

Wirral Health and Care Commissioning
Commissioning & Transformation Strategy
2018-2021



Final Draft ONLY
Version 0.15
Date: 17.5.2018

1. EXECUTIVE SUMMARY

This Commissioning and Transformation Strategy outlines the high level commissioning intentions of the integrated commissioning team up to 2020/21.

NHS Wirral CCG and sections of Wirral Council are coming together from April 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 constrained funding, increasing demand, fragmentation of services and the need to deliver better health, better care and better value for the people of Wirral.

The ambition of providing services at the most appropriate local 'place' level has led to development of the '51-9-4-1 model' based on supporting health and delivering care at the most appropriate level. The intention is for services and pathways of care to be delivered through the 51 (as at January 2018) General Practices, nine neighbourhoods, four localities and one district. Development of the nine neighbourhoods is a priority for 2018/19 as this will be the cornerstone of place based care. Neighbourhood teams, with representatives from a variety of health and care disciplines and organisations, will be led by a GP, and will focus on the implementation of care to meet the needs of people within the neighbourhood.

By 2021/22 WHaCC will have a single multi-year contract with the PBCS for the delivery of agreed population based outcomes. The contract will incentivise a shift in resources to community, primary care and prevention services and initiatives to achieve a reduction in demand on hospital and long term care services.

In order to enable the transition and development of a PBCS, Wirral Integrated Commissioning will phase in the approach for segments of the population as follows:-

- 2019/20 – older people (50+) – with a focus on frailty pathways
- 2020/21 – all adults
- 2021/22 – all age population

Collaborative work will be undertaken during 2018 to develop the prospectus, which will outline the required delivery of care, for the first segment of the population. Wide engagement will be essential to ensure that the prospectus is co-produced with the public and wide health and care provider system. The prospectus will outline the agreed outcomes important to the people of Wirral and define how services can be transformed to meet these outcomes. Providers will be required to work collaboratively together to deliver integrated services/pathways, which are sustainable, resilient and flexible to meet the holistic health and care needs of patients and improve patients' experience and outcomes.

During the next two years WHaCC will continue to commission services in different ways and identify opportunities to facilitate the development of a PBCS. We will seek to develop formal contracts only with Providers who are working in collaborative arrangements required to deliver the defined outcomes. We intend to use contracting models in these areas to move towards the new PBCS approach, these will be viewed as enablers supporting the system move towards the aim of a PBCS by 2021.

2. INTRODUCTION

This Commissioning and Transformation Strategy sets out the key priorities and plans of the NHS Wirral CCG and Wirral Council partnership (known as *Wirral Health and Care Commissioning*).

From 2020/21 Wirral Health and Care Commissioning (WHaCC) will undertake place based commissioning to improve population health outcomes in Wirral. This strategy outlines our vision, how we will move towards the commissioning of high level population based health and care outcomes, and the timeline for achieving this change.

Our strategy is intended to support, in a phased approach, a level of collaboration between local providers that enables the development of a *Wirral Place Based Care System (PBCS)* focused on people and not organisations. A timeline is shared within this Strategy for the stepped changes that are required in order to achieve our ambition of a PBCS. The new commissioning model outlined in this document brings together health, care and public health resources in one place (under the WHaCC umbrella) to drive the necessary reforms and innovation needed to support the delivery of PBCS.



Our strategy is framed around the need to improve health and care outcomes for Wirral residents. The case for change within this strategy is clear that we have opportunities to improve our outcomes. Transformation in the way we commission and deliver services is required and supported by all parties through the Healthy Wirral Partners Board and by Wirral Health & Well Being Board partners.

The commissioning priorities and work programmes described in this strategy are designed to drive the work of our newly integrated commissioning team during the next three years. They are also designed to help our providers to design and deliver local health and care services which are sustainable, resilient, flexible and able to adapt to the changing future needs of our population and improve quality of life.

This Commissioning & Transformation Strategy is a living document which will change and develop as the new system evolves and will be reviewed annually.

3. STRATEGIC CONTEXT

The Strategy has been developed in the context of a number of national and local drivers. These include:

Local

- *Healthy Wirral Plan*¹ www.wirralccg.nhs.uk/healthy-wirral/ - Healthy Wirral is a partnership plan with the aim of transforming how health and wellbeing services are delivered and designed in Wirral, putting residents at the heart of services.
- *The Wirral Plan: A2020 Vision(2015)* ² www.wirral.gov.uk/about-council/wirral-plan-2020-vision – The Wirral Plan is a set of twenty pledges which the Council and partners are working to deliver by 2020. The plan has three main themes: People (protecting the most vulnerable in the borough); Business (driving economic growth) and Environment (improving the local environment).
- *NHS Wirral Clinical Commissioning Group Operational Plan (2017/18)*³ www.wirralccg.nhs.uk/about-us/plans-publications-and-reports/ - A one-year operational plan which describes the NHS Wirral Clinical Commissioning Group's (Wirral CCG) actions and priorities throughout this period.
- *Wirral Residents Live Healthier Lives Strategy (2016)*⁴ www.wirralintelligenceservice.org/media/2119/residents-live-healthier-lives-strategy.pdf www.england.nhs.uk/wp-content/uploads/2016/04/gpfp.pdf www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdfGP- The strategy is looking to address lifestyle change and work with local people to support them to take control over their health and wellbeing.

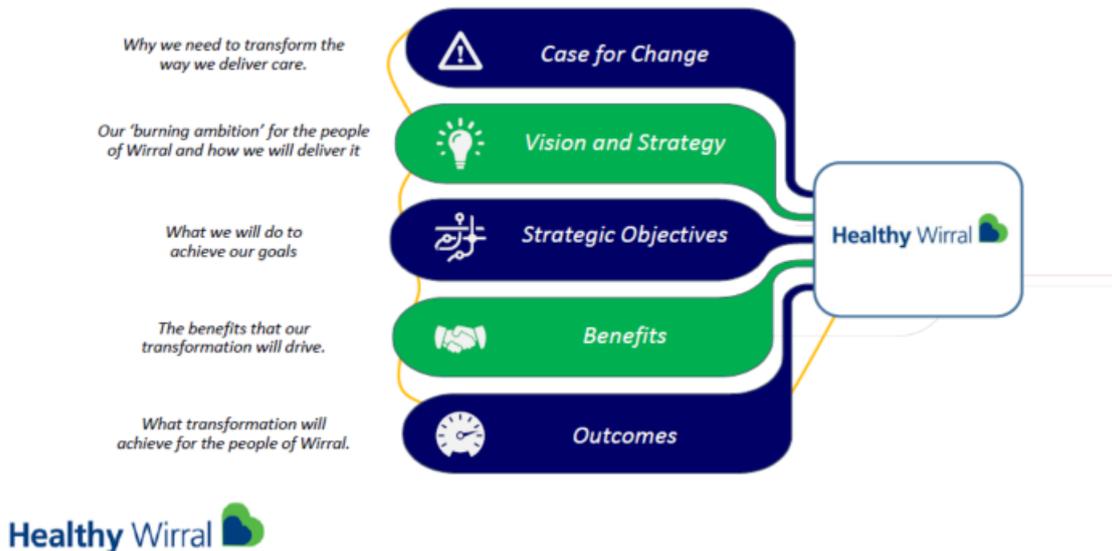
National

- Better Care Fund – Care Act (2014) drives integration of health, care and other public services
 - *NHS 5 Year Forward View (2014)*⁵ www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf - sets out the strategic vision for the NHS by 2020/21. It details a shared view on how services need to change and the models of care that will be required in the future.
 - *Next Steps on the NHS Five Year Forward View (2017)*⁶ www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf- sets out the strategic vision for the NHS by 2020/21. It details a shared view on how services need to change and the models of care that will be required in the future.
 - *General Practice Forward View (2016)* – sets out the NHS strategic plan for the development of Primary Care by 2020/21
-

- *Five Year Forward View for Mental Health (2016)* – sets out the NHS strategic plan for the development of mental health services by 2020/21
- *Transforming Care Programme for Learning Disabilities and/or Autism (2015)* - national strategy for improving health and care services so that more people can live in the community, with the right support, and close to home.
<https://www.england.nhs.uk/learning-disabilities/care/>

None of the above narrative is new and whilst all the above strategies and plans have similar aims and objectives there has not previously been a single, place based, narrative that brought together a “Golden Thread” for the Wirral health and social care system and local people. The Healthy Wirral Partners Board therefore came together in May and June 2017 to agree a single Case for Change, Mission, Vision, Strategy, Benefits and set of Strategic Outcomes – a golden thread that key local stakeholders could buy into providing partners with a core baseline against which to transform. This single version of the truth has been used as a reference for the commissioning and transformation strategy presented in this document and can be used track our progress going forward.

