Neighbourhoods		
2020/21	• Create Leadership model framework for Neighbourhoods in context of PCN's • Work closely with the community and voluntary sector to understand what increased capacity is required • Develop agreed TOM (Y1) • Population health - Integrating system (Health & Care) (Y1)	• Neighbourhoods have clear priorities and support • Population health issues are identified by neighbourhood • Neighbourhood priorities feed into a neighbourhood delivery plan • Population health improvements
2021/22	• Development of Neighbourhood operating model: - Integrated infrastructure fully operational (Y2) continues to develop and working relationships between neighbourhoods and PCN's clear • Integrated efforts to improve population health	
2022/23 **2023/24**	*(2 year programme which finishes end of year 2020/21. All transformation embedded and into Business as Usual delivery starting 2021/22)*	
Children and Families		
Timescale	**Actions**	**Outcomes**
2020/21	• Ensure effective implementation and localisation of new 0-19s service (core Healthy Child Programme) • Implement HPV vaccination programme for all boys aged 12 and 13 years • Re-procure Community Midwifery service • Implement a Family Nurse Partnership-led pilot to support families with complex needs (including	• Effective and timely support from Health Visitors, School Nurses and Family Nurses • Reduction of HPV infections amongst boys that may cause specific cancers. Reduction in spread of HPV infections to girls. • Safe and effective midwifery care within the community • Breaking the cycle of 'trauma'. Reduction in family breakdown, social care intervention, health and care

	adverse childhood experiences) • Implement the new Mental Health Support Teams across 43 Primary Schools in the 40% Lower Super Output Areas • Develop community support offer for children and young people with autism • Evaluate 'Family Connector' model and build business case for expansion if required • Review risk-management offer to young people	service usage • Children and Young People able to access fast and effective support for low-level mental health issues • More appropriate support within the community as oppose to hospital admission at time of crisis • Families accessing low-level practical support, avoiding the need for more intrusive, expensive intervention
2021/22	• Empower frontline staff to work in 'trauma-informed' way and drive 'Be The Difference' across key frontline staff groups • Develop a community 'deal' for Children, Young People and Families • Using the evidence from the Family Nurse Partnership pilot, expand support to vulnerable families with complex needs (*NOTE: This will need to be driven as a priority across all 5 years of plan*) • Increase 'Continuity of Carer' performance for local maternity services, with particular emphasis on BME and disadvantaged women	• Issues resolved in a more timely and practical manner. Reduction in 'pass it on' culture. Increased job satisfaction • Families taking responsibility where appropriate, leading to increased resilience and less reliance on statutory services • Families avoid crisis, breakdown, need for social and health care interventions. Children grow up free from legacy of adverse childhood experiences • Increased continuity of care leading to less miscarriages and pre-term births. Greater satisfaction for clients and staff

	• Develop more integrated risk-management offer for young people	• Reduction of duplication, increasing efficiencies of resource use, smoother pathway for young people
2022/23	• Review treatment pathway for children with severe complications related to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health • Evaluate mental health crisis care delivery for children and young people	• More children treated appropriately for complications due to obesity • More accessible support at times of mental health crisis
2023/24	• Ensure that local women have access to their maternity notes/advice and information through their smart phones or other devices • Increase availability of postnatal physiotherapy	• Women enabled to make choices about their care and access services and information in a more convenient and efficient way. • Less women experiencing mild to moderate incontinence and prolapse
Planned Care		
When will we do it?	What Will we do?	What will be different?
2020/21	**Respiratory:** Admission Avoidance: • Development of community offer Prevention: • Air quality and Air Pollution - Link with Health Connectors • Advice on healthy eating and exercise Management: • Virtual clinic/ advice and guidance business model for patients with Chronic Obstructive Pulmonary Disease (COPD). Diagnosis: • Dual screening for lung cancer and COPD	• High quality, safe services delivered consistently • Improvement in referral to treatment times in line with national targets • Quality premium will be achieved if e-referral utilisation increases • Lower 'Did Not Attend' rates, reduce need for return visits • Move towards tier 2 services that are capable and resourced to triage all primary and consultant to

