staffing levels (Planned & Actual), staffing, vacancies, systems, processes, 7 day service and function.
- The current resource is reportedly spread thinly across the various community providers and could potentially better support any new “home-first” and/or new T2A (Bed) model.
- The feasibility of proposing a single overarching service and resource, (Base is not important) responsible for supporting patients in both the Acute & Community settings to be explored as part of a more radical redesign or a phased approach.
- This combined staffing resource (IDT, T2A, SPA) could be flexible in its approach, could work across key areas (as part of one service) support the trusted assessor and assessment model, and could underpin a truly collaborative and overarching transfer of care service which supports the whole system.

8 WUTH & Front-Door Support

- WUTH does not currently have a comprehensive and generic “Community Facing” presence within the Emergency Department (ED) or Assessment areas. This presence could support the Trust in turning patients around at the front door, accessing appropriate community services, and avoiding inappropriate (NEL) admissions.
- A community facing resource, based within the ED, with access to the full range of community and voluntary services available, and with a clearly defined remit and criteria, to be explored.
- The current (SNOP) service, is for a specific cohort of staff, however the impact of this service requires clarification, including the demand, capacity and volume of patients “Turned-Around” at the front door.
- The BCF review confirmed that only 12 referrals were made into the “Rapid Community Response” (RCR) service from the Emergency Department.

Clarification regarding the service offered (By RCR) to patients who attend the ED, is urgently required. We need to understand the potential opportunity to turn-around

patients at the front-door of the ED via RCR.

9 System-Wide Therapy Provision

- There is an urgent requirement to refresh and deliver on the key therapy recommendations and system-wide therapy offers (Both WCFT & WUTH) as part of the previous comprehensive proposal & review of Acute & Community Therapy care for Wirral. This has now been refreshed by therapy leads (WCT/WUTH) and will feed into the new UCOG & AEDB structures.

10 Future Overarching Transfer of Care Model- Commissioning.

- The system needs to develop the current “Transfer of Care” offer in Wirral along best-practice guidance i.e. the East Lancashire approach. Wirral has all the components and resources in place already, but these are not coordinated effectively or of the right quantities in key areas.
- WCCG and system leads to Review commissioning model & approach to ensure current services are brought together into a coordinated and streamlined model, with key services to be considered under single management, governance and service structures.
- This could include a future reduced sub-acute bed model (Replacing T2A beds) under one provider, whilst community facing services & teams (i.e. IDT, T2A MDT etc.) could potentially be governed by another provider with a focus on community services

11 Trusted Assessor & Assessment

- The system urgently needs to further develop the trusted assessor model and enhance this by considering up-skilling the workforce, including the independent workforce. The current (TOC) form requires urgent review, and consideration given to an agreed “Screening tool” to support rapid access into ALL community services (Including Home-First & T2A Beds).
- The more robust assessment would then be carried out within the patient’s own home (for the majority of patients) or within a T2A bed, for the minority.

12 System-wide 7-Day offer & enhanced Weekend Support

There is limited evidence of a robust 7 day integrated offer within either the acute or the community settings. This is exacerbating the LOS in both the acute and T2A settings, reducing the level of discharges at weekends, and impacting patient flow within the hospital.

There is an urgent requirement to confirm and address the system-wide 7 day offer to ensure the following is available particularly at weekends

- Daily Board Rounds & updating whiteboard cerna
- Maintain the level of (NEL) discharges & senior Dr Review from WUTH.
- Consider Nurse led Criteria led discharge (weekends)
- To adopt comprehensive Front Door (ED) Support to turnaround patients from the front door of the ED.
- Improve 7 day access to community services, particularly weekends.
- To provide robust IDT support at weekends
- To continue with Primary Care Streaming.

13 Bed Based Review & BCF Review

- Commissioners to review the current bed-based commission with a view to front-loading home-first services, reducing bed-based volume and addressing quality as part of the bed based review in a shift towards the home first model
- Commissioners will utilise the forthcoming capacity and demand work with VENN to inform the new bed-based model for Wirral.

Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to part decommission: Group 6 Communications
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 Funding has been provided by BCF for communications for home first and a comms and engagement lead, both of which will continue will reduced funding as majority of comms work has already been undertaken effectively. Funding will continue to include salary required for comms and engagement lead so no impact on staff anticipated.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) No impact as majority of comms work undertaken, with adequate funding remaining for comms lead
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		type y or n	Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	N	NA
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	N	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	N	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	N	
15	Do you plan to publish your information? Include any "Decision Reports"	N	
16	Can you minimise any negative effect? Please state how.	N	
17	Do you have any supporting evidence? If YES please list the documents.	N	
18	Have you/will you engage with affected staff and users on these proposals?	N	

IMPACT  There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK  There is a high risk

HUMAN RIGHTS IMPACT		type y or n	Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	N	
20	Will the policy/decision lead to degrading or inhuman treatment?	N	
21	Will the policy/decision limit a person's liberty?	N	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	N	
23	Will the policy/decision result in unlawful discrimination?	N	
24	Will the policy/decision limit a person's right to security?	N	
25	Will the policy/decision breach the positive obligation to protect human rights?	N	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	N	
27	Will the policy/decision interfere with a persons right to participate in life?	N	

RISK  There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		type y or n	Comments (provide example)
28	Will the project involve the collection of new information about individuals?	N	
29	Will the project compel individuals to provide information about themselves?	N	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	N	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	N	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	N	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	N	
34	Is the information to be used about individuals' health and/or social wellbeing?	N	
35	Will the project require you to contact individuals in ways which they may find intrusive?	N	

RISK  There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:


Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 6 Communications

Brief description of scheme:

Funding has been provided by BCF for communications for home first and a comms and engagement lead, both of which will continue with reduced funding as majority of comms work has already been undertaken effectively. Funding will continue to include salary required for comms and engagement lead so no impact on staff anticipated.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A				0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N/A				0	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A				0	

Please describe your rationale for any positive impacts here:

Page 285

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT Page 290	Does the proposal involve reducing staff posts? If so describe the impact this will have		0	0	0	
	Is the loss of posts likely to impact on remaining staff		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?	It is not anticipated that there will be an impact on patient experience.	0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income		0	0	0	
	Other providers (specify how/what)		0	0	0	
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____ Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint
Local resolution		Local resolution go to independent
Single failure to meet internal standards		Repeated failure to meet standards
Minor implications for patient safety if unresolved		Major patient safety findings are
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality		Late delivery of service due to
		Unsafe staff competence
		Low staff morale
		Poor staff attendance/mandatory/
Breach of statutory legislation		Single breach of legislation
Reduced performance rating if unresolved		Challenging recommendation notice
Local media coverage –		Local media coverage
short-term reduction in public confidence		long-term reduction in public confidence
Elements of public expectation not being met		
<5 per cent over project budget		5–10 per cent over project budget
Schedule slippage		Schedule slippage
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	2 Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
	3	4
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Carers Short Break (Respite) Beds Report

January – August 2018

Background

In September 2016 a pilot for the Carers Short Break beds was provided through an eleven bed unit at Park House. The unit offered a mixture of residential, residential EMI and nursing care beds and 1 nursing EMI bed was provided in the specialist wing of the home.

A review of the service identified that a significant number of beds were being spot purchased outside of the block beds, when there was availability on the block. The reasons provided for people being booked into other homes included:

- Poor CQC ratings of Park House in the past
- Negative comments received from other Carers, and/or professionals
- Not close enough to the individuals home
- The mixed unit arrangement did not suit some people seeking residential breaks

In autumn 2017 a tendering process was completed for the re-provision of the Carers Short Break beds. The number of beds tendered was increased from 12 to 20, taking account of the previous activity for respite care outside of the block booked beds.