Figure 1– The Wirral Golden Thread

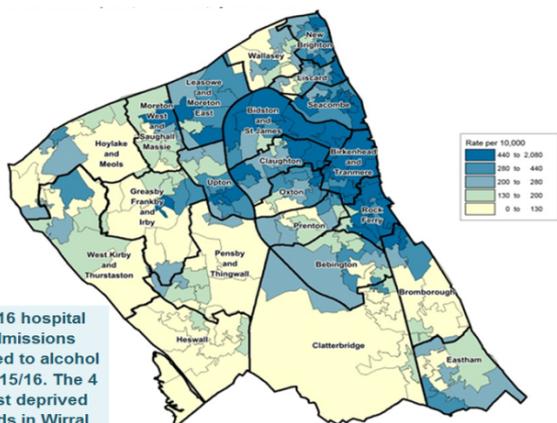


4. CASE FOR CHANGE

Health & Well Being

Wirral's population is just over 321,000 people. It is a borough of contrasts, both in its physical characteristics and demographics. Rural, urban and industrialised areas sit side by side in a compact peninsula. Despite its small area, the health and wellbeing of people in Wirral is varied, both across the peninsula itself and when compared with the England average⁷ Public Health England: Wirral Health Profile 2017. <http://fingertips.phe.org.uk/profile/health-profiles> (see also Appendix B).

Wirral is one of the 20% most deprived districts in England and about 24% of children live in low income families, with significant problems relating to alcohol usage in both adults and young people.



9,516 hospital admissions related to alcohol in 2015/16. The 4 most deprived wards in Wirral had the highest rates of all

The number of physically active adults across Wirral is significantly lower than the England average.

These issues present a difficult challenge for public health, commissioners and providers of health and care services across the region.

For the younger population there are some key issues to address:

- One in four children in Reception are overweight or obese
- One in three children in Year 6 are overweight or obese
- The number of Looked after Children is still too high at 842 (as at 8th January 2018)
- A head teachers survey (Dec 2017) which asked about the key issues affecting the mental health and wellbeing of pupils identified; lack of self-confidence, low self-esteem and poor self-image as having the greatest impact. This was followed by exam/school pressure, behavioural problems and issues in the home/family environment.

People are living longer and it is estimated that by 2031 the proportion of older people aged 65 and over will have increased faster than any other age group. This is key, because older people are more likely to be living with complex health conditions, necessitating regular intervention from health and care services.

IF WIRRAL WAS 100 PEOPLE



32 OF THEM WOULD LIVE IN AREAS DESCRIBED AS DEPRIVED

Source: Wirral Joint Strategic Needs Assessment 2015

Life expectancy is 11.7 years lower for men and 9.7 years lower for women in the most deprived areas of Wirral compared to the least deprived areas.

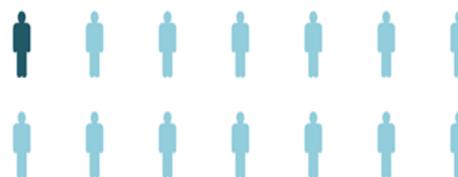
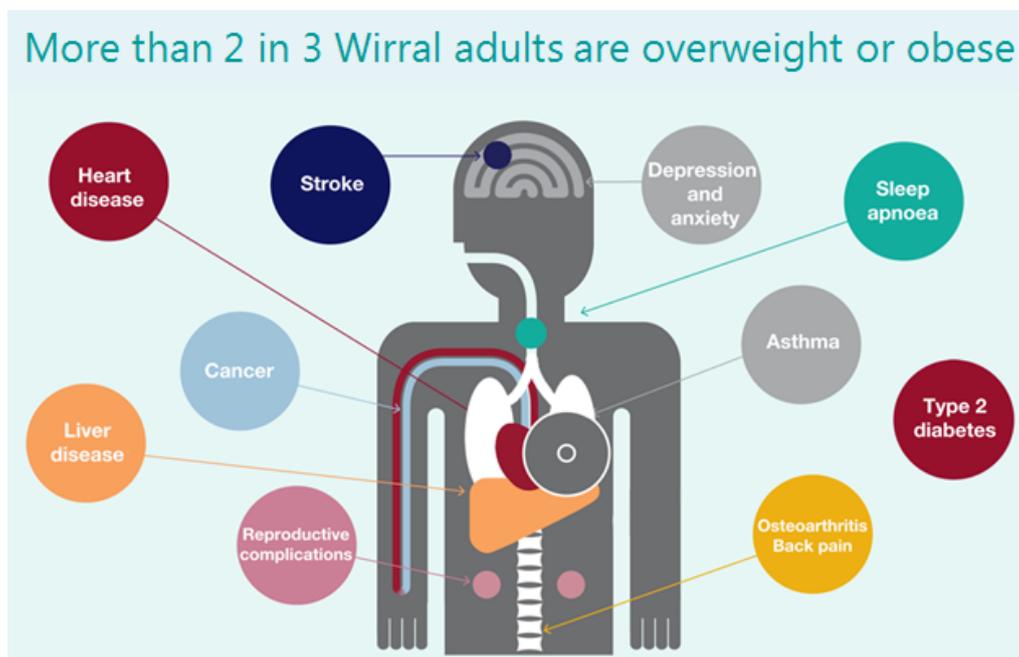
IF WIRRAL WAS 100 PEOPLE



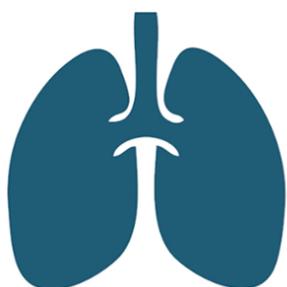
68 OF THEM WOULD BE AN UNHEALTHY WEIGHT (BMI THAT PUTS THEM IN THE OVERWEIGHT OR OBESE CATEGORY)

Source: Wirral Joint Strategic Needs Assessment 2015

Consequently, health and social care services across Wirral - in line with the rest of England – are experiencing a period of sustained financial pressure. Demand for health and care services are increasing, at the same time that the funding for health and care services remains flat (or is decreasing in real terms)⁸ Wirral Council and NHS Wirral Clinical Commissioning Group Integrated Commissioning : Financial Risks and Mitigations (PwC, September 2017). The statistics below provide a snapshot of some of the issues that Wirral faces:



20,000 people in Wirral have diabetes. This means 1 in every 14 adults are more at risk of complications such as sight loss, stroke, heart attack and amputations.



8,400 people with COPD in Wirral (2016/17)
 Prevalence is 25% higher in Wirral than England
 Three emergency admissions each day due to COPD (2015/16)

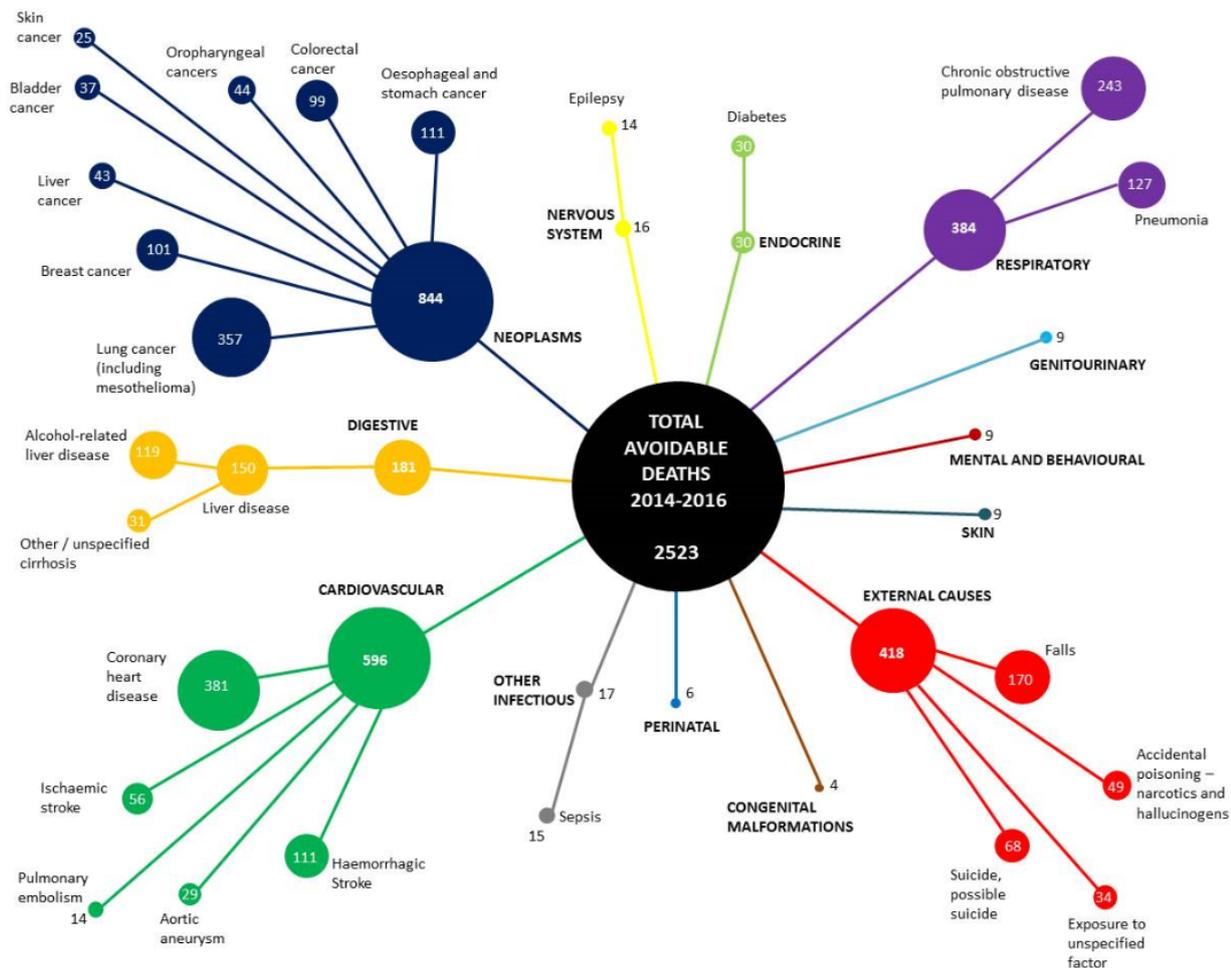
People with mental ill health were more likely to:

- have an emergency admission
- stay longer in hospital
- be admitted overnight

What causes Wirral residents to die early?