	Long Term Conditions: Healthy Wirral Review: • Phase 2, Development of a Long Term Conditions Community Model of Care **Endoscopy:** • Pilot Referral Assessment System (RAS) for referral triage • Review GIRFT (Get It Right First Time) data and agree actions • Monitor referral rates and provide referral guidance and support as appropriate • Undertake data analysis and ensure effective referral **Ophthalmology:** • Review options for E-referral by Community providers directly to providers • Explore opportunities for E-consult and electronic interfaces between community and secondary care to undertake pre-referral assessment • Seek further opportunities to "shift left" • Implementation of new ophthalmology model • Effective triage within the community to support right place, right time. **Stroke Pathway Improvement:** • Improve the use of self-care and early diagnosis technology for Atrial Fibrillation to avoid emergency admissions and strokes • Improved outcomes for patients on Wirral from preventative diagnostics and reduced strokes on Wirral Enhanced Early Supported Discharge model of care to be agreed • Delivery of the targets in the Long Term Plan	consultant referrals • Clinic space released for agreed alternative use; consultant workload altered • Improved reported patient satisfaction of outpatient care • Delivery of patient choice of first outpatient appointment • Better patient experience • Optimal rates for virtual outpatient clinics • Increase use of advice and guidance/ advice only referrals and reduction of face to face first outpatient appointments • Reduction of need for face to face follow up appointments and increase in non-face to face approaches • Reduction in consultant to consultant referrals and increase in primary care appointments • Reduce unnecessary hospital visits through acute hospital efficiencies and adoption of best practice, supporting delivery of national standards. • Reduce avoidable hospital visits where care could be supported or provided more appropriately or effectively elsewhere.

	relating to Stroke **Nephrology:** Reduction of referrals: • Continue to monitor new referral pathway Cardiovascular: **Cancer:** Prevention: • All boys aged 12 and 13 to be offered the Human Papilloma Virus (HPV) vaccination Early Detection: • new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days • Work with Public Health England to develop a plan for extension of the bowel cancer screening programme, to cover reduction in age to 50, and increase in sensitivity level • Support Cheshire & Merseyside Cancer Alliance to establish one RDC for the region • Continue rollout of HPV primary screening for cervical cancer • Support the Cancer Alliance in the rollout of Faecal Immunochemical Test (FIT) in the bowel screening programme Follow up pathway: • All breast cancer patients will move to a personalised (stratified) follow-up pathway once their treatment end • Colorectal and Prostate cancer patients will move to a personalised (stratified) follow-up pathway once their treatment ends. **Outpatient Redesign:**	• Impact on carbon emissions via reduced patient travel

	• Continuation of Advice and Guidance (e-RS RAS) 6 Month Trial – Gynaecology, ENT and Renal – Wallasey PCN (North Coast Alliance) and Birkenhead PCN (Arno Primary Care Alliance) • Review and widespread rollout to remaining PCN's • Continue to support and enable Wirral University Teaching Hospitals (WUTH) and GP's to collaborate together to find agreement on devising novel new treatment pathways in: - Nephrology - Urology - Haematology - Orthopaedics (part of MSK) - Ophthamology • Refer to, and implement where appropriate, the ideas and suggestions put forward in the published NHS England Elective Care Guides. • Engage with the Cheshire & Merseyside Programme work streams and implement their solution design appropriate to Wirral: - Dermatology - End of Life - Endoscopy (Gastrointestinal) - Haematology - Nephrology - Ophthalmology - Orthopaedics (part of MSK) - Urology **End of Life:** • In conjunction with "Place" review the education, training and support needs of the system with a particular focus on Personalisation and early identification. • Review electronic records, identifying initiatives to	

	improve information flow to ensure a quality package of care within the integrated system. • Implement “Place” initiatives identified in the year 1 planning process and monitor progress through QOF • Monitor process against Year 1 initiatives, developing further as required. **Dermatology:** • Continue to monitor and evaluate pilot study for treating dermatology patients in Primary Care	
2021/22	**Long Term Conditions**: Healthy Wirral Review: • Phase 2, Development of a Long Term Conditions Community Model of Care **Cardiovascular Disease:** • Early response: improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest **Cancer:** Follow up pathway: • Identify other cancer patients that could benefit from a personalised (stratified) follow-up pathway once their treatment end Early Detection: • Targeted Lung Health Checks Programme (continuation) **End of Life:** • Support the wider system to provide enhanced levels of support and care through for example education and training with a clear emphasis on	

