NHS
Wirral Community Health and Care
NHS Foundation Trust

Organisational Strategy

2018 – 2021

for you, with you

Applies to:	All staff
Committee for Approval	Board
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Review and Amendment Log

September 2019	Revised version reflecting increased focus on social care, including principles and service integration, and updated terminology

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Foreword

More people are living longer and with multiple long term health conditions. This requires new thinking about how high quality, sustainable health and social care services can actively support people to stay well and independent as well as treat specific conditions or illnesses.

We are working in a time of rapid change, with much greater emphasis on how organisations can work together to meet the challenges of improving health and care services and equity of health outcomes, and do so affordably.

The 2019 NHS Long Term Plan and Primary Care Network contract both identify the need for primary and community care providers to work together even more effectively to best support the health and wellbeing of our population. The Department of Health and Social Care priorities include the development of a social care strategy to address sustainability, quality and fairness.

Responding to this challenge, we are working with partners to develop a Place-Based Care model to provide more proactive, better coordinated care with expanded and integrated primary and community services, focused on promoting wellbeing throughout life.

Realising the potential of Place-Based Care requires effective integration of many services. WCHC has a critical role to play. Uniquely, we have expertise in both community health and social care with the ambition, scale and ability to act as a system integrator, working with organisations and groups in primary care, mental health, secondary care and the independent and voluntary, community & faith (VCF) sectors.

This ambitious strategy describes what WCHC, in partnership with local people, intends to do to realise the potential of Place-Based Care and improve people's lives.

Karen Howell
Chief Executive

1 Introduction

Wirral Community Health & Care NHS Foundation Trust (WCHC) is a high performing and vital organisation within the health and care systems of Wirral and Cheshire. Our vision is to be the **outstanding provider of high quality, integrated care to the communities we serve**.

This is informed by our values:

- Health and wellbeing at the heart of everything we do
- Exceptional person-centred care
- Actively supporting each other
- Responsive, Professional, Innovative
- Trusted to deliver

We are intensely ambitious for the health and wellbeing of our communities. Our services, from 0-19 through to End of Life care services, provide care and support for people from birth to death, often in their own homes. They are at the heart of person-focused care.

Significantly, in 2017, we transferred a number of Adult Social Care services and staff from Wirral Council to provide a range of delegated statutory social work duties. This means that Wirral is one of a handful of places in England to have begun a ground-breaking journey towards truly integrated health and care provision. This has provided opportunities for practitioners to work in a more coordinated way and reduce duplication. It will support people to be independent as long as possible, live the life they wish to live and improve health and care outcomes.

Place-Based Care, described in section 2, is a way of providing health and care more suited to the needs of current and future generations. It will require a new approach to working with people and communities to support health and wellbeing in its widest sense as well as providing high quality services.

It will need us to continue focusing intensely on developing the relationships between professionals to create integrated primary-community teams operating at the scale of Primary Care Networks. These teams must then link with their communities so that health and social care services become partnerships between people and care providers.

We also need to review and refine our approach to care pathways, so that early identification and support can help people stay well and independent as long as possible.

This will depend on joined up Information Technology to support sharing information and coordinating care. We can radically simplify the way health and care is experienced, so that a single contact leads to the most effective, bespoke service provision.

Similarly, we must fully utilise population health data and Business Intelligence tools to deeply understand the health and wellbeing and needs of people and communities, and understand how well we are working and the outcomes we are helping people to achieve.

Through innovative use of digital technology, such as the Wirral Care Record and Trust Information Gateway we have already begun this journey. Realising its potential will require continual innovation and close working with partners, especially GPs.

The Strategic Programmes that we are developing to deliver this strategy are described in section 5.

2 Context

2.1 Responding to socio-demographic and financial pressures

Wirral is home to around 321,000 people. Despite a small geographical footprint, life expectancy varies by 12 years for men and 10 years for women between the most and least deprived areas. Although it has areas of great affluence, Wirral remains one of the 20% most deprived districts in England, with nearly one quarter of children living in low income families.

Wirral's Joint Strategic Needs Assessment projects an increasing number of people living with long-term conditions and persistent health inequalities and Wirral, like other areas, is facing the challenge of reconfiguring services to meet projected increases in demand within available resources.

Cheshire East faces a similar set of circumstances, with demographic pressure and the health and care consequences of an ageing population, plus very constrained finances.