The key reasons of causes of what is classed as avoidable deaths has been analysed by Wirral’s Intelligence Service. The main causes are outlines in Figure 2 below:

Figure 2 - Causes of avoidable mortality in Wirral 2014-2016 (calendar years) pooled data



As Figure 2 shows, the largest cause of avoidable death in Wirral for the period 2014-16 was Cancer (neoplasms). Definitions of avoidable conditions are produced nationally and relate to specific age ranges¹². For example, a death from breast cancer is considered avoidable if it occurs under the age of 75, whereas deaths from falls are avoidable at all ages

Cancer accounted for 1 in 3 of all avoidable deaths in Wirral (n=844) in this period. The next largest cause was cardiovascular disease (CVD), which accounted for 1 in 4 of all avoidable deaths (24% or 596 deaths). Reductions in smoking and other risk factors produce reductions in CVD more quickly than cancer. Hence, deaths from CVD are falling while deaths from cancer are not reducing as quickly. It is worth noting that alcohol will have had a wider impact than the 119 deaths from alcohol-related liver disease reported, as it will have made a sizeable contribution to deaths from other causes such as circulatory disease, cancer and digestive disease.

In addition to the above drivers, expectations from the public have increased and there is rising public expectations of the NHS for personal and convenient care and effectiveness of prevention. Services need to deliver more personalised, patient centred services. Expectations have also risen due to new forms of diagnosis and treatment which have contributed to long term improvements in population health.

Financial Pressures

The Wirral health and care system is facing financial pressures and changes are required, in order to ensure health and care services are sustainable in the future and able to meet the predicted changes in the Wirral population. Within Wirral, organisations are facing significant financial challenges. A “do nothing” approach would see the expected funding gap over the next five years increase substantially.

Between 2011/12 and 2015/16 spending on NHS Foundation Trusts and NHS Trusts increased by 11%, while Council spending on adult social care has reduced by 10% since 2009/10 (17% in real terms). Adult social care is the most unpredictable element of a Council’s budget and is not ring fenced, this makes it almost impossible for councils to completely protect social care from cuts. During the same period the number of ‘people aged 65 and over’ has increased in England at more

than twice the rate of the increase in the population as a whole. It is more difficult for people to get publicly funded social care, with the numbers of people receiving social care having fallen by 25% since 2009. This lack of access to social care is increasing the potential risk of people being delayed in hospital when they are ready to be discharged.

The continuation of these trends will result in three widening gaps:

- 1) A health and wellbeing gap – a failure to prioritise primary prevention, health promotion and self-care will stall improvements in life expectancy and health inequalities will widen
- 2) A care and quality gap – unless care is integrated and re-designed to tackle variations in quality and safety, then patients' needs will go unmet
- 3) A funding and efficiency gap – if demand is not controlled across health and social care, and if services are not integrated to maximise efficiencies, minimise duplication at a time of resource constraints, the financial challenges and pressures for the commissioners of health and care services across Wirral will result in worse services, fewer staff, deficits and restrictions on new treatments.

The financial challenge facing the Cheshire & Merseyside health system is significant. The 'do nothing' financial gap for this area is forecast at c.£908million by 2020/21⁹ www.democracy.wirral.gov.uk/documents/s50037828/STP%20Update%20with%20Cheshire%20and%20Wirral%20LDS%20Plan%20161116.pdf with Cheshire and Wirral facing a c.£314m financial gap. The NHS in Wirral is facing an estimated £100m gap in the same period¹⁰ Source: Outputs from Healthy Wirral Accountable Care Workshops (May & June 2017). Workshops facilitated by PwC involved: NHS Wirral CCG, Wirral Council, Wirral Community NHS Trust, Wirral GP Provider (GPW-FED) Limited, Wirral University Teaching Hospital NHS Foundation Trust, Cheshire & Wirral Partnership NHS Foundation Trust and Primary Care Wirral Limited. It is forecast that Wirral Council will be required to reduce its spending or generate more income, by at least £130 million by 2021¹¹ www.wirral.gov.uk/sites/default/files/all/About%20the%20council/Performance%20and%20spending/2017-2021%20Medium%20Term%20Financial%20Strategy%20.pdf.

By 2020/21 the financial position of the health and care system in Wirral is projected to result in a £124 million deficit if no changes are made to how services are delivered.

Within the Healthy Wirral Programme we have committed to creating a health and care system that will be financially balanced and sustainable by 2020/21. Delivering our ambitions for a new way of commissioning, as outlined in this strategy will contribute to meeting the financial challenge whilst also ensuring that services meet the needs of local people by achievement of outcomes agreed with them and the system.

The Key Issues

There is a strong case for changing the commissioning and delivery of health and care in Wirral, as the current system is not sustainable for the following reasons:

- An ageing population is increasing demand and pressure on the system
 - Wirral people have poor health outcomes relative to the England average
 - There is a wide variation in outcomes across Wirral – there is a difference in 11 years in life expectancy between the east and west side of Wirral peninsula
 - Our health and care organisations do not always work effectively together so people do not always receive joined up care
 - Too many people spend too much time in hospital, when they could be cared for in a more appropriate setting
 - People have increased expectations of the care they should receive
-

- Without significant transformation in both the commissioning and provision of health and care there will be not be the workforce available or sufficient funding to maintain the quality and standards that we want local people to experience.

5. MISSION & VISION

System Wide Transformation – Towards Place Based Commissioning

The Healthy Wirral Partnership recently agreed a mission and vision statement as below:

Mission

Better health and wellbeing in Wirral by working together

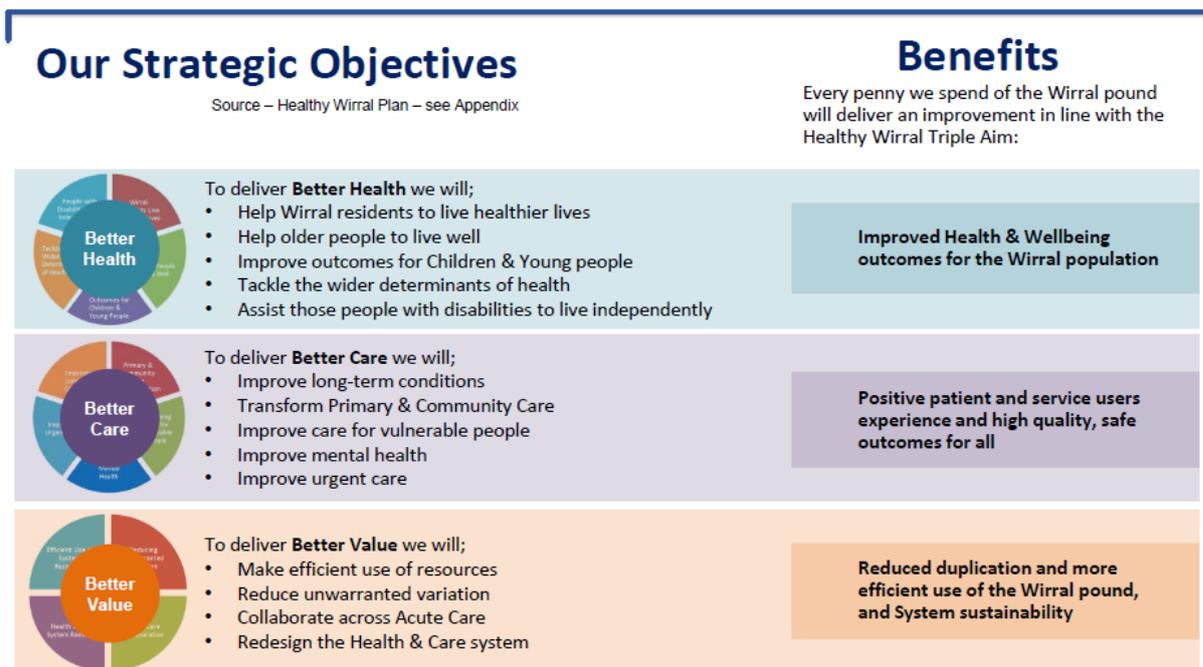
Vision for Wirral Place Based Care System

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.