The following 19 beds were commissioned, with the contract commencing on 1st December 2017:

- Elliot House 9 Residential
- Homecrest 4 Residential EMI
- Summerfields 2 Residential EMI
- Acorn House 2 Residential EMI
- Park House 2 Nursing

There were no bids received to deliver a Nursing EMI bed.

A negative CQC inspection for Homecrest in August 2018 led to the suspension of referrals to the service. Monitoring of the home since the start of the contract showed that the occupancy levels had remained low; therefore a termination notice for the contract was issued*. 2 Residential EMI beds were transferred to Summerfields with effect from 1st September to ensure sufficient availability of beds.

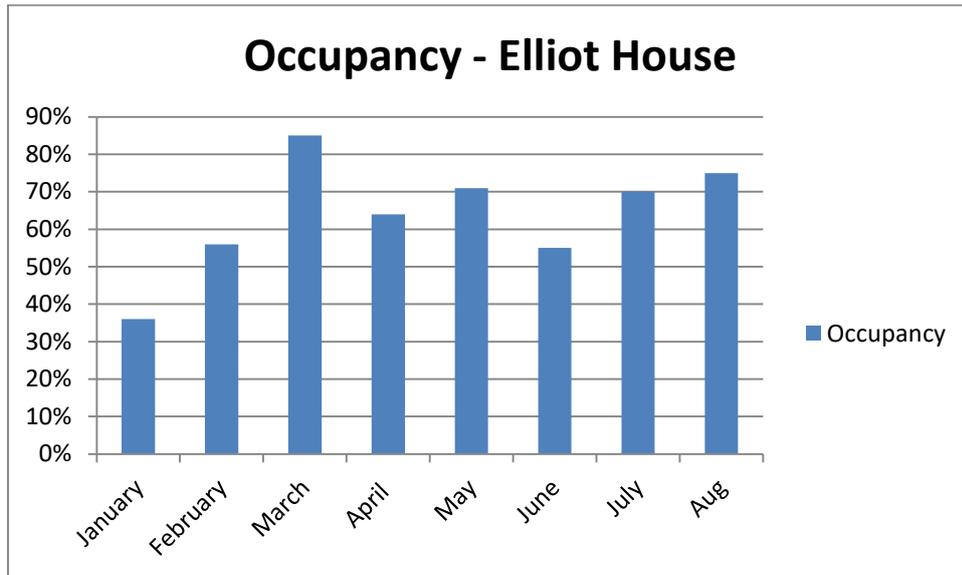
All commissioned beds are provided at the Wirral rate with no additional top up payments required.

** RB Care, the new owners of Homecrest, accepted the termination notice; they are working to make the required improvements to the care home.*

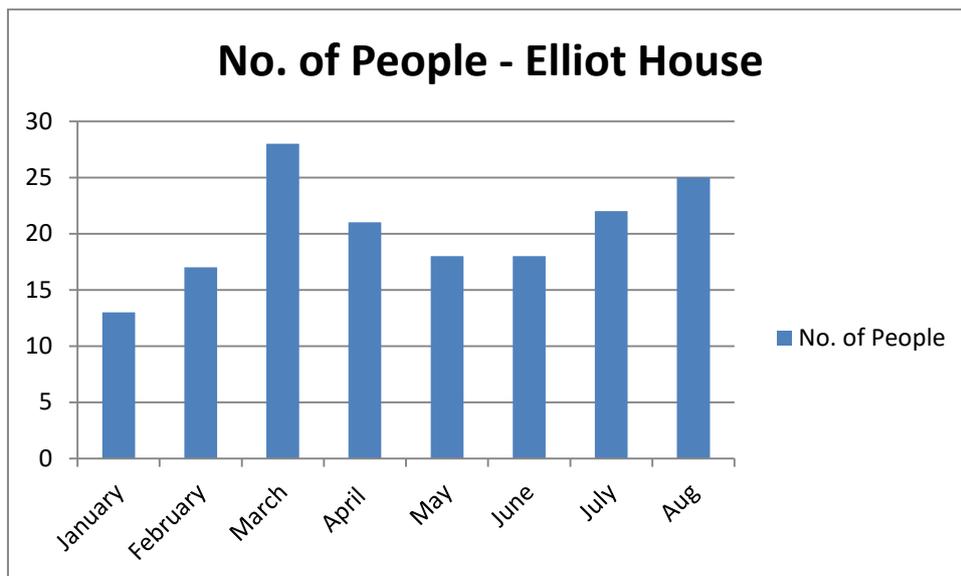
Occupancy Rates for the commissioned beds January – August 2018

Referrals were slow at the start of the contract in December and across the festive period, referrals over the first month tended to be emergency or short notice respite bookings; therefore, data for December 2017 have not been included in this report.

Elliot House – 9 Residential



The occupancy levels range from 36% - 85%, with March being the busiest month. The average occupancy rate over the period is 64%

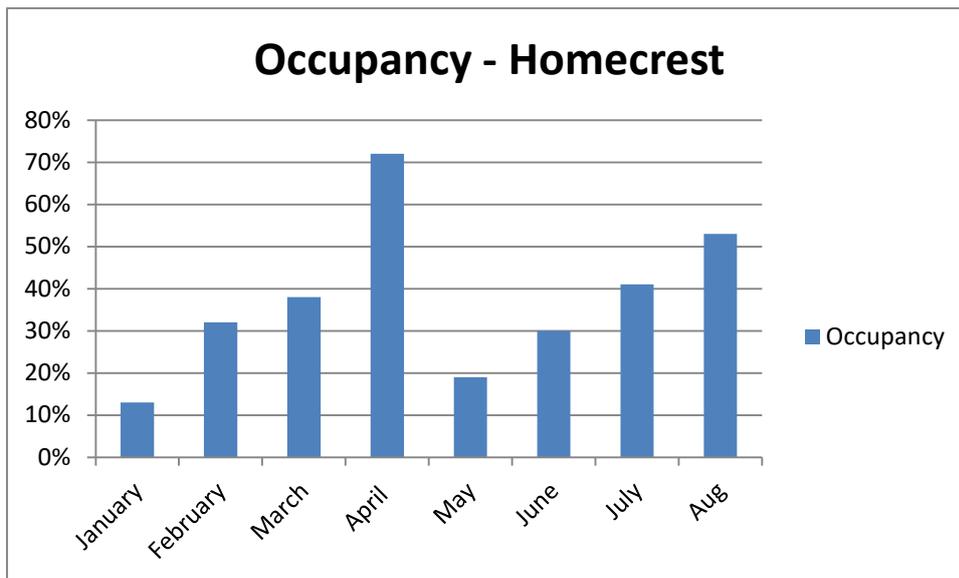


A total number of 162 people have used the residential beds over the period.