	"place" at the heart of patient pathways e.g. care homes, community assets, carers. • Review access to Specialist Palliative Care to ensure it is robust and meets the needs of patients and the wider system • Ensure case reviews and peer reviews are undertaken within Primary Care Networks (PCNs) to support the identification of further improvements • Monitor process against Year 2 initiatives, implementing and developing further as required. **Outpatient Redesign:** • Continuation of Advice and Guidance (e-RS RAS) 6 Month Trial – Gynaecology, ENT and Renal – Wallasey PCN (North Coast Alliance) and Birkenhead PCN (Arno Primary Care Alliance) • Review and widespread rollout to remaining PCN's • Continue to support and enable WUTH and GP's to collaborate together to find agreement on devising the novel new treatment pathways: • Refer to, and implement where appropriate, the ideas and suggestions put forward in the published NHS England Elective Care Guides. • Engage with the Cheshire & Merseyside Programme work streams and implement their solution design appropriate to Wirral: **Gastro / Endoscopy:** • Review opportunities relating to shared decision making and self-management • Review impact of Direct access fibroscan • Review impact of community based fibroscan pilot.	
2022/23	**Long Term Conditions**: Healthy Wirral Review: • Phase 2, Development of a Long Term Conditions	

	Community Model of Care **Cancer:** Early Detection: • Targeted Lung Health Checks Programme Outpatients: • Stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers. **End of Life:** • Ensure equal access is integral to plans at "Place" level. • Develop volunteer networks within the "Place" model to support patients and carers throughout the pathway. Ensure robust education and training to maximise the support give. • Ensure equal access is integral to planning at "Place" level. Review access to Palliative and End of Life Care and the patient experience with consideration to factors that impact equal access, for example: deprivation, homelessness, learning disabilities, and dementia. • Monitor process against Year 3 initiatives, implementing and developing further as required. **Outpatient Redesign:** • Embed new ideas and processes • Continue to review and develop policies. • Continue to support and enable WUTH and GP's to collaborate together to find agreement on devising the novel new treatment pathways • Refer to, and implement where appropriate, the ideas and suggestions put forward in the published NHS England Elective Care Guides.	

	• Engage with the Cheshire & Merseyside Programme work streams and implement their solution design appropriate to Wirral:	
2023/24	**Long Term Conditions**: Healthy Wirral Review: • Phase 2, Development of a Long Term Conditions Community Model of Care **Cancer:** Early Detection • Targeted Lung Health Checks Programme Outpatients: • Stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers. **End of Life:** • Develop champions within Primary Care Networks to further embed enhanced services, whilst identifying on –going development of services at "Place" level. • Monitor process against Year 4 initiatives, implementing and developing further as required. **Outpatient Redesign:** • Embed new ideas and processes • Continue to review and develop policies. • Continue to support and enable WUTH and GP's to collaborate together to find agreement on devising the novel new treatment pathways • Refer to, and implement where appropriate, the ideas and suggestions put forward in the published NHS England Elective Care Guides. • Engage with the Cheshire & Merseyside	

	Programme work streams and implement their solution design appropriate to Wirral:	
Unplanned Care		
When will we do it?	**What Will we do?**	**What will be different?**
2020/21	Agree the clinical model and estate design for the new "Hospital upgrade project" through active engagement of all economy partners. Commence procurement exercise for "hospital upgrade project) – Spring 2021 Reduce bed occupancy to 95% Reduce patients in hospital 21 days by 50% Implement community urgent care pathway with single clinical governance Implementation of phase 1 pre-UTC of a single minor injuries and minor illness service provision at Arrowe Park site Further development of SPA offer and the link with Clinical Assessment Service – to include ensuring interoperability To meet requirements of Same Day Emergency Care Review of new clinical standards and whether improvement in service delivery is required Increase use of tele health in the admission avoidance and discharge pathways To implement revised 'two hub' model for Intermediate care Reduce length of stay in intermediate care beds Capacity and demand model – expand across system and review of acuity levels	Reduce number of beds in hospital – closure of one ward Reduce risks to patients due to prolonged hospital stay such as deconditioning leading to increase in physical dependency Better patient experience Consistent pathways Increase patient's independence and ability to remain in their own bed and home. To meet constitutional standards linked to urgent care To improve efficiencies in both clinical resource and also financial resource