The vision stresses the importance of preventing ill health and our people being in the right place at the right time. The outcomes highlighted in blue are what local people can expect to experience.

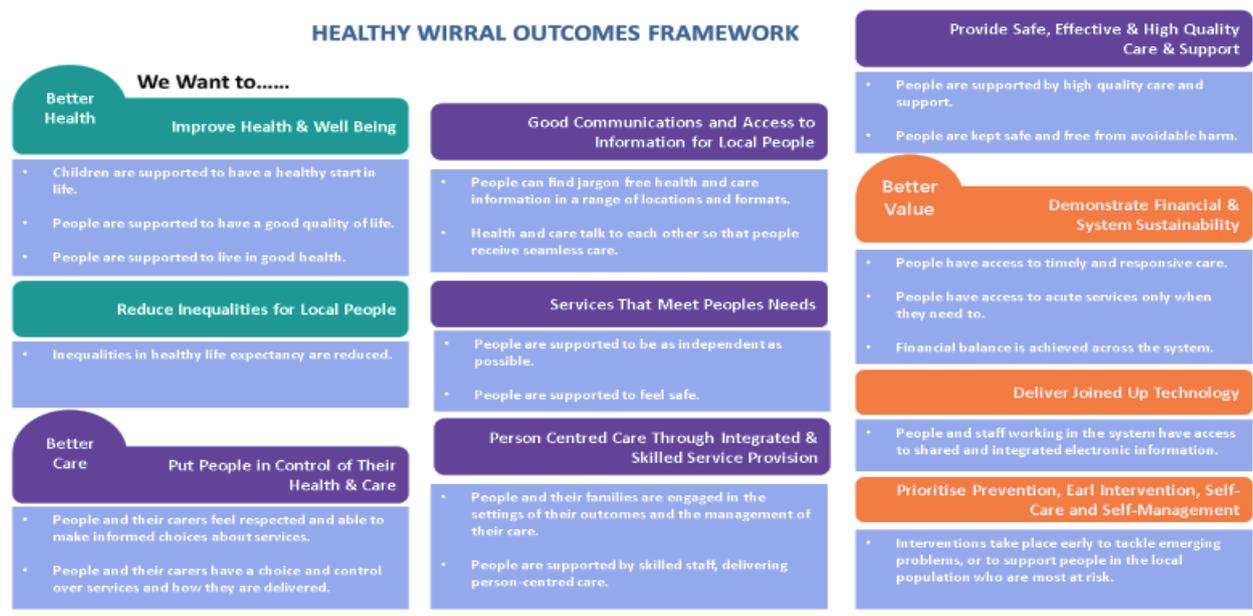
The members of the Healthy Wirral Partners Board are committed to working together to ensure that every penny we spend of the Wirral pound will deliver an improvement in line with the strategic objectives of Healthy Wirral which are outlined in figure3 below.

Triple Aim: Figure 3



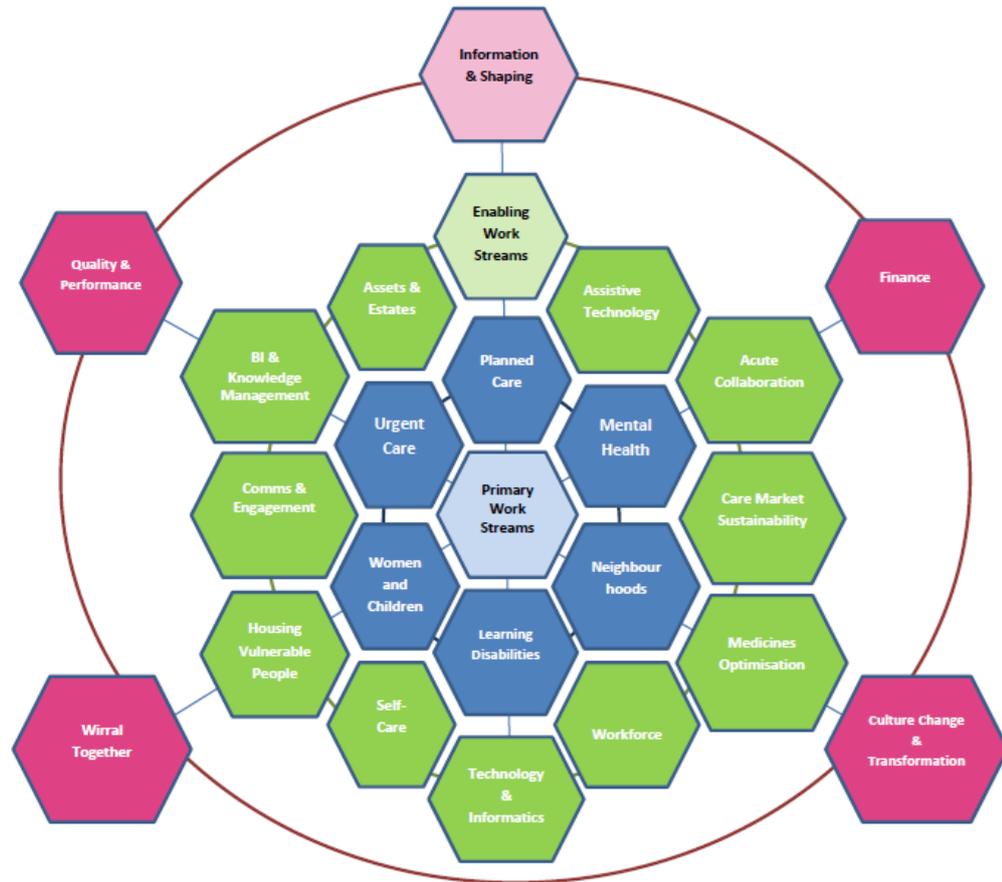
A proposed outcomes framework is included here (and in more detail within the Appendix) which shows the partnership’s commitment to measuring the progress of transformation plans against the health and care priorities that matter to local people. For local people using health and care services in Wirral that means a way to measure whether the services they receive (activities) will improve their health, wellbeing and experience of care and support (outcomes). The full outcomes framework is included in the Appendix, including indicators and measures. Before these draft outcomes are adopted, work will be undertaken with people and other stakeholders to agree the outcomes indicators, measures and level of achievement expected. A high-level summary of the outcomes framework is provided below.

Figure 4 – Healthy Wirral Outcomes



As part of the future place based care system, these outcomes will be reviewed and additional outcomes developed in partnership with local people and the wider health and care system.

In order to deliver the Healthy Wirral and 2020 Plan, Wirral Partners Board have agreed a number of enabling and primary work streams which are shown below. Each of these have identified leads from across the system and will report progress. The primary work streams are also reflected in the commissioning intentions described within this Strategy.



6. Wirral Health and Care Commissioning (WHaCC)

In order to facilitate the development of PBCS fundamental changes are required in how commissioners and providers work together. In December 2017 Wirral Council and Wirral CCG presented papers through their governance arrangements advocating the development of joint commissioning arrangement for health and social care. Both the Council Cabinet and CCG Governing Board recognised that to deliver sustainable high-quality care to the populations they served that they needed to look beyond their own organisational boundaries to ensure that collective resources could be deployed to maximum benefit. The proposals for a new commissioning model for Wirral to reflect this stated ambition have been in development for over a year.

Our vision for the commissioning model is designed to:

- Drive implementation of the new arrangements
- Be aspirational

Vision for Wirral Health and Care Commissioning Model

A single, fully integrated commissioning body (joint vehicle) with the delegated authority to commission all age health, social care and public health services for the Wirral population – using a single budget, under a single governance arrangement and a fully integrated management structure.

It is assumed that Commissioners will remain statutorily responsible for improving the health and wellbeing of the populations they serve. The role of the CCG and Council as system leaders is crucial in shaping the provider landscape, orchestrating the set of provider relationships that allow the PBCS to come into being and ensuring that the PBCS is commissioned in a way that delivers maximum value.