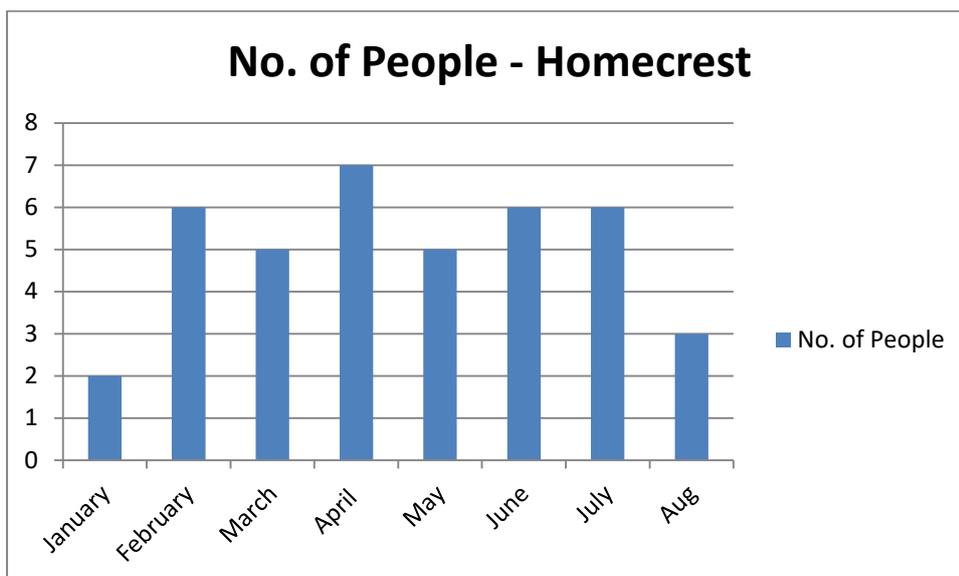
Length of stay

The majority of breaks were 6 -10 days, followed by 3- 5 days and 11 – 15 days. 13 people stayed for between 21 – 30 days.

Homecrest – 4 Residential EMI



The occupancy levels range from 13% - 72%, with April being the busiest month. The average occupancy level is 37%.

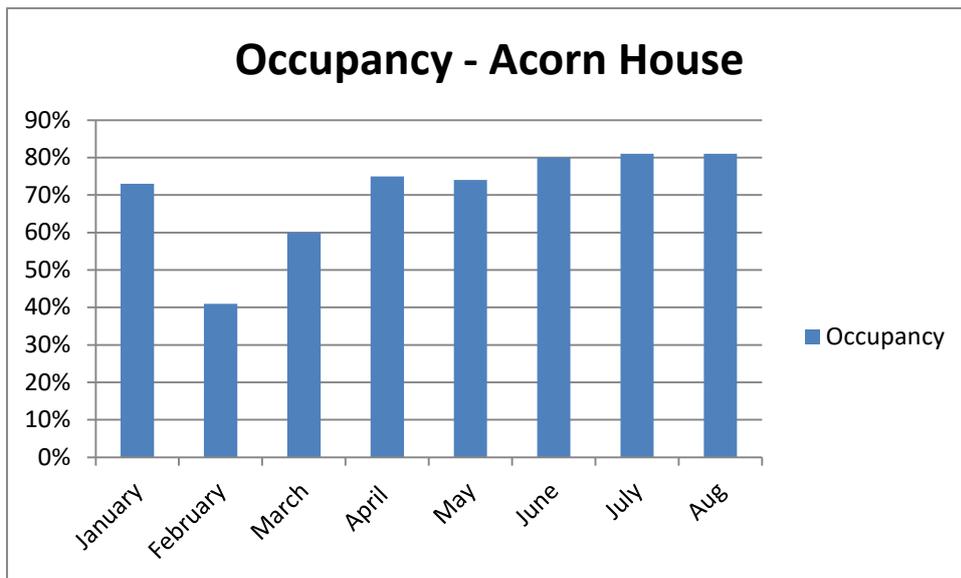


A total number of 40 people have used the Residential EMI beds.

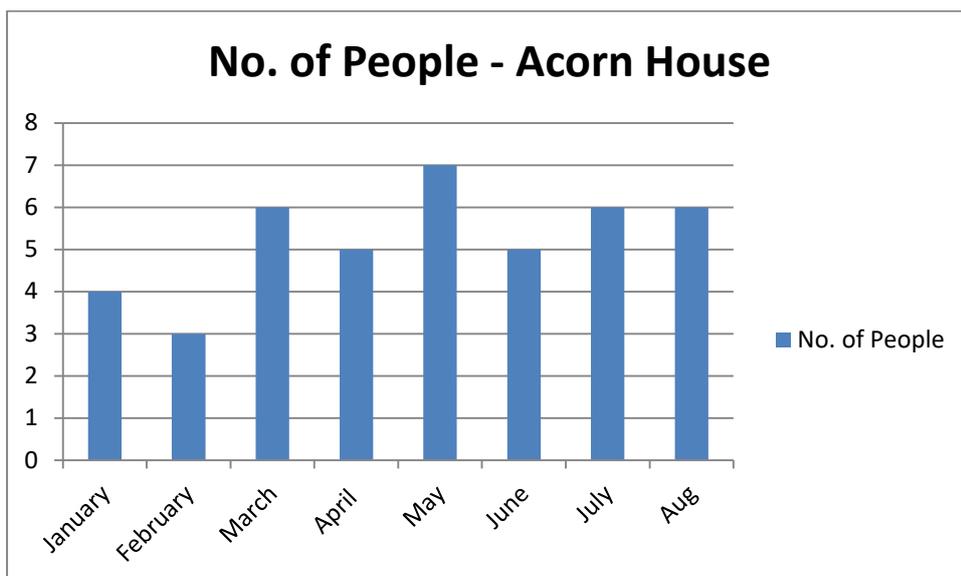
Length of stay

The majority of breaks were 6 -10 days, followed by 3- 5 days and 11 – 15 days. 3 people stayed for between 16 -25 days.

Acorn House



The occupancy levels range from 41% - 81%, February being the quietest month. The average occupancy level is 71%.

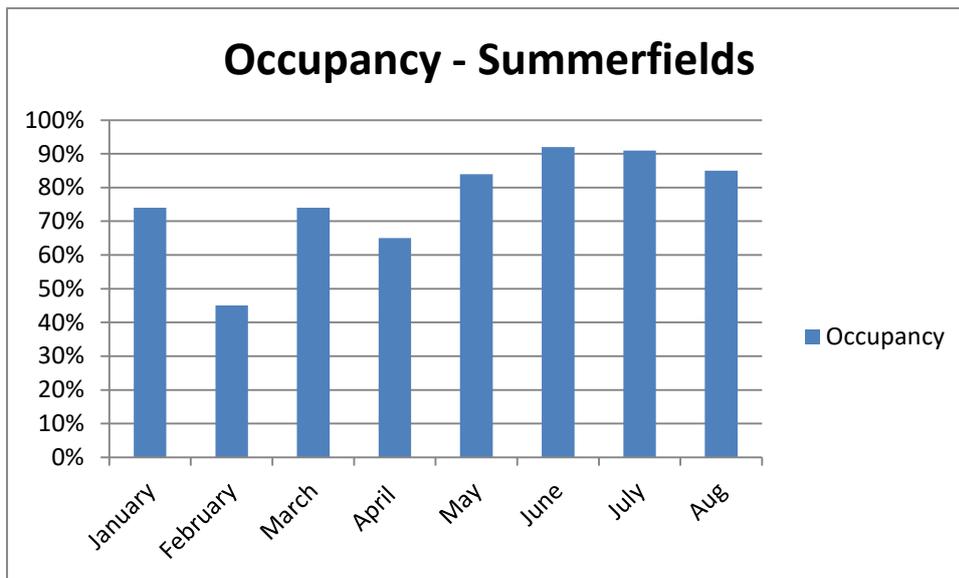


A total number of 42 people have used the Residential EMI beds.