These pressures are felt nationwide. Recognising the increasing pressures of demography, finance and demand, the NHS Long Term Plan (2019) highlighted the need for greater integration of health and care services to achieve a service that is more:

- joined-up and coordinated in its care
- proactive in the services it provides
- differentiated in its support offer to individuals

Nationally, there is now a move towards creating Integrated Care Systems in which commissioners and providers agree a shared responsibility for using their collective resources to benefit local populations. They aim to:

- create more robust cross-organisational arrangements to tackle systemic challenges
- support population health management, e.g. recognising and supporting those at risk of developing acute illness and hospitalisation
- deliver more care through re-designed community-based and home-based services, in partnership with social care and the community and voluntary sector
- take collective responsibility for performance and health outcomes

These principles are reflected in the development of local Place-Based Care systems across Wirral and Cheshire.

2.2 Place-Based Care in Wirral and Cheshire

In Wirral, the Healthy Wirral Partners in 2017 collectively described an asset-based population health model[1] with many services provided and coordinated within areas of up to ca. 50,000 people.

Wirral's Primary Care Networks (PCNs), agreed in May 2019, have contractually consolidated relationships between GP surgeries at this scale. Community providers are required to align their services to PCNs to ensure effective service delivery. A similar model applies across Cheshire.

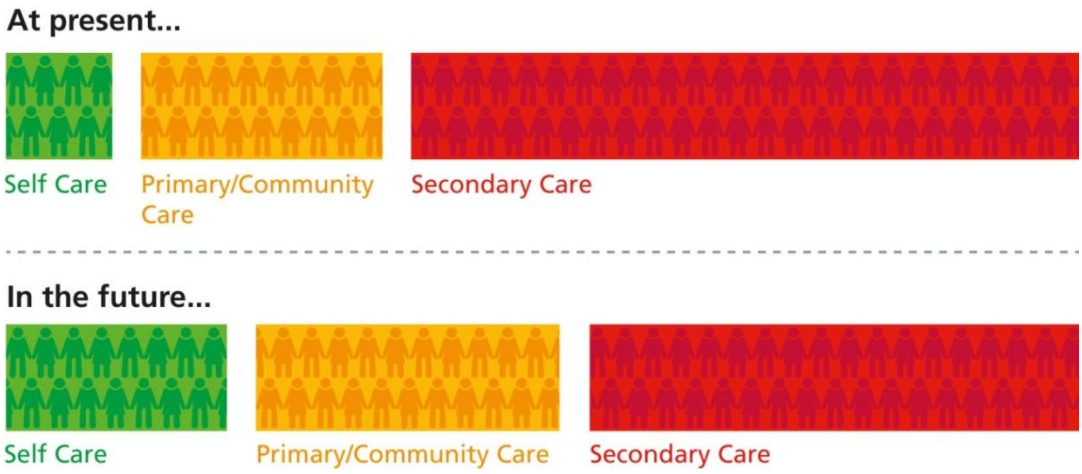
Improving coordination between all members of the health and care system at a local level will mean better care for those with complex, ongoing needs. It will also enable proactive identification of people at risk of ill health, helping them stay well and maintain independence and quality of life.

We aim to create better links between people and services at a local level to:

- help people improve their wellbeing and quality of life with less reliance on statutory services through focusing on empowerment, prevention and proportionality
- ensure effective support and intervention for those at risk and requiring protection
- reduce health inequalities
- use risk-based analysis of individual and wider population health to inform provision of proactive, well-coordinated support and care
- enable health and care professionals to work better together
- better understand communities and their assets

National and international examples are providing an emergent evidence base that demonstrates the power of this way of working to improve care and reduce cost (see appendix 3).

This is sometimes known as a 'shift left' in care provision, increasing the amount of self-care and activity in primary and community settings (see below).



[1] **Strategic Outline Case for an Accountable Care System** (2017)

Integrated commissioning

From April 2018, NHS Wirral CCG and sections of Wirral Council came together to form a single commissioning function, Wirral Health & Care Commissioning (WHaCC). WHaCC will jointly commission all age health, care and public health services for the Wirral population using a single budget, under a single governance arrangement and a fully integrated management structure.

In 2018, WHaCC published a draft Commissioning and Transformation Strategy, with a focus on transforming service delivery to reduce costs and improve health and wellbeing. WHaCC intends to incentivise resource shifts to community, primary care and prevention services to reduce demand on hospital and long-term care provision and achieve agreed population health outcomes. This, plus Wirral Council's Market Position Statement, with its reference to The Care Act aims and emphasis on self-care and independence is also aligned with WCHC's strategy.