WHaCC will be responsible, in conjunction with residents and patients, for setting the population level outcomes that the PBCS will be expected to deliver and for holding the PBCS to account for delivery. It is recognised that commissioners will need to move to one contract for the future PBCS partnership. Our role will be to:

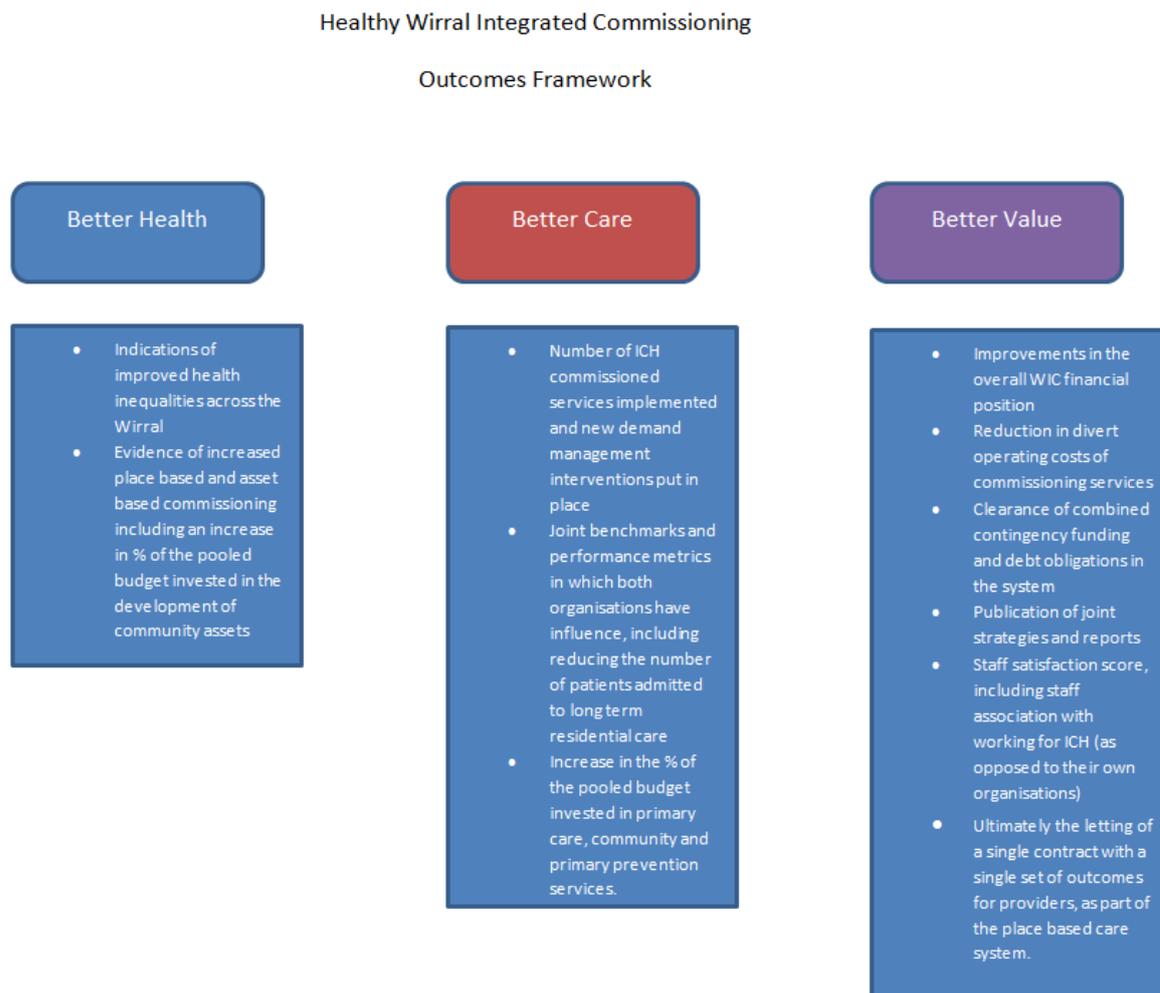
- Commission services that provide better health, better care and better value by improving health and care outcomes for the people of Wirral
- Focus on place and population health needs, taking a holistic view of health, care and wider public-sector reform - setting outcome measures at the population level and defining the broad models of care required from providers
- Ensure statutory duties are met
- Ensure that outcomes are co-produced with the people of Wirral and that commissioned services address equity and reduce the variation in health outcomes and years of life with disease burden currently experienced by local people.
- Develop integrated health and care strategic planning arrangements
- Ensure alignment with broader public services e.g. employment, education and housing
- Keep abreast of national and international best practice ensuring that this is implemented by providers as appropriate
- Commission population based, multi-year placed based contracts – we will commission a system on behalf of the whole population not services from individual providers
- Support the development of a Place Based Care System that provides safe, high quality, evidence based, appropriate services offering choice, where appropriate, and control to residents
- Continually assess the requirements and needs of the population to ensure our contracts with the provider system deliver population based outcomes in line with national benchmarks
- Develop innovative contracts to enable services to work together and hold providers as a whole to account for delivery against agreed outcomes
- Create incentives and disincentives to deliver aligned place based service aims and outcomes, to support innovation and best practice
- Undertake strategic market shaping and oversight
- Ensure financial, performance and quality targets are met – on a system wide basis
- Ensure continuity of care and mitigate against market failure
- Maximise the use of technology as part of the solution required to meet needs of the population
- Continue to develop the right intelligence to understand our population now and in the future to ensure commissioning based on resident need.

As part of the WHaCC's approach to commissioning we will also emphasise the need to build and enhance an 'asset based' and 'place based' population management approach working with the four localities and nine neighbourhoods making up the Wirral peninsula.

Our ambition is to drive significant behaviour change across our population, organisations and workforce. Our population need to be less reliant on public services and more proactive in their lifestyle choices. Our organisations need to think beyond their organisational boundaries towards people and place. Our workforce needs to think differently in their relationships with local people and with other organisation.

7. COMMISSIONING INTENTIONS

WHaCC has a number of high level aims which we wish to achieve through our commissioning activities.



The principles we will adopt are detailed below:-

- A. **Empowering Citizens and Communities.** We want to support local people to take control of their own lives, health and care. This will require a significant culture change in our organisations and communities which will shift the balance of power from services and service providers to citizens themselves. We need our commissioning process to enable local people to develop the skills and confidence to take control of their own lives, reducing dependency on our traditionally paternalistic health and care system. New commissioning approaches to achieving behaviour change are a key feature of our strategy. Our approach will be asset based, co-production, utilising social capital, inclusive and equitable.
- B. **Commission for the 'Whole Person'.** We will commission services that will take responsibility for accommodating and supporting the psychological, emotional, economic and social aspects of people's lives in seeking to improve their health, wealth and wellbeing; this includes taking account of the needs of the wider family. We are committed to supporting the most vulnerable people in the community and where long-term support is required this will be community and outcomes focused to maximise independence and wellbeing.

- C. **Create a Proactive and Holistic Population Health System.** While interventions focussed on individuals and integrating care services for key population groups are important, these must be part of a broader focus on promoting health and reducing inequalities across whole populations. We want to improve outcomes from individuals, local communities and the whole population.

Our commissioning activities need to support the development of a local population health system that improves the conditions in which people are born, live and work. The most significant factors that impact on health and wellbeing include poverty, housing, education, lifestyle and employment. It will therefore be a real advantage of the close alignment of WIC to these wider community factors.

We need to use our collective commissioning capability and capacity to support the development of strong whole system leadership that will tackle these wider determinants of health and wellbeing. We also need to reduce the variance in health and wellbeing outcomes across our local system; reducing inequalities across Wirral.

- D. **Take a 'Place-Based' Commissioning Approach.** Take a place based commissioning approach to improving health, wealth and wellbeing. By this we mean:

- Operating as one integrated system, focussing on people and places rather than organisations or sectors, pulling services together and integrating them around people's homes, neighbourhoods and towns. This will lead to more 'one stop' appointments for people where they can access a range of help at the same place and time ensuring efficiency is also achieved in the delivery of services.
- By having a rich picture of local needs and assets we will harness these assets that exist in communities to align and co-ordinate them with local government, health and care services, for the benefit of people living in those communities.
- Increasing community resilience and supporting communities to use their own assets (skills, strengths and resources) to tackle the issues that affect their lives.
- Tailoring commissioning activity and care delivery to the specific needs of local communities taking account of the assets that already exist there, utilising an asset-based community development approach.

- E. **Target Commissioning Resources Effectively.** We have a universal responsibility for population health. However, within this we need to differentially target our commissioning resources to different groups of people e.g. frail and vulnerable people and those that are considered at high risk.

We intend to use an approach that will breakdown the population by place, to enable services to adapt care and resources according to the needs of that place, and the ability to deliver the most benefit; this will also have a positive impact on reducing health inequalities.

We also need to target our resources towards evidence based and cost-effective care, optimising both outcomes and value for money and to actively decommission services that are not value for money and / or are not improving outcomes. WHaCC will agree measures against which these decisions will be made with the people of Wirral and our stakeholders. We will work with people and providers to improve outcomes.

The use of technology and innovative interventions will be key to the delivery of these principles.

We will measure the effectiveness of our strategy using national sources of benchmarking information together with local information to provide us with objective and comparative performance data on the delivery against our outcomes. This will in turn inform our future commissioning intentions and our ongoing priorities.

Development of a Place Based Care System (PBCS)

Wirral CCG and Wirral Council intend to lead the development of a PBCS in Wirral through their actions of becoming an integrated commissioner, and the intention of moving to place based commissioning to improve the population health outcomes.