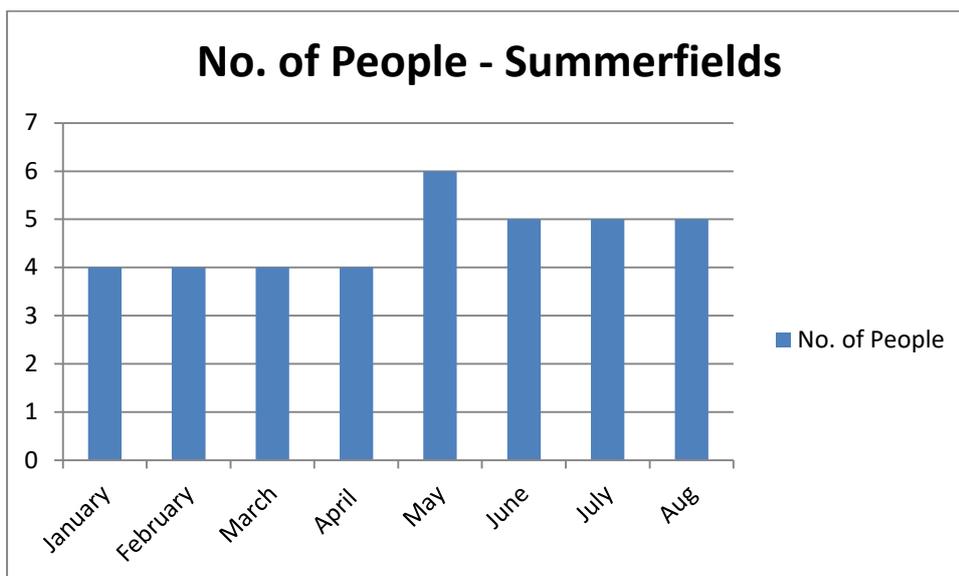
Length of stay

The majority of breaks were 6 -10 days, followed by 11 – 15 days and 3- 5 days. 3 people stayed for between 16 - 20 days.

Summerfields – 2 Residential EMI



The occupancy levels range from 45% - 92%, February being the quietest month. The average occupancy level is 76%.

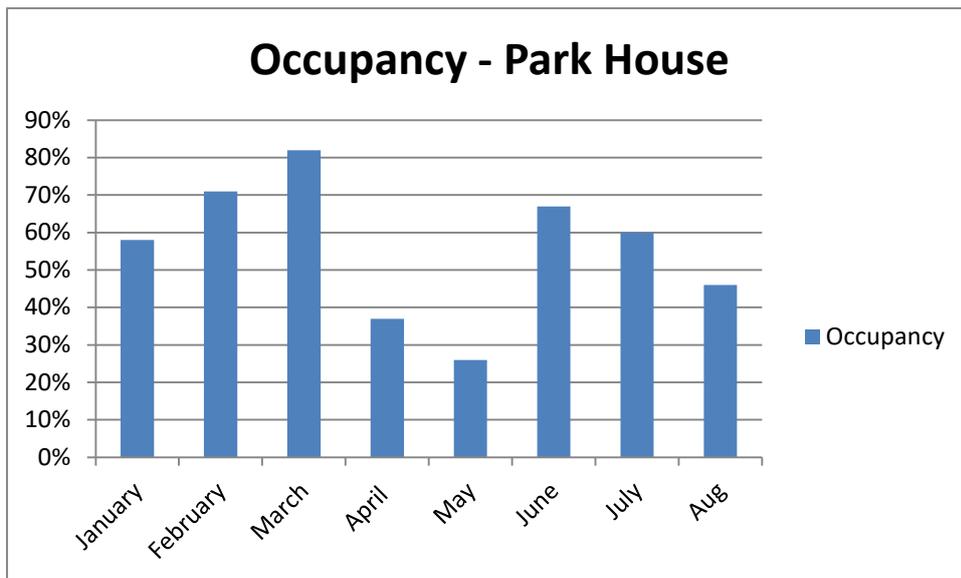


A total number of 37 people have used the Residential EMI beds.

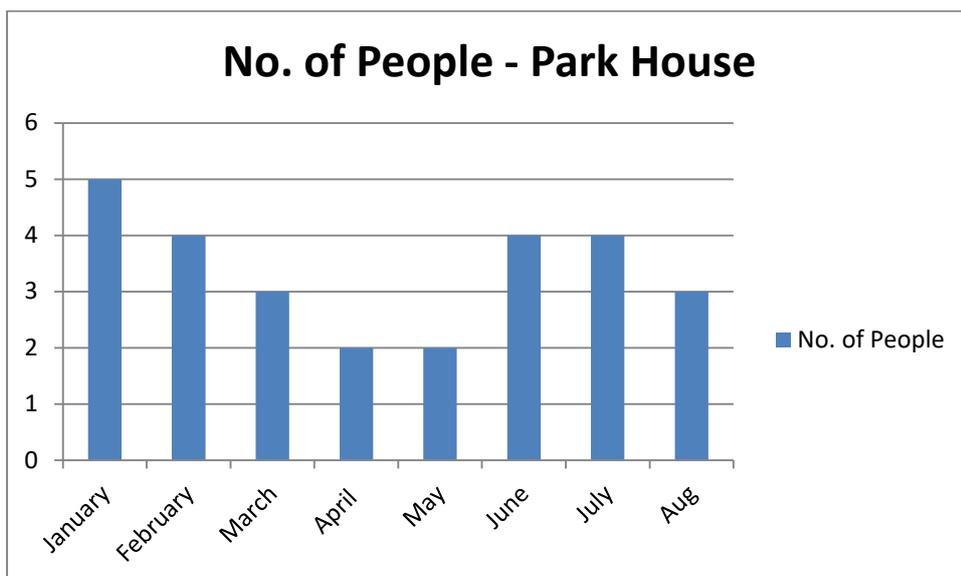
Length of stay

The majority of breaks were 6 -10 days, followed by 3- 5 days and 11 – 15 days. 4 people stayed for between 21 - 25 days.

Park House – 2 Nursing



The occupancy levels range from 26% - 82%, April and May being the quietest months. The average occupancy level is 56%.



A total number of 27 people have used the Nursing beds.

Length of stay

The majority breaks were 11 – 15 days, followed by 6 - 10 days and 3 - 5 days. 1 person stayed for between 31 - 35 days.

Summary

The care homes are delivering predominately pre-bookable short breaks for Carers and have generally responded well to taking emergency placements. The lack of pre-bookable beds had been highlighted at earlier consultation events with Carers.

Issues have occurred when a care home is refusing to accept a referral, this usually occurs for emergency placements where there is no paperwork or up to date assessment accompanying the person, an example of this was where the home was not able to meet the person's nursing and mobility needs, therefore the person had to be transferred to another safe and appropriate placement, this was an extremely distressing experience for the individual, the family and the staff. All bookings are placed through the Care Arranging Team, who co-ordinate the bookings and send out reminders to social care workers for completed paperwork before admission.

As stated earlier, the contract for 4 Residential EMI beds with Homecrest was terminated in August 2018. 2 Residential EMI beds have been transferred to Summerfields. The current Residential EMI Short Break bed provision is around the Birkenhead area of the borough, we will be looking to transfer, pilot and monitor 2 of the Residential EMI beds in another location in Wirral.

This report is based on data from the Care Arranging Team, the Wirral Intelligence Service are currently looking at a reporting system based on information from the Liquidlogic. Therefore, it is currently not possible to report on the number of short break beds being spot purchased.

For the Short Break (Respite) beds:

There were 5 homes providing a total of 19 beds

There have been 308 people in total using the service.

Only one person in a nursing respite bed stayed over 30 days

For the majority of people their length of stay was less than 15 days

This report should be considered in conjunction to the usage of the Short Term placement beds.

Data for the Short Term Care beds January – September 2018:

There are 85 homes providing residential, residential EMI and nursing beds.