2021/22	Development of a full Urgent Treatment Centre (UTC) at Arrowe Park Hospital site Elimination of patients in hospital 21 days Review of MDT and pathways and new innovative ways of integrating therapies Further development of telehealth Link with Primary Care Networks in the admission avoidance and discharge pathways Market shaping and development of the domiciliary care market – including recruitment and retention of staff and development of an integrated workforce model. Award construction contract for "hospital upgrade project" – Late Summer 2021	Reduce number of beds in hospital – closure of one ward. Meet winter pressures within existing capacity Increase patients independence and ability to remain in their own bed and home. To meet constitutional standards linked to urgent care To improve efficiencies in both clinical resource and also financial resource Reduce risks to patients due to prolonged hospital stay such as deconditioning leading to increase in physical dependency Better patient experience Consistent pathways
2022/23	Implement UTC via new build at Arrowe Park Hospital site Maintain elimination of 21 day hospital stays Integrated capacity tracking across the whole system Opening of "hospital upgrade project" redesigned Estate at Arrowe Park Hospital site – Late summer 2022	Increase patients independence and ability to remain in their own bed and home. To meet constitutional standards linked to urgent care To improve efficiencies in both clinical resource and also financial resource Reduce risks to patients due to prolonged hospital stay such as deconditioning leading to increase in physical dependency Better patient experience Consistent pathways
2023/24	Maintain elimination of 21 day hospital stays Telehealth embedded in admission avoidance and discharge pathways Centralised acute service across the two hospital sites – Clatterbridge Hospital being the centre for planned non-complex care	Increase patients independence and ability to remain in their own bed and home. To meet constitutional standards linked to urgent care To improve efficiencies in both clinical resource and also financial resource Reduce risks to patients due to prolonged hospital stay such as deconditioning leading to increase in physical dependency

		Better patient experience Consistent pathways
Mental Health		
When will we do it?	What Will we do?	What will be different?
2020/21	**Perinatal Mental Health** • Review and develop existing specialist perinatal care to: - Ensure increased access for women from pre conception to 24months post birth. - Offer an assessment to partners of women accessing specialist care to enable support and signposting as required. • In partnership with Insight Concern develop a pilot of maternity outreach clinic to combine maternity, reproductive health and psychological therapies for women experiencing mental health difficulties **Children and Young People** • Undertake baseline assessment of access rates of 0-18 and 18-25 accessing funded mental health services in 18/19 and 19/20. • Increase access to wider NHS funded services through the Children & Young People (CYP) pathway launch and wider communication campaign. • Maintain existing Eating disorder standards for assessment and treatment. • Pilot and implement joint working with adult liaison and street triage service to widen access for CYP crisis care.	Women and their partners will receive the emotional health and wellbeing support required from pre conception up to 2years post birth. Improvement in sustained family relationships. Support new parents with maintaining everyday activities and return to work where appropriate. New parents wider health needs are met in one setting with multi-agency work. Robust mental health pathway to meet needs of 0-25 cohort. Clear understanding across Wirral population of how and where to access support including early help and prevention. CYP with an eating disorder are assessed and treated in a timely manner and to maximise recovery. Increased crisis provision and points of access for CYP in urgent mental health need.

	• Continue to refresh the CYP Long Term Plan on an annual basis through the 'Future in Mind' steering group and multi-agency commitments from Partnership for Children and Families strategy.	Partnership plan to deliver improved MH outcomes for CYP which is aligned across different strategic directions.
	• Review alignment of Special Educational Needs and Disabilities (SEND) agenda in line with CYP Mental health and identify robust action plans to align strategic planning.	Improved visibility and oversight within MH planning of the needs of SEND.
	• Consider national and regional guidance regarding the implementation and alignment of services for 0-25 and develop project scope for implementation.	Improved support for 18-25 cohort who are not ready to transition to adult services.
	Improving Access to Psychological Therapies (IAPT) and Common mental health problems • Undertake a targeted focus of older adults access levels	Increased number of older adults accessing IAPT with an improvement in overall health and well-being.
	• Fully implement Long term Conditions IAPT pathways in at least 4 condition pathways	Integrated MH and physical health delivery pathways to improve holistic needs of patients.
	• Ensure delivery of referral treatment times and recovery targets.	Patients are seen within national referral to treatment timeframes and improvement in recovery and longer term outcomes for wellbeing.
	Adult Severe Mental Illnesses (SMI) Community Care • Implement the recommendations from the physical health and Mental health task and finish group to deliver an integrated care model in line with the neighbourhoods, initially focusing on SMI.	Patients will have their physical and mental health needs met within a primary care setting.
	• Consider the recommendations from the Cheshire & Merseyside (C&M) Personality disorder work stream in delivering new models of care across C&M for this	Improved community model for support for people with a personality disorder and a reduction in out of area, high cost placements