Placed based care is being developed in response to the challenges Wirral health and care system faces of constrained funding, increasing demand, fragmentation of services and the need to deliver better health, better care and better value for the people of Wirral.

In Wirral the Place Based Care System approach will build on previous efforts to integrate health and care services, across organisational boundaries, including the Better Care Fund. Our local approach will involve an alliance of providers delivering place based integrated healthcare from an integrated commissioner of health and social care. Not all aspects of health and care need to change; indeed there is a great deal to be proud of locally.

This strategy is designed to support the development of a Wirral Place Based Care System within which the providers of services work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them rather than each organisation adopting a 'fortress mentality' in which it acts to secure delivery of their individual contract, regardless of the impact on others. The aim of our PBCS is that local people who access care will have seamless care pathways without any impact of organisational boundaries.

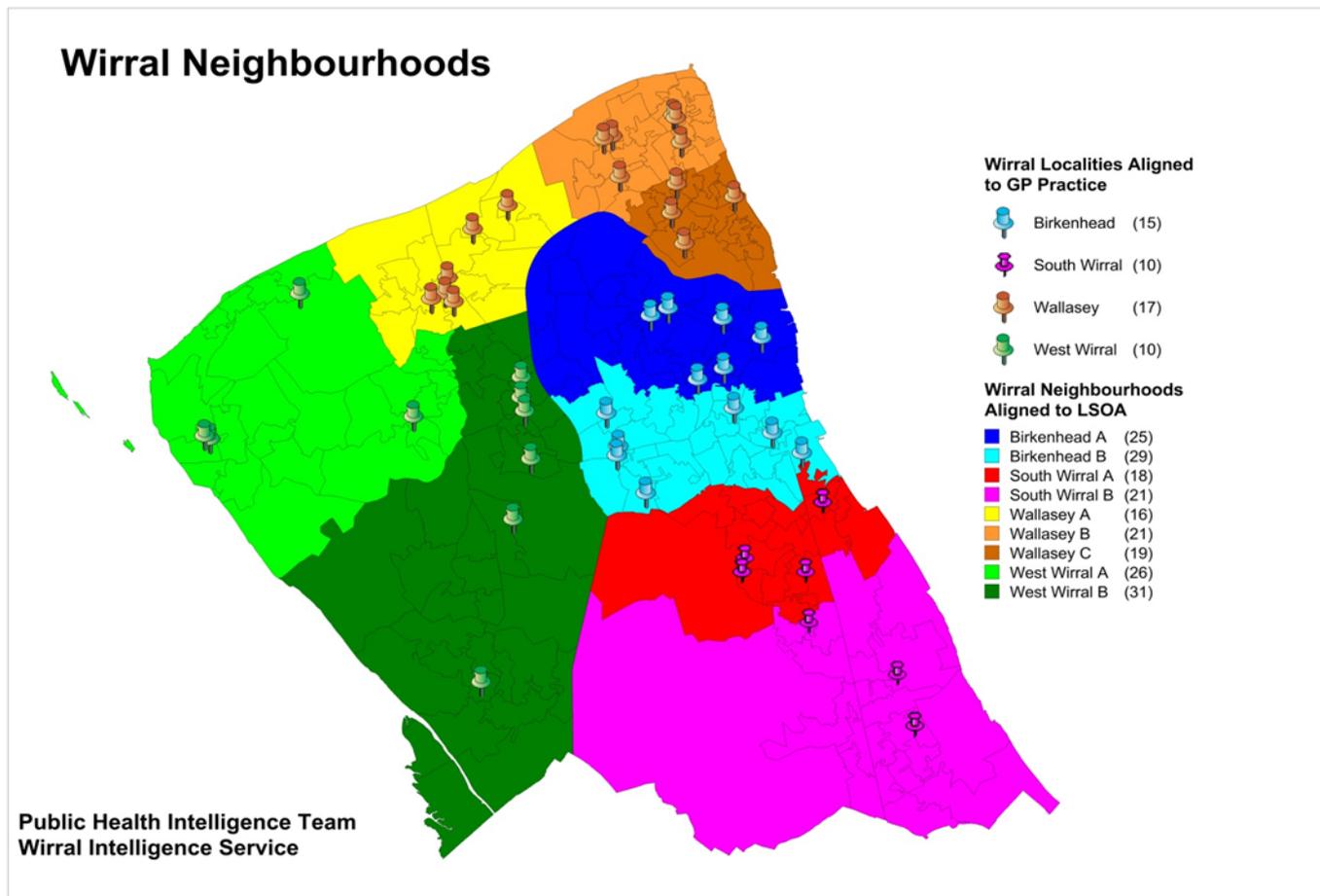
For providers of health and care services there will be a requirement for commitment to work in partnership across a wide range of organisations that impact on the health and care of Wirral residents. It is recognised that there is an important role for the Third Sector and Independent services in the delivery of PBCS.

As part of PBCS it will also be expected that an asset based approach will be adopted. Using asset based approaches considers what the assets within a community are, how assets can be supported and developed, what communities can do for themselves, how individuals and families can be enabled to connect with their community and how this impacts on outcomes.

Development of Place

A focus on providing services at the most appropriate local 'place' level has led to the '51-9-4-1 model' based on supporting health and delivering care at the most appropriate level. The intention is for services to be delivered through 51* General Practices, nine neighbourhoods, four localities and one district. Each of the nine neighbourhoods will be 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. Each of the four localities would have a population of between 60-100,000 residents. The neighbourhoods would be contained within each of the four localities. The district would be where services should only be provided once at this level. Primary care leaders, including General Practice (GPs), will be at the centre of the PBCS, transforming community-based services and care pathways for a defined population.

- 51* Wirral general practices, 'population health' approach
- 9 neighbourhoods serving communities of 30-50,000 people, supporting better coordination and a risk-based approach to care planning
- 4 localities with more specialist services
- 1 Wirral district



Neighbourhood teams will become the cornerstone of delivery of place based care and therefore their development is a priority for 2018/19. Within the neighbourhoods it is expected that services will collaborate to meet the needs of the people in that particular place and these needs may well be different from other places within Wirral. Services will need to flex their approaches towards delivery and to meet these needs and achievement of system outcomes. As General Practices (GPs) are at the centre, services will wrap around GPs to ensure a seamless access point and pathway for people. The neighbourhood teams will be led by a GP to ensure co-ordination of health and care. This is expected to free up GP time as more care will be delivered proactively to people. Neighbourhood services will include a number of community services such as drug and alcohol teams, social care teams, advocacy services, primary mental health and rapid response teams. The expected benefits of the improved co-ordination between these teams include patients having to tell their story once due to shared information, improved knowledge of the place such as what is available in the community to help support people and keep them independent and well, and enhanced crisis prevention and intervention.

Services within the 4 localities are also expected to collaborate with GPs and neighbourhood services to deliver place based care. These services will be more specialist community services such as specialist mental health services, specialist outpatient clinics e.g. memory clinics and rehabilitation services.

The one Wirral district will be provided from one location, such as in-patient hospital services, and such services will also be expected to collaborate to ensure a seamless pathway.

51 GP Practices

There will be no change to the core GP contract national requirements. Involved at this level is the team within the GP practice including all clinicians and those with special interest. These could provide services for other GP practices as per local agreement.

This could include the opportunity to share back office functions across practices.

It is important to recognise that GPs are highly trained and their time should ideally be focused on:

- managing clinical (therefore cost) risk through the long term nature of the professional relationship with the patient
- managing complex patient care
- working preventatively and proactively
- maximising MDT team working (clinical and non-clinical) within the practice and also neighbourhood team engagement
- managing health seeking behaviour, specifically around low risk common conditions

The role of GPs as medical generalist will remain critical for success in delivery of care. This involves deep contextual knowledge of patients and their family and social situation to understand and interpret symptoms and problems. It enables GPs to hold clinical risk in the community without onward referral to other services. Evidence shows that for about a quarter of patients it can help to 'de-medicalise' problems for which medicine may be unable to find an answer.

This role of the GP practice and being able to improve the ease of access to more self-help low level community intervention is a critical aspect of place based care.

Place based care will enable GPs to spend their time more effectively by freeing up capacity as a result of the wrap around services that will be easily accessible.

Neighbourhoods

An integrated workforce, with a strong focus on partnerships spanning primary, secondary, mental health and social care and importantly community and voluntary groups. Neighbourhoods 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.

Neighbourhood teams will work with the GP practices and the overall approach is of one team:

- who know and have affinity with the local population and their needs
- to stratify the neighbourhood population to identify people who would benefit from proactive multidisciplinary support and co-ordinated care planning – those people with rising risk
- to have intervention and priority for addressing those with complex care needs, classed as rising risk and also those that are mainly well.
- with knowledge of people, services and community assets and where people are empowered to make the best choices, plans and actions for health and wellbeing
- who “make every contact count” to promote health and wellbeing.

The neighbourhood leadership team will be led by a GP to ensure co-ordination of the neighbourhood team in the delivery of health and care pathways. There will be a clear focus on the delivery of prevention, early intervention and proactive care to reduce the demand for reactive and specialist care.