Number of Days	Count of Duration Since Jan 18 to End Date or Current Date
Under 3 days	11
3-5 Days	22
6-10 Days	46
11-15 Days	57
16-20 Days	28
21-25 Days	32
26-30 Days	63
31-35 Days	29
Over 35 Days	309
Grand Total	597

For the majority of people their length of stay was greater than 30 days (309 out of 597 placements).

However, 136 of the placements were for less than 15 days. Potentially, some of these placements that were to provide a break for the Carer could have been allocated to the block booked respite beds.

The remainder of the placements, 152, length of stay was between 16 – 35 days.

Recommendations:

- Provide approval to seek the relocation of 2 residential EMI Short Break beds in a home (s) outside of the Birkenhead area
- Ensure that the blocked booked Short Break Beds are utilised to their maximum capacity through identification of breaks for Carers
- Promote the requirement for appropriate paperwork to be put forward when booking both planned and unplanned breaks

Mental Health BCF Overview of schemes

BCF Schemes	Contract Value
Dementia Nurse (Crisis/Liaison)	£ 150,576

Detention transport (iBCF)	£	70,000
Street Triage (iBCF - enhanced hours)	£	112,668

TOTAL £ 263,244

Background

The Dementia Liaison service began in Jan 2018 with the following aims:

1. To prevent admission/re-admission to acute for those people living with dementia, cognitive impairment, memory problems within a hospital/care home setting
2. To support staff within hospital/care home setting to manage patients with dementia, cognitive impairment, memory problems

NWAS, Merseyside Police, DASS, WUTH and CWP

highlighted that there was an ongoing issue that individuals who have been detained under the Mental Health Act, or assessed under the act, and require admission were waiting several hours for transport by NWAS Paramedic Ambulance.

During this period of waiting they are accompanied by AMPHs, sometimes Police, sometimes WUTH staff if they are in A&E.

There are circa 500 occasions each year where NWAS is called upon to provide transport in these circumstances.

Core service hours are midday to midnight, 7 days a week.

The enhanced service hours cover Tues, Wed, Thurs from 8am-2am. The days of the week where CWP are wanting to introduce additional coverage is as a result of looking at peak periods of s136 activity. Both police and CWP figures concurred with the suggested enhanced hours of operation.

Please note that CWP struggled to recruit for the street triage enhanced and street triage NWAS. In January 2019 CWP successfully recruited for street triage enhanced. As such we have no outcome data to share for 18/19 for enhanced street triage. We have therefore shared data from core and what we expected to see with the enhanced offer.

Service Spec	Bid documentation
<p>The service operates 7 days a week, from 8am to 6pm.</p> <p>The service is easy to access with a short referral form and referrals can be via email, telephone or direct from the MDT meetings.</p> <p>The service responds quickly and aims where possible to see people within 48 hours of receiving the referral.</p> <p>In particular the service liaises with Older Peoples Assessment Unit (OPAU) and Transfer to Assess patients.</p> <p>Currently there are 7 care homes with 103 beds these include Residential Nursing EMI Residential and EMI Nursing.</p> <p>Draft spec:</p> <div data-bbox="300 1200 497 1361" data-label="Image"> </div>	<div data-bbox="868 1093 995 1189" data-label="Image"> </div>
<p>No spec was developed as part of this BCF service</p>	

	
<p>The service spec for street triage is below. This spec will require updating to include the enhanced offer if we continue to commission the service.</p> 	

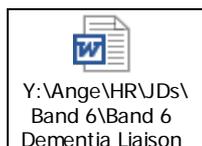
No of posts (Inc. band/WTE), date recruited name of post holders & job description

3 WTE (Band 6)

Cheryl Brown (15.01.18)

Matthew Edwards (26.02.18)

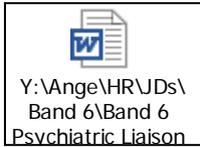
Rachel Ellis (22.10.18)



Porter, vehicle and fuel costs.

Service has been operational since January 2018

2 WTE (band 6)
Dave Lynch (07.01.19)
Kirsten Brown (04.03.19)



Evidence of VFM

Since Jan 2018 there have been over 330 contacts with the dementia liaison service.

Outcomes of assessments have been recorded as follows: 49 cases were recorded as advice, 45 referrals to the Wirral Memory Assessments service (WMAS)/Community Mental Health Team (CMHT), 38 supported with placement to EMI nursing, 37 supported with placement to EMI residential, 36 discharged back to GP, 22 complete assessments, 22 information sharing, 15 cognitive reviews, 9 admissions avoided, 5 recommendations into T2A and 53 recorded as other.

The service supports people across the care system including helping people to stay out of the acute trust for 1st stay or even as a re-admission.

The service helps to reduce ED attendances, as it offers an alternative to assessments in ED for service users in mental health crisis who do not have a physical health problem.

The nurses reach into OPAU to try and prevent admissions flowing into the WUTH wards. They also outreach to nursing residential homes. They attend the MDTs in OPAU and in the T2A establishments (8 meetings weekly). The team are also to support the staff in residential and nursing homes to improve their knowledge and skills when working with people who are living with dementia.

The service:

- Shares information between mental health and acute hospital trusts
- Conducts cognitive assessments and assessments for dementia or delirium
- Advises and educates in behavioural management of dementia and delirium
- Makes discharge recommendations for the T2A beds
- Liaises with the Care Homes who have T2A beds
- Liaises with Social Workers & other professionals e.g. GP, Discharge team and therapists
- Liaises with family and carers
- Makes recommendations for discharge from the acute trust to home or 24 hour care
- Refers to Wirral Memory Assessment Service (WMAS) and CMHT services
- In reach into inpatient wards if no Dementia Nurse is available
- Dementia Liaison nurses will be attend the IDT morning MDT meetings to offer support and input for discharges from the hospital into EMI T2A placements. Recently an increasing number of patients discharged from hospital are placed into EMI nursing and residential beds T2A inappropriately without receiving any input from Liaison Psychiatry, or any other mental health services. Very often the individuals do not have a confirmed diagnosis of dementia or cognitive impairment. This results in an increasing number of referrals to our service to re-assess patients within the T2A beds to determine the appropriateness of the placements.

During the time that the detention transport has been in place there has been a total of 921 occasions were

this service has been utilised. The period of time that this covers is April 18 to Jan 2019. Therefore the anticipated benefits have been exceeded by almost double (target number was 500).

Average response time is 25 minutes with average time taken to complete transfer of patient to ongoing destination is 1hr 40 mins.

It is anticipated that the overall reduction has been in excess of 2 hours.

This scheme assists with patient flow. It speeds up transfer of people being discharged from A&E so they don't need to wait for NWAS transport to an inpatient mental health bed (waits could be several hours in the past).

The service frees up a space in A&E whilst reducing demand on NWAS so they can be deployed to other calls. Also gives VFM in relation to freeing up AMPHs and police (if they are involved) to deal with their other duties.

It reduces the number of times NWAS has to dispatch a paramedic ambulance to provide transport previous data showed that this was requested up to 500 occasions each year. This allows the paramedics skills to be

As staff for the street triage enhanced service were only recruited in early 2019, we have summarised the benefits of the street triage core offer.

Street triage effectively diverts people away from ED - frees up NWAS, police and health resource. The service reduces the number of section 136s - which involves AMPHs, s12 approved dry's, police , ED and NWAS resource too. Also reduces the number of inappropriate arrests and detention in police custody of mentally disordered offenders.

From February 2018 through to January 2019 was a total 1551 contacts of street triage core contacts.