	patient group.	
	• Implement the SMI shared care guidance and mental health registry to increase numbers of physical health checks undertaken for people with an SMI.	Numbers of people with a SMI receiving a physical health check will increase which will improve life expectancy and reduce premature mortality and other conditions.
	• Monitor the implementation of the IPS service launched in Oct 19 and the numbers of people accessing IPS.	Individuals with a SMI are supported to return to employment or training as appropriate.
	• Continue to achieve the Early Intervention (EI) standards and ensure data quality issues affecting performance in 2019 have been resolved.	People with a diagnosis of EIP are seen within the national timeframes to support quality care delivery and avoidance of deterioration.
	• Monitor CWP EI action plan to deliver National Institute for Clinical Excellence (NICE) concordance supported through the additional investment committed in 2019/20.	Service staffed in line with NICE guidance.
	Mental Health Crisis Care and Liaison • Implement the enhanced Crisis resolution & Home Treatment (CRHT) service for adults in line with additional investment and transformation bid.	People in Mental health crisis have their needs met within the local community and without having to attend A&E
	• Further commitments are outlined in CYP section.	
	Therapeutic Acute Mental Health Inpatient Care • Continue to maintain no out of area bed usage for CWP.	Patients and families have a better experience of inpatient care as they do not have to travel to receive specialist treatment.
	• Undertake a review of bed status given East Cheshire community redesign and escalation status of inpatient services during 2019, ensuring appropriate bed usage and capacity to meet demand.	Ensure the appropriate number of beds are available to meet demand, considering any trends with admissions.

	Suicide Reduction and Bereavement Support • Continue through the Crisis Care Concordat to monitor the progress of the Wirral Suicide reduction programme and consider any wider C&M benefits. • Align our actions on Wirral to support the achievement of the C&M goal for zero suicides **Problem Gambling mental health support** • Monitor existing gambling provision from Beacon Trust and CAB gambling programme to consider demand and capacity. **Rough sleepers** • Understand opportunities for co-commissioning of homeless provision across PC, MH and Public health contracts **Place Addition** • Establish shadow arrangements for Integrated Provider with delegated commissioning functions	Reduce the numbers of incidents of suicide across Wirral. Understand local population gambling habits to commission appropriate gambling service provision. Robust integrated provision for rough sleepers that combines housing, social, mental and physical health needs. Proposed shadow year for testing an Integrated Provider model to include delegated commissioning functions
2021/22	**Perinatal Mental Health** • Review outcome and learning of pilot from maternity outreach clinics and implement fully. **Children and Young People** • Consider opportunities for alignment of NHS 111 (2) and CYP advice line. • Pilot inclusion of CYP delivery into CRHT and consider any alignment with CYP assertive outreach teams. • Consider use of Beyond Places of Safety (BPOS) (Spider project) for 15-18 cohort and review any alternative provision required to provide alternative to Accident and Emergency Department for CYP. • Review CYP approach re addictive gaming habits as	Understand opportunities to fully implement wider maternity outreach clinic. Single point of access for mental health crisis for all ages. More CYP will be supported in the community and reduced need for inpatient admission. CYP will be able to access alternative crisis provision and reduced need to attend A&E. Increased awareness of long term effects of gaming and

	part of wider Partnerships for Children and families strategy and link to future planning for gambling clinics.	risks relating to gambling.
	Improving Access to Psychological Therapies (IAPT) and Common mental health problems • Maintain delivery of all national IAPT standards.	Wirral population receive timely access to IAPT services.
	Therapeutic Acute Mental Health Inpatient Care • Consider therapeutics outcomes and average bed usage to drive forward reduction to 32 days.	Improved experience for people admitted to an inpatient bed.
	Rough sleepers • Develop options appraisal and explore opportunities for additional funding to support specialist provision for rough sleepers.	Rough sleepers have improved access to specialist provision.
	Place Addition • Shadow arrangements for Integrated Provider with delegated commissioning functions	Proposed implementation of Integrated Provider with delegated commissioning functions
2022/23	**Children and Young People** • Undertake final evaluation of CYP crisis care requirements and delivery options and develop clinical pathways to meet requirements for all age crisis care service.	Robust clinical pathway for all age crisis service.
	Improving Access to Psychological Therapies (IAPT) and Common mental health problems • Maintain delivery of all national IAPT standards.	Wirral population receive timely access to IAPT services.
	Adult Severe Mental Illnesses (SMI) Community Care • Consider wider community integration for PD, Mental Health rehabilitation and Eating disorders with primary care – specifically evaluating the learning from SMI.	Improved community provision of specialist services.