Provider relationships

Wirral's three NHS foundation trusts (WCHC; Wirral University Teaching Hospital NHSFT; Cheshire & Wirral Partnership NHSFT) and two GP federations (Primary Care Wirral; General Practice Wirral) with other providers including Wirral Hospice and Age UK Wirral have come together as a group of providers, 'Wirral Provider Alliance' to work together with common values and purpose to accelerate service improvements for the local population.

SWOT analysis

An analysis of the Trust's Strengths, Weaknesses, Opportunities and Threats, recognising the points above, is provided at Appendix 4.

3 Progress

WCHC is committed to system-wide collaboration and leadership and our ambitions are fully aligned with plans in the wider health and social care economy. This translates into WCHC directors and senior managers' membership of the Healthy Wirral Partners Group and other Healthy Wirral groups, and chairing of the Wirral Provider Alliance.

The ongoing integration of Adult Social Care staff into the Trust is building a foundation for more integrated provision of health and social care services, ensuing collective decision making, reducing complexity and improving people's experience of services. Strategically, this has also led to a strengthening of our links to both national and regional social care partners including the Association of Directors of Adult Social Services (ADASS).

We are pursuing integration and more person-centred, efficient care through new ways of working, such as the Trusted Assessor model. We are working with other organisations to build relationships between professionals and to enable better care coordination and make improvements to pathways, e.g. our award-winning teletriage service for care homes[2].

WCHC continues to develop its Information Management & Technology (IM&T) and Business Intelligence (BI) infrastructure and capability. We have also launched a national exemplar BI system (the Trust Information Gateway, TIG) that can provide near real time information about all aspects of care, from division to team and individual clinicians. We are partners in the development of the Wirral Care Record, which will provide a full longitudinal care record, created from data drawn from multiple health and care providers.

Our transformation programme is initially focused on nursing. Alongside improving quality and efficiency through reducing variation, we are developing a model of practice-level care teams based on some of the principles of the Dutch Buurtzorg model. This is focused on providing holistic care and promoting independence for people, and increasing the autonomy and improving the experience of health and care team members. These principles are also fundamental to Place-Based Care.

On an ongoing basis, WCHC has a central role in supporting other parts of the health and care system in Wirral. This includes streaming patients from the Arrowe Park Emergency Department and managing transitions of care, improving flow between community and hospital, preventing unnecessary hospital admissions and improving discharges.

Recognising that more integrated working will be crucial for proactively supporting wellness and providing care, WCHC is investing time in relationships with potential partners and stakeholders across a number of sectors. (Appendix 2 provides the key criteria by which WCHC assesses organisations for formal partnerships.)

[2] Empowerment Award at the Cheshire & Merseyside Digit@LL Awards 2019

4 Strategic Objectives and Goals

WCHC's development is planned around three Objectives with accompanying Goals to provide focus on particular needs or development areas. They sit alongside the Strategic Programmes described in Section 5 of this Organisational Strategy.

Progress against these Objectives and Goals is delivered by the action plans covered in more detail in WCHC's other strategies.

4.1 Our Populations

Objective: An outstanding trust, we reliably provide the highest levels of safe and person-centred care through integration and collaboration with partners and patients

Goals:

- Outstanding, safe care every time
- More person-centred care
- Improving services through integration and better coordination

Provision of high quality services, defined by their safety, effectiveness and the positive experience of people receiving them, are central to our strategic development.

We are focused on:

- Achieving a minimum rating of 'Good' across all CQC key lines of enquiry, working towards an 'outstanding' CQC inspection rating
- Demonstrable reductions in variations in care
- Further improvements in patient safety outcomes
- More effective engagement with staff and local people
- Engagement with North West ADASS Sector Led Improvement Board and the Principal Social Worker network to ensure continuous service improvement

More detail and accompanying action plans are presented in our Quality Strategy, which also describes the development of Quality Improvement skills, infrastructure and culture, which is fundamental to successfully planning and delivering new ways of working.

As we develop more integrated and devolved care provision, a future focus will be how service quality and safety can be assured, and unwarranted variation minimised, across care teams and Neighbourhoods, with greater use of person-centred outcomes to understand how we affect people's lives.

Furthermore, the principles of co-design need to be embedded in our Trust and the wider system, ensuring we have a deep understanding of people's needs and their involvement in our service developments.

The Goal of 'Integration and better coordination of services…' within a Place-Based Care model is described as a priority throughout this Organisational Strategy.