During the period February 2018 - January 2019 (inclusive) there were a total of 279 Section 136s avoided.

From October 2017 to December 2018 there were 97 ED attendance advised, 30 recorded ED admissions avoided and 905 cases of advice/signposting. It is likely that without street triage a proportion of these 905 will have attended ED.

If the total number of cases that did not attend A&E are calculated (279+30+905) then this is a potential system saving of £165k (assuming that average ED attendance is £136)

The rationale for introducing enhanced street triage is to expand the hours of operation of the service which will further divert more people away from ED attendance.

Case study	Commissioner recommendation
<div data-bbox="231 472 429 611" data-label="Image"> <p>Document</p> </div>	<p>The commissioner recommendation would be to continue to fund this service for a further 12 months whilst there are system conversations linked to the Healthy Wirral Mental Health programme, of which Dementia is a key priority.</p>
	<p>The commissioner recommendation is that this</p>

	<p>service continues for a further 12 months with specific KPI monitoring reported through the CWP contract meeting and crisis care concordat dashboard. It is proposed that early discussions commence with system leads across the acute, mental health and CCG to ensure sustainable funding.</p>
	<p>The commissioner recommendation is that this service is funded for 12 months with specific KPI monitoring reported through the CWP contract meeting and crisis care concordat dashboard. This data flow will help build a case of whether funding should continue in 20/21.</p>

BCF schemes that have been built into CWP core contract:		Contract value
1	Street Triage	£ 152,000
2	Complex Needs	£ 250,000
3	Wirral Homeless Practitioner Dementia Nurse (75,290) 1.64 WTE (Band 6)	£ 70,000
4	Robert Elliot (1WTE) works in Wirral Memory Assessment service (was previously Don Walmsley)	£ 75,290
5	Early Onset Team	£ 146,000

Total: £ 693,290.00

BCF schemes that will not be continuing:		Contract value	Rationale
1	Street Triage NWAS (£174,752) unable to recruit, monies returned to CCG	£ 174,752	CWP could not recruit to post
2	Adults Winter Support Cambrian beds (£49,332) funding only until end of March 2019 to cover winter pressure period	£ 49,332	Funding only available until March 2019 for Winter pressure period
3	Dementia nurse iBCF (£75,290)	£ 75,290	From discussions with CWP we don't think this money was ever released for a second dementia nurse post. One is now part of core contract so iBCF funding is to be returned to CCG
Total:		£ 299,374	

EQUALITY IMPACT & RISK ASSESSMENT STAGE 1 SCREENING TOOL



Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to part decommission: Group 6 Communications
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 Funding has been provided by BCF for communications for home first and a comms and engagement lead, both of which will continue will reduced funding as majority of comms work has already been undertaken effectively. Funding will continue to include salary required for comms and engagement lead so no impact on staff anticipated.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples) No impact as majority of comms work undertaken, with adequate funding remaining for comms lead
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	NA
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT ● There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK ● There is a high risk

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	NA
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK ● There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	NA
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK ● There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:

Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 6 Communications

Brief description of scheme:

Funding has been provided by BCF for communications for home first and a comms and engagement lead, both of which will continue with reduced funding as majority of comms work has already been undertaken effectively. Funding will continue to include salary required for comms and engagement lead so no impact on staff anticipated.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A				0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N/A				0	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A				0	

Please describe your rationale for any positive impacts here:

Page 34

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
CONTINUAL QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT Page 339	Does the proposal involve reducing staff posts? If so describe the impact this will have		0	0	0	
	Is the loss of posts likely to impact on remaining staff		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?	It is not anticipated that there will be an impact on patient experience.	0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income		0	0	0	
	Other providers (specify how/what)		0	0	0	
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____ Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint
Local resolution		Local resolution go to independent
Single failure to meet internal standards		Repeated failure to meet standards
Minor implications for patient safety if unresolved		Major patient safety findings are
Reduced performance rating if unresolved		
Low staffing level that reduces the service quality		Late delivery of service due to
		Unsafe staff competence
		Low staff morale
		Poor staff attendance/mandatory/
Breach of statutory legislation		Single breach
Reduced performance rating if unresolved		Challenging recommendation notice
Local media coverage –		Local media
short-term reduction in public confidence		long-term reduction in public confidence
Elements of public expectation not being met		
<5 per cent over project budget		5–10 per cent over project budget
Schedule slippage		Schedule slippage
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	2	
	Unlikely	Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
3	4	5
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Organisation: Wirral CCG	Service:
Project Lead: Jacqui Evans	Service Area: BCF Schemes - Decision to decommission: Group 2 - project management capacity - BCF Scheme Lead/ROI Evaluation and Transformation Programme Manager
Person responsible for this Assessment: Heather Harrington	Date of Review: 17-Apr-19

Brief explanation of what is happening / being assessed (MAX 1000 CHARACTERS)
 Funding was previously utilised to fund a dedicated BCF scheme lead and transformation manager. These have now been absorbed within existing resource. Note, this decommission has not involved any redundancies.

QUESTION No.	EQUALITY IMPACT	type y or n	Comments (provide example)
1	Does this issue plan to withdraw a service, activity or presence?	N	Example (click for examples)
2	Does this issue plan to reduce a service, activity or presence?	N	
3	Does this issue plan to introduce or increase a charge for Service?	N	
4	Does this issue plan to change to a commissioned service?	N	
5	Does this issue plan to introduce, review or change a policy, strategy or procedure?	N	
6	Does this issue plan to introduce a new service or activity?	N	
7	Is this primarily about improving access to, or delivery of a service?	N	
8	Does this affect employees or levels of training for those who will be delivering the service?	N	
9	Does this issue affect Service users?	N	
10	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	

EQUALITY RISK		Comments (provide example)
11	Have you got any general intelligence (research, consultation, etc.)? If YES please list any related documents.	Section N/A
12	Have you got any specific intelligence (research, consultation, etc.)? If YES please list any related documents.	
13	Have you taken specialist advice? (Legal, E&I Team, etc). If YES please state.	
14	Have you considered your Public Sector Equality Duty? Please provide a rationale.	
15	Do you plan to publish your information? Include any "Decision Reports"	
16	Can you minimise any negative effect? Please state how.	
17	Do you have any supporting evidence? If YES please list the documents.	
18	Have you/will you engage with affected staff and users on these proposals?	

IMPACT There should be little or no impact. There is no requirement to carry out a Stage 2 assessment

RISK

HUMAN RIGHTS IMPACT		Comments (provide example)
19	Will the policy/decision or refusal to treat result in the death of a person?	
20	Will the policy/decision lead to degrading or inhuman treatment?	
21	Will the policy/decision limit a person's liberty?	
22	Will the policy/decision interfere with a person's right to respect for private and family life?	
23	Will the policy/decision result in unlawful discrimination?	
24	Will the policy/decision limit a person's right to security?	
25	Will the policy/decision breach the positive obligation to protect human rights?	
26	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	
27	Will the policy/decision interfere with a persons right to participate in life?	

RISK There is little chance of Human Rights breach. There is no requirement to carry out a Stage 2 assessment

PRIVACY IMPACT		Comments (provide example)
28	Will the project involve the collection of new information about individuals?	
29	Will the project compel individuals to provide information about themselves?	
30	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	
31	Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	
32	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	
33	Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.	
34	Is the information to be used about individuals' health and/or social wellbeing?	
35	Will the project require you to contact individuals in ways which they may find intrusive?	