	Suicide Reduction and Bereavement Support • Consider scope of existing bereavement and third sector suicide bereavement support and develop options appraisal to deliver requirement of suicide bereavement support services. Engage in wider C&M work stream discussions re this agenda. • Align our actions on Wirral to support the achievement of the C&M goal for zero suicides **Problem Gambling mental health support** • Pilot early help/prevention approach to CYP and families relating to gambling and gaming addiction. **Rough sleepers** • Pilot rough sleepers Mental Health provision services considering links with housing, social care and MH services.	People who have been bereaved by suicide will receive targeted support. CYP and families receive targeted support and awareness relating to gambling. Robust integrated provision for rough sleepers that combines housing, social, mental and physical health needs.
2023/24	**Children and Young People** • Successfully implement 24/7 all age crisis services inc CYP. **Improving Access to Psychological Therapies (IAPT) and Common mental health problems** • Maintain delivery of all national IAPT standards **Problem Gambling mental health support** • Ensure the implementation of gambling clinics for specialist problem gambling treatment	CYP receive the same level of crisis support as adults. Wirral population receive timely access to IAPT services. CYP and families receive targeted support and awareness relating to gambling.
Learning Disabilities and Autism		
When will we do it?	What Will we do?	What will be different?
2020/21	Maintain reduction in inpatient bed base for both children and adults	More community services for people with learning disabilities and/ or autism who display behaviour that challenges, including those with a mental health condition. (Building the Right Support, BRS, NHS Long

		Term Plan & Transforming Care (TCP)) Utilise DSD to maximise required effect and become more preventative and less reactive.
	Ensure community services are robust and can provide the right care at the right time in the right environment.	Reduced admissions & facilitate timely discharges. Les reliance on inpatient facilities Improve people's quality of life and ensure that nobody loses one day in the community than is necessary for their good health and well-being.
	Annual Health Checks	Decreased mortality rates and increased quality of life
	Increase in the use of technology	Increase people's ability to remain in the community and increase self-management and independence where possible.
	Housing - Ensure we have good quality and appropriate accommodation to meet the needs of our local population.	Reduction in failed placements and increase in meeting individual needs/outcomes
2021/22	Maintain reduction in inpatient bed base for both children and adults	The development and sustainability of ISF would be to ensure providers have the required skills to meet individual needs and maintain their aptitude for their clients to remain within a community setting.
	Actions to improve the accuracy of GP registers to support the delivery of Annual Health Checks	Decreased mortality rates and increased quality of life
	Continuation of research into, and deployment of technology	There is a range of technology to support people to maintain their independence and be supported in the community
	Housing - Ensure we have good quality and appropriate accommodation to meet the needs of our local population.	A robust and responsive market that will enable them to support people in the community.
2022/23	Work towards having an increase in screening numbers to support Annual Health Checks	Decreased mortality rates and increased quality of life

2023/24	Maintain reduction in inpatient bed base for both children and adults	Robust all age community services to ensure that admission to hospital is the exception.
	Continue work towards achieving national targets for Annual Health Checks	Decreased mortality rates and increased quality of life
	Increase technology	A wider range of technology available to support all aspects of people remaining in the community.
	Housing - Ensure we have good quality and appropriate accommodation to meet the needs of our local population.	People will have a home within their community, to be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.
Getting the Best from Medicines in Wirral		
When will we do it?	What Will we do?	What will be different?
2020/21	Develop an integrated service to deliver medicines optimisation without boundaries	Pharmacy services, working as one to realise quality outcomes for patients, safety management systems within medicines processes and cost savings for the system.
	Respond and support as a system the changes in the community pharmacy contract (Community Pharmacy Contractual Framework – CPCF) (Year2) moving community pharmacy into a more integrated central role within primary care, enabling the sector to help to deliver the ambitions set out within the NHS Long Term Plan including referrals from GP surgeries and NHS11 online	Utilise the planned changes to optimise medicines optimisation in Wirral Place