Localities

In this footprint the pathways will join with more specialised services and teams that will be available in the four localities across Wirral. These will include more specialist services, such as for specific long term diseases e.g. diabetes, respiratory, memory clinics and will require involvement of more specialist clinical involvement to deliver the patient care. In this part of the model there will be opportunity for the provision of services that are currently provided in the acute hospital, such as some outpatient clinics.

Wirral District

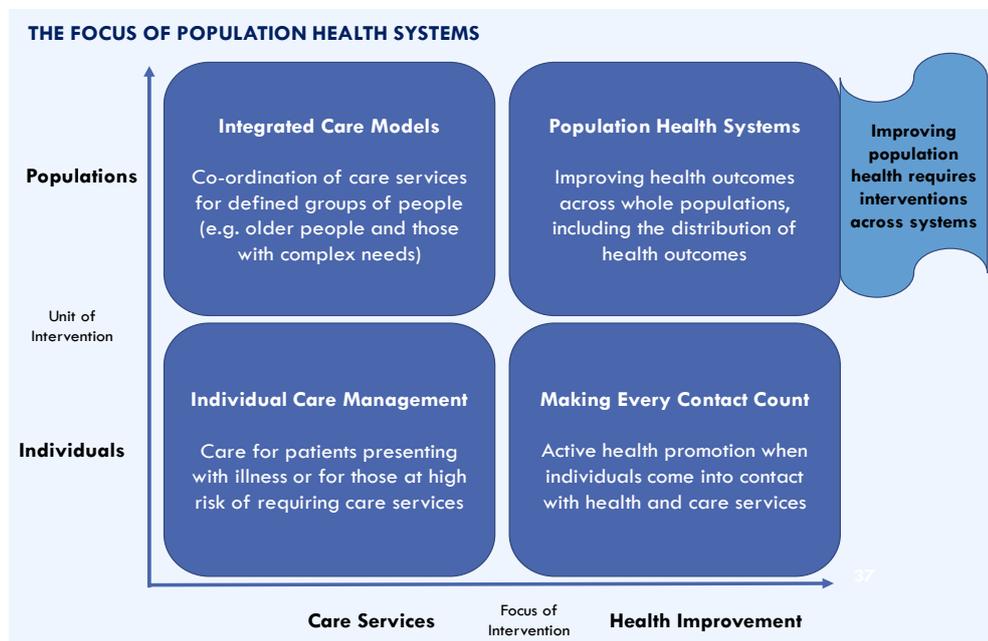
View of overall population group and with services can only be provided at this level, such as provision of inpatient beds and urgent treatment centre. These services will be part of the community offer and the pathway to and from hospital will need to be linked to the work of the neighbourhoods and localities. There will remain a proportion of services that will need to be commissioned across a wider geographic footprint, such as Cheshire and Merseyside. These services require a larger population in order to ensure clinical outcomes and sustainability both clinically and financially can be maintained. Examples of such services are specialised services, emergency and patient transport services and some aspects of obesity services.

Commissioning Approach

To support this journey of moving to PBCS the commissioning priorities and work programmes described in the following section are designed to drive the work of our newly integrated commissioning team during the next two years. As a consequence, they are also designed to help our providers to design and deliver local health and care services which are sustainable, adapt to the changing, future needs of our population and improve quality of life.

In order to develop a Place Based Care System it will be critical to develop the system, the outcomes and how services are delivered with local people. Both commissioners and providers will work in partnership with local people to coproduce the future outcomes and how services are delivered. This will ensure that local people will be at the centre of what their care in their particular 'place' will look like in the future and what improvements they can expect.

As outlined in the figure below, what we are describing here is the use of PBCS as means of delivery of population health. This enables our system to have a wider scope and impact than most of the approaches to integrated care in Wirral and elsewhere in England to date. While interventions focused on individuals and integrating care services for key population groups are important, these must be part of a broader consideration on promoting health and reducing health inequalities across whole populations. **Figure 5 – Health Systems**



Place Based Care System Commissioning Timeline

The ambition of the WHaCC is to commission on a place based care basis, with a capitated budget in place by 2021. The scope of the financial budget will be agreed as we progress towards this date. In order to achieve this goal and to ensure development of a sustainable health and care system, a gradual approach will be adopted, where locally driven evolution will be key. We will phase in this approach for segments of the population, as indicated below:

- 2019/20 – older people (50+) with a focus on frailty
- 2020/21 – all adults
- 2021/22 – all age population

To support the approach described above the ambition of WHaCC is to work with all stakeholders between July and November 2018, to co-produce a prospectus. This will include neighbourhood teams undertaking wide engagement and consultation with local people to ensure that they are involved in how services and pathways are transformed for the frailty population. This feedback will form the detail within the prospectus and will define our placed based commissioning requirements for the frailty population and will include agreement of the definition for frailty. We will outline what is expected from providers to meet the outcomes and requirements of the particular pathways to be agreed for inclusion within this segment of PBCS.

The prospectus will identify our populations needs and the outcomes that are important to the people we serve in their particular place, and this will include defining what success looks like. These outcomes, against which system performance will be measured against, will be linked to our vision and include the proposed outcomes framework shared in the Appendix.

On completion of the prospectus a response will be required from providers of health and care on how the expectations and outcomes within are to be met. As a result of the expected transformation of pathway delivery it is expected that the response will be a collaborative response incorporating the wide provider system, including third sector and independent sector. Within the response, as well as meeting the agreed PBCS outcomes it will also be a requirement for assurance from providers that they will meet the NHS constitutional standards.

Commissioning/Contracting enablers for development of PBCS

As a next step towards the ambition of whole population/ outcome based contract with the Wirral PBCS, our intention is to support the development of the Single Service Model approach i.e. a single contract, for a single population/set of services/ pathways with providers working collaboratively together. We will work with our regulators in order to gain assurance on our approach. Our future commissioning and contracting approach will therefore be based on the following principles:

- Delivering an agreed set of outcomes for our population ensuring our legal duty to involve patients in all aspects of commissioning is maintained
- Enabling providers to work together to deliver integrated services/pathways to meet the needs of patients and improve patients' experience
- Enabling the development of a strategic health and care commissioner with reduced transactional and transformational functionality as this migrates within the remit of the PBCS.

As we transition from volume-based to value-based health and care, the population approach will be fertile ground for incentives around reducing risk, driving appropriate utilisation and improving outcomes.

Contractual approach

Wirral commissioners have sought to integrate pathways through contracting models. There are various options for contracting and formalising how providers can work together in PBCS. WHaCC will work with providers to agree the most appropriate contractual option for PBCS in the development of the prospectus.

These options will include prime contracts, alliance contracts and contractual joint ventures. Wirral commissioners have utilised the prime provider contracting model in order to facilitate providers to work collaboratively and to reduce the transactional burden of contract management on the commissioner. The prime provider moves from potentially many providers holding contracts with the commissioner to one provider, who is responsible for the whole service pathway including

costs, outcomes, quality etc. It is important to note that the prime provider is only one example of a contract framework that can be adopted to enable providers to collaborate across pathways/services. Other collaborative contracting arrangements may be utilised depending upon specific circumstances and outcomes to be achieved and WIC will engage with providers to agree which option wherever feasible.

During the next two years WHaCC will continue to commission services in a different way and have identified opportunities to facilitate the development of a PCBS. These enablers are identified below, and we will seek to develop formal contracts only with Providers who are working in appropriate collaborative arrangements and the most capable to deliver the required outcomes. We intend to use contracting models in these areas to move towards this new PBCS approach to the commissioning of health, care and public health services. These will be viewed as enablers of moving the system towards the aim of a PBCS by 2021 and all such services and contracts will become part of the future PBCS.

- Muscular Skeletal Services
- Drug and Alcohol Services
- Urgent Care Service
- Frailty pathways
- Obesity
- Mental Health – integration of primary and secondary mental health

Figure 6 – Commissioning Timeline

Commissioning/Contracting Enablers

2017/18	2018/19	2019/20	2020/21	2021/22
<ul style="list-style-type: none"> • Diagnostics – Prime Provider Contract – Wirral University Teaching Hospitals NHS Foundation Trust (April 2017). 	<ul style="list-style-type: none"> • MSK – Prime Provider Contract - (Summer 2018). • Diabetes Pathway – Contract Model • Respiratory Pathway – Contract Model • Urgent Care Services – Contract Model TBI (December 2018) • Drug and Alcohol Services – Contract Model TBI (Date TBI). <p>* Work undertaken with PBCS to develop Commissioning Prospectus.</p>	<ul style="list-style-type: none"> • Older People Living Well – Contract Model TBI (April 2019). • Obesity, Mental Health, Learning Disabilities, T- Contract Model TBI (Date TBI). • Shadow (Year 1) Older Peoples Population, Outcome Based contract with Shadow Place Based Care System • Mental health and IAPT/emotional health and wellbeing (Date TBC). 	<ul style="list-style-type: none"> • All Adults population, outcome based contract with the Wirral PBC. • By April 2020 Wirral will have a fully integrated Place Based Care System with a formal agreement to collaborate on risk and reward for the benefit of the whole system to deliver improved value for money and improved patient outcomes. 	<ul style="list-style-type: none"> • Whole population, outcome based contract with the Wirral PBC.