RISK There is little chance of a Privacy breach. There is no requirement to carry out a Stage 2 assessment

PLEASE SEND YOUR COMPLETED STAGE 1 SCREENING TOOL TO THE EQUALITY & INCLUSION TEAM EMAIL: equality.inclusion@mhs.net

GENERAL GUIDANCE
 Please use the comments section to explain any 'RED' scores or to further elaborate what is being assessed is necessary
 All 'RED' scores will require further action in future planning regardless of the requirement to carry out Stage 2 approaches.

Signature of person completing the screening tool:


Comments (MAX 250 CHARACTERS)

Signature of Equality & Inclusion Business Partner & Date

Comments (MAX 250 CHARACTERS)

Wirral Clinical Commissioning Group: Quality Impact Assessment Tool v5

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found in the 'Risk Scoring Matrix' tab.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 8 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Title and lead for scheme: BCF Schemes - Decision to decommission: Group 2 - project management capacity - BCF Scheme Lead/ROI Evaluation and Transformation Programme Manager

Brief description of scheme:

Funding was previously utilised to fund a dedicated BCF scheme lead and transformation manager. These have now been absorbed within existing resource. Note, this decision has not involved any redundancies.

Answer positive/negative or not applicable (P/N or N/A) in each area. If N, please score the impact and likelihood. If score greater than 8 a full stage 2 assessment will be required.

Area of Quality	Impact question	P/N or N/A	Impact	Likelihood	Score	Full Assessment - Stage 2 to be completed
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N/A			0	
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	N/A			0	
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	N/A			0	
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	N/A			0	
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	N/A			0	

Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	N/A				0	
Vacancy Impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	N/A				0	
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	N/A				0	

Please describe your rationale for any positive impacts here:

NA

Page 349

Signature: 	Designation: Senior Commissioning Lead Unplanned Care	Date: 18.04.19
--	--	-----------------------

Stage 2

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions. In accordance with Health and Social Care Act 2008 Section 139?		0	0	0	
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?		0	0	0	
	What is the impact on strategic partnerships and shared risk?		0	0	0	
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to PCT Equality Impact Assessment Tool)?		0	0	0	
	Are core clinical quality indicators and metrics in place to review impact on quality improvements?		0	0	0	
	Will this impact on the organisation's duty to protect children, young people and adults?		0	0	0	
PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/ incidents)		0	0	0	
	How will it impact on choice?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIE	Does it support the compassionate and personalised care agenda?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
PATIENT SAFETY	How will it impact on patient safety?		0	0	0	
	How will it impact on preventable harm?		0	0	0	
	Will it maximise reliability of safety systems?		0	0	0	
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?		0	0	0	
	What is the impact on clinical workforce capability care and skills?		0	0	0	
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?		0	0	0	
	How will it impact on clinical leadership?		0	0	0	
	Does it support the full adoption of Better care, Better Value metrics?		0	0	0	
	Does it reduce/impact on variations in care?		0	0	0	
	Are systems for monitoring clinical quality supported by good information?		0	0	0	
	Does it impact on clinical engagement?		0	0	0	
PREVENTION	Does it support people to stay well?		0	0	0	
	Does it promote self-care for people with long term conditions?		0	0	0	
	Does it tackle health inequalities, focusing resources where they are needed most?		0	0	0	
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?		0	0	0	
	Does it eliminate inefficiency and waste?		0	0	0	
	Does it support low carbon pathways?		0	0	0	
	Will the service innovation achieve large gains in performance?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it lead to improvements in care pathway(s)?		0	0	0	

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
VACANCY IMPACT	Does the proposal involve reducing staff posts? If so describe the impact this will have		0	0	0	
	Is the loss of posts likely to impact on remaining staff morale?		0	0	0	
	Can arrangements be made to prioritise and manage workload effectively?		0	0	0	
	Are vacancies likely to impact on patient experience?		0	0	0	
	Will services be negatively impacted by the loss of posts for a short term, medium term or longer term?		0	0	0	
RESOURCE IMPACT	Describe how this proposal may/will have a resource impact with regard to:					
	Estates		0	0	0	
	IT Resource		0	0	0	
	Funding streams/income	Contribute to BCF savings	4	2	8	Positive impact
	Other providers (specify how/what)		0	0		
	Social care/voluntary/third sector		0	0	0	

Signature: _____

H. Langton

Designation: _____ Date: _____

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors
1
Negligible
Informal complaint/inquiry
Short-term low staffing level that temporarily reduces service quality (< 1 day)
No or minimal impact on breach of guidance/ statutory duty
Rumours
Potential for public concern
Insignificant cost increase/ schedule slippage
Small loss Risk of claim remote

Loss/interruption of >1 hour

Minimal or no impact on the environment

Likelihood score

Rare

This will probably never happen/recur

		2	
Minor (Green)		Moderate (
Formal complaint (stage 1)		Formal complaint	
Local resolution		Local resolution go to independent	
Single failure to meet internal standards		Repeated failure to meet standards	
Minor implications for patient safety if unresolved		Major patient safety findings are	
Reduced performance rating if unresolved			
Low staffing level that reduces the service quality		Late delivery of service due to	
		Unsafe staff competence	
		Low staff morale	
		Poor staff attendance/mandatory/	
Breach of statutory legislation		Single breach	
Reduced performance rating if unresolved		Challenging recommendation notice	
Local media coverage –		Local media	
short-term reduction in public confidence		long-term reduction in public confidence	
Elements of public expectation not being met			
<5 per cent over project budget		5–10 per cent over project budget	
Schedule slippage		Schedule slippage	
Loss of 0.1–0.25 per cent of budget		Loss of 0.25–0.5 per cent of budget	

	Claim less than £10,000	Claim(s) be £100,000
	Loss/interruption of >8 hours	Loss/interru
	Minor impact on environment	Moderate in
1	Unlikely	2 Possible
	Do not expect it to happen/recur but it is possible it may do so	Might happen occasionally

3	4	5
Yellow)	Major (Orange)	Catastrophic (Red)
complaint (stage 2)	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
ation (with potential to independent review)	Low performance rating	Inquest/ombudsman inquiry
ailure to meet internal	Critical report	Gross failure to meet national standards
nt safety implications if not acted on		
y of key objective/ to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
ding level or e (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
orale	Loss of key staff	Loss of several key staff
ttendance for key training	Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
ch in statutory duty	Enforcement action	Multiple breeches in statutory duty
g external relations/ improvement	Multiple breeches in statutory duty	Prosecution
	Improvement notices	Complete systems change
	Low performance rating	Zero performance rating
	Critical report	Severely critical report
a coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
eduction in public		
		Total loss of public confidence
ent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
lippage	Schedule slippage Key objectives not met	Schedule slippage Key objectives not met
5–0.5 per cent of	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget

between £10,000 and	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
	Purchasers failing to pay on time	Loss of contract / payment by results Claim(s) >£1 million
ruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
mpact on environment	Major impact on environment	Catastrophic impact on environment
3	4	5
	Likely	Almost certain
en or recur y	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently



HEALTH AND WELLBEING BOARD

17 JULY 2019

REPORT TITLE	INCREASING INDEPENDENCE AND TRANSFORMING CARE, A LEARNING DISABILITY PROGRAMME UPDATE
REPORT OF	JASON OXLEY

REPORT SUMMARY

This report provides an update on the progress made in commissioning services for people with Learning Disabilities with a specific focus on the implementation of the Transforming Care Programme (TCP) priorities in Wirral.

RECOMMENDATIONS

It is recommended that the Health and Wellbeing Commissioning Board note the report.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 This report is for noting only.