	Support the new GP contract (Year 2) 1. supporting prescribing safety with(a) the expansion of clinical pharmacists in general practice; (b) the nationally-backed roll-out of the pharmacist-led information technology intervention for medical errors (PINCER or equivalent) by the AHSNs35; (c) the drive to tackle polypharmacy for complex patients, including in care homes; and (d) the quality payment scheme for community pharmacy 2. Support the new national structured medication review and care homes requirements. 3. The expansion of clinical pharmacists working in networks.	Increase the numbers of pharmacists maximising medicines outcomes in primary care networks
	Support the Anti-Microbial Resistance 5 year strategy working closely with the population health work stream	Reduce antibiotic consumption across the place Reduce the proportion of broad spectrum antibiotics prescribed Gain a greater understanding of formulary compliance across the system Public facing messages prepared and co-orindated collaboratively Reduce the number of blister packs in the system
	Waste – Review dispensing for Care Homes and Domiciliary care providers to reduce the need for blister packs	Improve safety of medicines administration in care settings

	System wide response to the Medicines Safety Assurance Model Optimise medicines for patients in care homes through medication use review TCAMs extend project to increase benefits. Medicines reconciliation will form part of this from the CPCF Extend not dispensed scheme to maximise savings Extend to DOAC work to include all DOAC preparations	National guidance followed in Wirral Place Continue to improve prescribing and enhance mediciness optimisation Increase numbers, decrease bed days Reduce wasted medicines All DOAC patients will be prescribed most appropriate cost effective medicine for their condition
2021/22	Support the new GP contract (Year 3) 1. Mental Health focus 2. CVD and inequalities requirement Respond and support as a system the changes in the community pharmacy contract (year 3) moving community pharmacy into a more integrated central role within primary care, enabling the sector to help to deliver the ambitions set out within the NHS Long Term Plan including referrals from urgent treatment centres, potential national case finding service for CVD and expansion of new medicines service AMR 5 year strategy (covered in Population Health Programme). Consider the need for Wirral place to have a system wide Antimicrobial Stewardship Pharmacist Delivery of QIPP/CIP programmes with multi-sector	Review how Pharmacy Medicines Optimisation can support PCNs and wider primary Care to implement these changes focussing on in year priorities Utilise the planned changes to optimise Medicines Optimisation in Wirral Place

	support as detailed by individual stakeholders	
2022/23	Support the new GP contract (Year4) Support the new Community Pharmacy Contract (Year 4) AMR 5 year strategy (covered in Population Health Programme Delivery of QIPP/CIP programmes with multi-sector support as detailed by individual stakeholders	Review how Pharmacy Medicines Optimisation can support PCNs and wider primary Care to implement these changes focussing on in year priorities Utilise the planned changes to optimise Medicines Optimisation in Wirral Place
2023/24	Support the new GP contract (Year 5). Networks will have 5 clinical pharmacists. Review of prescribing incentive schemes Support the new Community Pharmacy Contract (Year 5) AMR 5 year strategy (covered in Population Health Programme Delivery of QIPP/CIP programmes with multi-sector support as detailed by individual stakeholders	Review how Pharmacy Medicines Optimisation can support PCNs and wider primary Care to implement these changes focussing on in year priorities Utilise the planned changes to optimise Medicines Optimisation in Wirral Place
Our People		
When will we do it?	**What Will we do?**	**What will be different?**
2020/21	• **Aligning Capability** – The Aligning Capability gap analysis and Culture Assessments are scaled-up beyond the original 'pilot sites' with a key focus on 100% Wirral Neighbourhoods coverage - The size of this scaling-up will very much depend on OD resource availability vis-à-vis funding. In addition progress will be determined by the pace of the infrastructure integration detailed within the overarching Healthy Wirral 5 Year Summary	• Aligned common purpose/vision and consistent approaches • Shared language across the system's partners • Improved team work and conversational capability • Conflicts surfaced and addressed effectively across the system • Reduced duplication and improvement of

