WIRRAL HEALTH & WELLBEING BOARD

15 APRIL 2015

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

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

1.2 Initially, NHSE have invited interest in four models:

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

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

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

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

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

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

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

2.0 **RECOMMENDATIONS**

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

APPENDIX 1: Vanguard Registration of Interest

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

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

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

Key participating health and social care local organisations involved include –

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

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

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

Key Partner Organisations to this application include –

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

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

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

Q2. What are you trying to do?

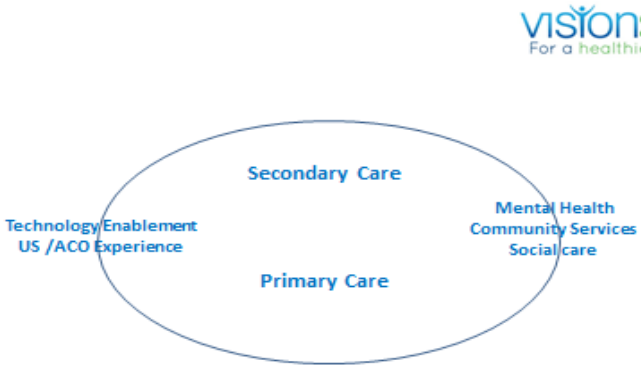
(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

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

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

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

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



Wirral Health Partners

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

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

The Wirral peninsula, a population of 330,000 has many of the challenges seen in other areas of England with the added challenge that Wirral has the largest gap in Disability Free Life Expectancy (Marmot indicators 2012) for males and females for any authority in England (20 years for men, 17 years for women). It has a relatively high older population and relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole and the population over 85 is projected to increase by 29.9% by 2021. The gap in life expectancy between the most and least affluent within Wirral was 14.6 years for men and 9.7 years for women. (Marmot indicators 2012). In this regard, the Wirral provides ***an ideal test bed for the whole NHS*** for the development of new models of care, as indicated by our highly diverse range of health needs and opportunities, but with a high degree of co-terminosity of health and social care boundaries and care provision.

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

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

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

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

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

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

Delivery partners

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

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

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

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

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

Wirral Health Partners model

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

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

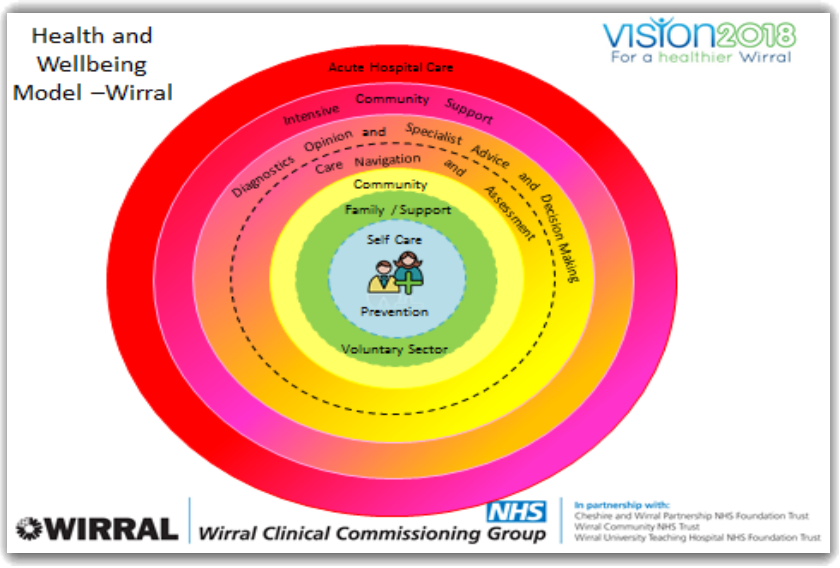
- Integrated care services
- Integrated world class IT systems and advanced predictive analytics
- Patient and citizen engagement and activation
- Aligned incentives and payment models
- Active prioritisation of future workforce planning and implications of new models of care

Integrated care services

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

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

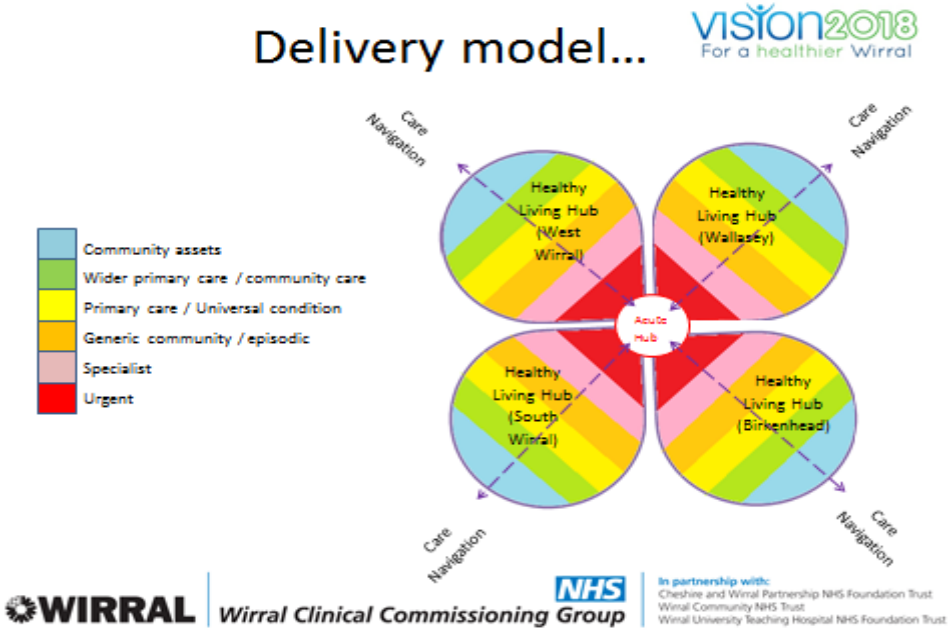
Figure 2: Health and Wellbeing Model



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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By April 2016 we anticipated we will have addressed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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