2.0 OTHER OPTIONS CONSIDERED

N/A

3.0 BACKGROUND INFORMATION

- 3.1 Wirral has a general population of approximately 322,000 people (Wirral Joint Strategic Needs Assessment (JSNA), 2017). 5,914 are known to have a learning disability of some degree (Wirral Learning Disability Strategy 2017). Of these, 2,213 people are registered with their GP as having a learning disability. 8,858 school age children have a Statement of Special Educational Need with approximately 50% of these having a learning disability (Wirral JSNA 2017).
- 3.2 Clear effective and collaborative working relationships between specialist NHS services, primary care services and social care are important to this group because their health outcomes have been significantly worse than the rest of the population. People with a learning disability are on average three times more likely to die prematurely, with average age at death between only 55-60 years old. The NHS Long Term Plan sets a target of 70% of people who have a learning disability to have an annual health check. In Wirral, currently only 50% are achieved and this is a priority area for this year.
- 3.3 Around 1000 people from this group have support packages from the Council or from the NHS due to their complex needs. People with the most severe learning disability have the most intensive needs and a complete reliance on others for their day to day care and safety.
- 3.4 People can have needs ranging from moderately reduced intellectual functioning to very profound disabilities including a complete inability to manage mobility, personal care, toileting, eating and drinking and communicating even very basic needs. People with a learning disability sometimes have other conditions alongside, such as autism or mental health disorders. Behaviour that challenges can be a feature of people with learning disability which can range from minor antisocial behaviour to significant challenging behaviour such as shouting, physical aggression and sexualised behaviours.
- 3.5 Historically people with intensive needs have often found themselves in institutional highly controlled environments where their choices are significantly limited. The Transforming Care Programme (TCP) has taken the lead from social care to take a person-centred approach. It describes the need to develop alternative support for people with a learning disability in order that they can move on from Clinical and institutional environments to receive the support that they need to live independently in their own homes and within their own communities.

3.6 The TCP programme is led by NHS England (NHSE) and its key priorities are included in the NHS Long Term Plan. Wirral Health and Care Commissioning have included TCP priorities in its Operational and Business planning for 2019/20. Key priorities for the TCP are set out below:

Driver	Area	Areas for focus
Delivering on the Long-Term Plan priorities	Children and Young People with Learning Disability and/ or Autism: developing services	Autism diagnosis (full sensory assessments) Support through diagnosis Crisis provision 0-25 year service provision (early intervention)
	Adult Community Care for People with Learning Disability and/ or Autism	Intensive, crisis and forensic community support, moving to 24/7 services Autism only services
Delivering Sustainability	Appropriate hospital usage	Appropriate admission and prompt, safe discharge (leading to reduction in inpatient numbers and length of stay for people with LD/ ASC)
	Sustained community investment	Developing plans to sustain community infrastructure from 2021
	Forensic community services	Develop skill set in community services
	Workforce	Priorities within TCP Workforce Plan (5 listed below): 1. Increase the skills of the unpaid and frontline support worker workforce 2. Increase supply in terms of support workers 3. Increase supply in relation to higher skilled posts such as speech and language therapy, occupational therapy, assistant psychologists and learning disability nurses to meet demand 4. Increase the awareness and skill levels of existing health and social staff in relation to the Physical Health needs of people with Learning Disabilities and/ or Autism to reduce demand across all services 5. develop employment opportunities for people with learning disabilities and autism
Social Care	Strengthening of relationships to nurture market offer	Developing a range of housing and care provision, including care for more complex cases Developing “getting a good life” initiatives

3.7 Wirral Health and Care Commissioning are working with NHS England, Cheshire and Wirral Partnership NHS Foundation Trust and care provider organisations to achieve a different range of services that will rely less on hospital admissions and care in acute settings. Service development will be within the budget available and NHS England are supporting with additional non-recurrent funding in some areas.

3.8 The Learning Disability Strategy (2017) states a shared vision: “People with learning disabilities in Wirral live good lives as part of their community with the right support, at the right time, from the right people”. As part of this vision we aim to ensure that all people with a learning disability in Wirral have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a suitable home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life.

3.9 Progress against the delivery of the Learning Disability Strategy and Wirral Plan pledge is reported regularly to the Adult Care and Health Overview and Scrutiny Committee.

A summary of some key areas of progress is below:

- The employment rate for people with a disability registered “Equality Act core/Work Limited Disabled” is up 22.1% since the start of the Wirral Plan and is currently 45.8%.
- 85% of people with a learning disability live in their own homes.
- 300 new units of extra care housing will be delivered by 2021/22, with the first schemes for people with a learning disability being already occupied.
- People with a learning disability who are supported in hospital assessment and treatment beds for extended periods have reduced from 10 to 4 and we are now on target (Transforming Care Programme).
- More supported internship placements have been made available.
- Assistive technology developments are being trialled.
- Progress against the delivery of the Learning Disability strategy is monitored through a subgroup of the All Age Disability Partnership Board.

3.10 In relation to the TCP programme specifically key progress to note is the reduction from ten inpatients to four. This meets our NHSE target of four, and work is continuing to ensure that admissions only occur when required, and that discharges are planned collaboratively from the date of admission.

3.11 New services have been commissioned through social care providers which have enabled the safe hospital discharge of people with a learning disability and/or autism. Additionally, commissioners have are working collaboratively with service providers to achieve more flexible and responsive models of care. This, together with recent investment in fee rates for learning disability supported living providers creates a sustainable and responsive care market.

3.12 Integrated teams have been developed in partnership with Cheshire and Wirral Partnership NHS Foundation Trust (CWP) in 2018 and Wirral Community NHS Foundation Trust (WCT) earlier in 2017. Services have been arranged under Section 75 agreements and have involved the transfer of approximately 370 staff to the NHS under TUPE arrangements. These services are starting to see better outcomes for people with less duplication, better care coordination of health and care support, and steps are now beginning to be made to arrange support services on a neighbourhood model based around people’s natural communities.

3.13 Cheshire and Wirral Partnership NHS Foundation Trust are developing their workforce and their intensive support service. Workforce development is planned which includes professional staff teams as well as care staff and support workers within independent care organisation.

3.15 The existence of the Pooled Budget has promoted truly joined up working, where professionals are working together to meet the needs of the person, without the need for negotiation on which budget should pay the costs associated with the care that is needed.

3.16 Work is in the planning stage to enhance the support offer to young people and adults who have an autism only diagnosis. This involves working with partners to develop a support offer that is delivered with a community focus, with easy access and with opportunities to engage with a range of organisations and services.

4.0 FINANCIAL IMPLICATIONS

4.1 The budget for service for people with a learning disability and/or autism is held in a Pooled Budget for 2019/2020. The budget is subject to delivery of efficiencies through achieving greater levels of independence within the population, using assistive technologies and improved housing to create different models of care delivery, more choice and control for people together with better health outcomes.

5.0 LEGAL IMPLICATIONS

N/A

6.0 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

N/A

7.0 RELEVANT RISKS

N/A

8.0 ENGAGEMENT/CONSULTATION

8.1 The Wirral Plan, Healthy Wirral Plan, All Age Disability Strategy and Transforming Care Programme have been subject to significant engagement and consultation.

9.0 EQUALITY IMPLICATIONS

9.1 There is no relevance to equality.

REPORT AUTHOR: *Jason Oxley*
Assistant Director of Health and Care Outcomes
telephone: (0151) 666 6324
email: jasonoxley@wirral.gov.uk

HISTORY

Meeting	Date
Joint Strategic Commissioning Board	28 May 2019
Joint Strategic Commissioning Board	4 December 2018
Adult Care & Health OSC	27 November 2018
Health and Wellbeing Board	14 November 2018

This page is intentionally left blank