	• Following on from our work with the Communications and Engagement Programme, co-designing the Healthy Wirral Staff Awareness Survey, we will look to work with the teams/organisations that are shown to need our support as a priority. The People Programme will support in progressing the capability of teams, meeting them at their point of need and helping them prepare for large scale cross-organisational transformation. • **Leadership Capability** – The Healthy Wirral Leadership development programme matures from the 2019/20 3rd Sector programme model. This will include opportunities for delegates to increase their understanding of their own Wellbeing and that of their colleagues around them, not simply traditional leadership principles and methodologies. Delivered wherever possible by local qualified/experienced facilitators it will provide opportunities to both those who are new to leadership and those who are more experienced in their understanding • **Conversational Capability** – building on the work carried out with Chairs and Chief Executives this development opportunity will be delivered to system teams/areas that have been identified through the Aligning Capability diagnostic. Initially, Neighbourhoods will be focused on to support proactive systems change and continuation of relationship development. • The Task & Finish group will develop and create a Compact Agreement for inter-organisational behaviours. This will not only lay down a set of expectations for the behaviours that will be displayed when working with Healthy Wirral partners, but also an approach to follow when	processes, leads to capacity released which can be reinvested in multiple ways (Continues over following years as the Aligning Capability model is scaled-up across the Healthy Wirral footprint) • Individuals more empowered to deliver against their role • New roles and career pathways within the system are identified • Individual skills are utilised as effectively as possible and are not restricted by job description alone • Improved Leadership capability across the system

	people do not adhere to them; holding colleagues to account. • The Task and Finish group will develop and implement a bespoke training offer based on Imposter Syndrome. This is a subject that has kept resurfacing and colleagues have asked for more support in dealing with it. • **Attract, Develop and Retain Capability within the Healthy Wirral System** – a range of initiatives will be explored and developed which will include: a) Develop a Healthy Wirral approach to career progression b) Develop Healthy Wirral Apprenticeship(s) c) Develop Healthy Wirral approach to the identification of (and training for) new roles. d) Develop Healthy Wirral approach to workforce modelling which focuses on knowledge, skills and behaviours and new roles e) Develop a Healthy Wirral approach to recruitment and retention f) Establish opportunities for joint education and training programmes to support system organisational and workforce development • Developing a joined up approach to harmonising and utilising a single Trainee Nurse Associate programme. • Developing a process for cross-organisational shadowing to enable cross organisational knowledge transfer and learning, and enable large scale change with a single common purpose. • **Wellbeing** – Deliver a single Healthy Wirral approach to Mental Health First Aid training with a single procurement process across the footprint. • Once the MHFA offer has been implemented, the	

	Task and Finish group, will consider consolidating further offers and approaches to staff across Healthy Wirral including: ○ Flexible working options/policies ○ Training on Domestic Abuse ○ Know your numbers 'blood pressure' ○ Health Checks ○ Resilience and Change management training ○ Wellbeing Coaches	
2021/22	Objectives beyond 2021 will be further refined and scoped as the People Programme Task and Finish Groups progress through their respective P&OD pipeline. This will ensure Wirral People and System needs are routinely tracked and updated whilst also ensuring both National and Cheshire & Merseyside HCP development/priorities are taken into account. Equally, where the Healthy Wirral Programme Board or external factors dictate, the priority of these objectives and their proposed delivery date/year can be adjusted to help drive progress of the overall Healthy Wirral programme. • **Aligning Capability** – The People programme will continue to work with *Healthy Wirral* Communication and Engagement leads, and using insight from staff surveys and other intelligence to support teams/organisations to align to the 5 year plan. Further support will be offered utilising the Aligning Capability model to establish the root cause of any barriers and develop supportive action plans. • **Conversational Capability** – Cross-organisational coaching will be offered, giving more Healthy Wirral organisations access to a wider variety of coaches	• Reduced turnover and vacancies leading to reduction in use of bank/agency staff • Reduced absence and associated costs • Greater engagement and commitment of staff and Wirral people to the aims and objectives of the *Healthy Wirral* programme, and their role in delivery.

	– Both clinical and non-clinical • **Attract, Develop and Retain Capability within the Healthy Wirral System** – Develop a single Healthy Wirral approach to CPD investment • **Wellbeing** –explore the delivery of Flu Vaccination access for 3rd sector population facing colleagues • Explore the setup of Healthy Wirral Wellbeing Hubs at key staff locations across the footprint. The hubs will be open to all Healthy Wirral partners and will be a centre point for offering local services to staff in or near to their work environment.	
2022/23	**Attract, Develop and Retain Capability within the Healthy Wirral System** – Move towards an agreed Wirral-wide set academic/training time that is reserved for members of staff to focus on their personal development, considering equally the needs of clinical and non-clinical staff of all levels.	
2023/24	**Attract, Develop and Retain Capability within the Healthy Wirral System** – Develop a Healthy Wirral employment passport system, including DBS and including online career/development history.	Checks need only be performed once for colleagues looking to work with Healthy Wirral partners allowing for easier and more cost effective flow of employment within the Wirral system and the retention of skills and experience