To support the approach described above WHaCC will work with local people and providers to develop outcomes based contracts with the characteristics of the new population, outcome based commissioning approach. In effect the development of contracts in these areas will represent steps in the transformation of our commissioning approach which we will be testing with our provider system including:

- Detailed outcome based service specifications
- Capitated budgets and incentives for achieving outcomes
- Utilising a range of contractual approaches as we progress along the journey towards PBCS.

APPENDIX

A. Proposed Healthy Wirral Outcomes Framework

Proposed Outcomes Framework



The Healthy Wirral Outcomes Framework shows our commitment to measuring our progress against the health and care priorities that matter to you.

For local people using our services, that means a way to measure whether the services they receive (activities) will improve their health, well-being and experience of care and support (outcomes).

Overall we want to improve the health and wellbeing of our population, the quality and experience of health and care services, and keep this affordable.

Draft for Discussion

BETTER HEALTH

We want to improve health and wellbeing for local people

Outcomes	These indicators and measures will tell us how we are doing...	
Children are supported to have a healthy start in life	The proportion of babies who were fully or partially breastfed	Increase in percentage of babies aged 6-8 weeks who were fully or partially breastfed
	The rate of obesity among children	Reduction in excess weight in children aged 4-5 years Reduction in excess weight in children aged 10-11 years
	The proportion of mothers known to be smokers at the time of delivery	Reduction in percentage of mother known to be smokers at the time of delivery
People are supported to have a good quality of life	The proportion of people reporting a good quality of life	Improve health-related quality of life for older people Improve social-care-related quality of life for adults Increase in number of people who feel they have enough social contact
	The rate of overall mental wellbeing	Increase in proportion of people who say they are not anxious or depressed Decrease in attendances at A&E for self-harm per 100,000 of local population
People are supported to live in good health	The average number of years a person would expect to live in good health	Healthy life expectancy at birth for men Healthy life expectancy at birth for women
	The rate of preventable deaths	Reduction in preventable mortality Reduction in mortality amenable to healthcare

We want to reduce health inequalities for local people

Inequalities in healthy life expectancy are reduced	The gap in rates of obesity in children between the most and least deprived areas	Reduction in the gap in excess weight of 4-5 year olds between the most and least deprived areas Reduction in the gap in excess weight of 10-11 year olds between the most and least deprived areas
	The gap in health related quality of life for older people between the most and least deprived areas	Reduction in the gap in health-related quality of life for older people between the most and least deprived areas
	The gap in rates of preventable deaths between the most and least deprived areas	Reduction in the gap in preventable mortality between the most and least deprived areas Reduction in the gap in mortality amenable to healthcare between the most and least deprived areas

Outcomes	These indicators and measures will tell us how we are doing...	
People are supported by high quality care and support	The proportion of people reporting satisfaction with the services they have received	Increase in number of people who report they are satisfied with the care and support they receive Increase in number of carers who report they are satisfied with the care and support they receive Increase in number of people reporting being treated with care, kindness and compassion Increase in proportion of bereaved carers reporting good quality of care in the last three months of life
	People make a sustainable recovery post in hospital care	Improve the health gain people experience after elective procedures Increase in number of people still at home 91 days after discharge from hospital People feel supported in the community following discharge and during their recovery period
People are kept safe and free from avoidable harm	The number of healthcare-related infections and serious incidents	Reduction in healthcare-related infections Reduction in number of serious incidents in healthcare
	People using health and social care services are safe from harm	Increase in the number of adults who were asked what their desired outcomes of the safeguarding enquiry are, and of those how many were fully/partially achieved Care is provided in a safe environment, care is provided on the basis of evidence and takes a proportionate view of risk versus choice Staff are trained to understand key principles of the Mental Capacity Act and Deprivation of Liberties Standards Reduction in the number of adverse incidents
	The number of falls in the population of local people	Reduction in the number of falls in Wirral

We want to deliver person centered care through integrated and skilled service provision

People and their families are engaged in the settings of their outcomes and the management of their care	The proportion of people involved in setting the outcomes they want to achieve from their health and care services	Increase in proportion of people using services who are involved in determining the outcomes that are most important to them Increase in percentage of patients self-reporting improved outcomes in their general health following the elective procedure
People are supported by skilled staff, delivering person-centered care	The levels of staff satisfaction	Increase in staff satisfaction levels Reduction in staff turnover
	The proportion of staff who have received training in person-centered care	Increase in percentage of staff who have completed at least 80% of their mandated training Increase in proportion of staff who have the Care Certificate Increase in staff who have completed person-centered care and support planning training

We want to put people in control of their health and care

Outcomes	These indicators and measures will tell us how we are doing...	
People and their carers feel respected and able to make informed choices about services	The proportion of people using services who feel they have been involved in making decisions about their support	Ensure people using services receive self-directed support People receiving services feel they have enough choice over their care and support services People receiving services feel they have as much control as they want over their daily life
	The proportion of carers who feel they have been involved in decisions about services	Carers feel they have been involved or consulted as much as they wanted to be, in discussions about the support or services provided to the person they care for Carers feel that their needs as a carer were taken into account in planning their support
People and their carers have choice and control over services and how they are delivered	The number of people in receipt of direct payments for their carer or personal health budgets	Increase in the number of people using services who receive direct payments for their care Increase the number of people in receipt of personal health budgets Increase in the number of carers using services who receive direct payments

We want good communication and access to information for local people

People can find jargon free health and care information in a range of locations and formats	The proportion of people and carers reporting they find it easy to access and use information about services	People find it easy to find information and advice about support, services or benefits. Carers find it easy to find information and advice about support, services or benefits Carers assessments and respite arrangements are clearly articulated and understood
Health and care services talk to each other so that people receive seamless services	Carers feel connected to their communities, less lonely and socially isolated	People who contact us about their support have not had to keep repeating their story Carers who contact us about support have not had to keep repeating their story The proportion of people and carers reporting they have only had to tell their story once Carers are signposted to carers groups and or wider support networks

We want to deliver services that meet people's needs and support their independence

People are supported to be as independent as possible	People are supported to live at home and access support in their communities	Increase in people accessing the support available to them in their local communities Fewer people are permanently admitted to residential and nursing care homes
	The proportion of people with support needs who are in paid employment	Increase in the proportion of adults with learning disabilities in paid employment Increase in proportion of adults in contact with secondary mental health services in paid employment
	The proportion of people who regain their independence after using services	Proportion of people 65+ who are still at home three months after a period of rehabilitation Proportion of people needing less acute, or no ongoing, support after using short-term services
People are supported to feel safe	The proportion of people and carers who report feeling safe	People feel as safe as they want People feel care and support services help them feel safe Carers feel safe and have no worries about their personal safety

BETTER VALUE

We want to demonstrate financial and system sustainability

Outcomes	These indicators and measures will tell us how we are doing...	
People have access to timely and responsive care	The waiting times for primary care GP services and community support and care services	Waiting time to get a GP appointment Waiting time to initiation for home care packages
	Rapid response services enable support packages to be implemented in a timely manner	Response times for assessment and support planning Effective decision making in NHS CC packages
	The referral times for health treatment	Constitutional NHS standards are met
	The system supports the timely discharge of medically optimized patients back into their local community	Reduction in length of stay in hospital for identified cohort Reduction in delayed transfer of care out of hospital
People access acute hospital services only when they need to	The number of people accessing hospital in an unplanned way	Reduction in number of A&E attendances Reduction in number of non-elective admissions Reduction in emergency admissions for chronic ambulatory care sensitive conditions Reduction in emergency admissions by people with alcohol and or drug related dependencies
Financial balance is achieved across the system	Single Population Health Budget	Control totals are delivered across the system

We want to deliver joined up information technology

People and staff working within the system have access to shared and integrated electronic information	The proportion of staff in all health and care settings able to retrieve relevant information about an individual's care from their local system	Increase in proportion of staff able to retrieve relevant information about an individual's care from their local system using the NHS number Increase in number of settings across which relevant health and care information is currently being shared (through open APIs or interim solution) Implementation of Digital Integrated Care Records has started Use population level health information to improve decision making and to stratify and respond to individual risk
--	--	---

We want to prioritise prevention, early intervention, self-care and self-management

Interventions take place early to tackle emerging problems, or to support people in the local population who are most at risk	The flow of investment from acute hospital services to preventative, primary GP, and community health and care services	Increase the proportion of funding invested in preventative, primary and community provision
	The proportion of services developed to intervene proactively to support people before their needs increase	Activation measures demonstrate that people have knowledge skills and confidence in self care Number of people being screened for frailty Increase early interventions for people with psychosis Number of people who have a care plan from a proactive service Proportion of people accessing services through case finding Proportion of identified cohort who have access to active care coordination