4.2 Our People

Objective: We attract, enable, value and involve skilled and caring staff, liberated to innovate and improve services, releasing time to care

Goals:

- Improving staff engagement
- Advancing staff wellbeing
- Enhancing staff development

Achieving this objective requires the right numbers of appropriately trained, experienced and motivated staff:

- Our Workforce Plan identifies how we ensure a pipeline of new recruits in all professions, identify opportunities presented by the development of new roles and plan for the impact of workforce demographics
- Our Engagement Plan describes key structures and processes that build and support a strong bond between individuals and teams with wider Trust management
- Our Wellbeing Plan says how we promote good health, support staff to take care of themselves and how we will support them to live a healthy working life. This is also a feature of this Organisational Strategy
- Our Education, Training and Development Plan describes how we will continuously review and develop workforce skills to deliver high quality patient care

More detail and accompanying action plans are presented in our People Strategy.

The Interim NHS People Plan (June 2019) identifies priority areas to address to ensure we establish a fit for purpose workforce both now and for the future. This supports our workforce planning.

The Trust is a core organisation within the Healthy Wirral People Programme which is taking forward work to address recruitment, leadership, training and wellbeing on a system basis. We are taking a 'whole system' approach to developing the health and care workforce, blending and introducing new roles if needed.

We must also increase the ability of our staff to support people more holistically, enacting the cultural and organisational development that will enable integrated care teams to work most effectively and develop a shared identity.

4.3 Our Performance

Objective: We maintain financial sustainability and support our local system through efficiency, safe growth and a reputation for delivering outstanding services

Goals:

- Growing community services across Wirral, Cheshire & Merseyside
- Increasing efficiency of all our services
- Delivering against contracts and financial requirements

Growing community services across Wirral, Cheshire & Merseyside

We are open to providing community services anywhere in Wirral, Cheshire and wider Merseyside. Our primary focus is on remaining a fundamental provider within the Wirral health and care system, singly or in alliance with others, and an influential organisation within Cheshire.

As the focus of financial performance starts to shift from organisation to system, WCHC will measure growth in terms of increasing influence and greater provision of services in community settings.

This shift in emphasis means we will actively consider any opportunity to deliver services in community settings. We believe that our current portfolio is appropriate.

New contract opportunities will be reviewed on a case by case basis, balancing the need for financial sustainability with strategic priority and public benefit.

The significant programme of work needed to achieve the Strategic Programmes described below will require us to reject service development opportunities that do not directly further our strategic agenda.

There remains potential for significant transfers of activity and income to the Trust, either as standalone contracts or through hosting or joint venture arrangements.

We intend to be the default provider of existing and new services where we are best-placed to add value in terms of quality, effectiveness and efficiency. We aim to work in partnership and collaborate with other organisations where they are best-placed to provide services.

Increasing efficiency of all our services

The strategic development of services, pathways and integrated teams is dependent on also achieving internal transformation, including delivery of cost improvements, to allow resources to be directed and used most effectively by front line teams.

Increased efficiency also requires the further development of our corporate support services (IM&T, BI, Programme Management Office, Estates, Finance, Human Resources, Procurement, Communications etc).

We are committed to identifying the optimum level of trust income to spend on support services that balances effectiveness in supporting front-line staff with efficiency. We will consider any proposed consolidation of supporting infrastructure at either Cheshire & Merseyside or Wirral level.

Delivering against contracts and financial requirements

While we are regulated as a standalone organisation, our focus will remain on providing outstanding care quality, wherever this is delivered and whoever delivers it, supported by financial sustainability and ensuring effective discharge of our statutory duties including the embedding of any new legislative requirements.

This also means supporting the financial recovery of the wider system through managing our finances and resources effectively and ensuring that our services appropriately mitigate usage of the more costly and limited parts of the system. This includes supporting social care market sustainability.

We recognise that the development of system-level performance management means that this may change in future. This could mean the Trust's performance is monitored and regulated as part of a wider system, along with the ceding of some organisational decision-making through shared governance arrangements.

Performance management

During 2018/19 and 2019/20, we have reviewed our governance structure and have introduced enhanced performance rigour through the introduction of four key groups:

- Oversight and Management Board (OMB)
- Programme Management Board (PMB)
- Standards Assurance Framework for Excellence (SAFE) Steering Group
- Strategic Workforce Development Group

This is additional to the existing committee structure and divisional Quality, Performance and Risk meetings.

Utilising the Trust Information Gateway, OMB provides assurance to the Board of Directors, through the sub-committees of the Board, that effective performance management is being discharged across the organisation. The group monitors holistic operational performance, risk and service delivery and resolves operational issues as required.

5 Planned Strategic Developments

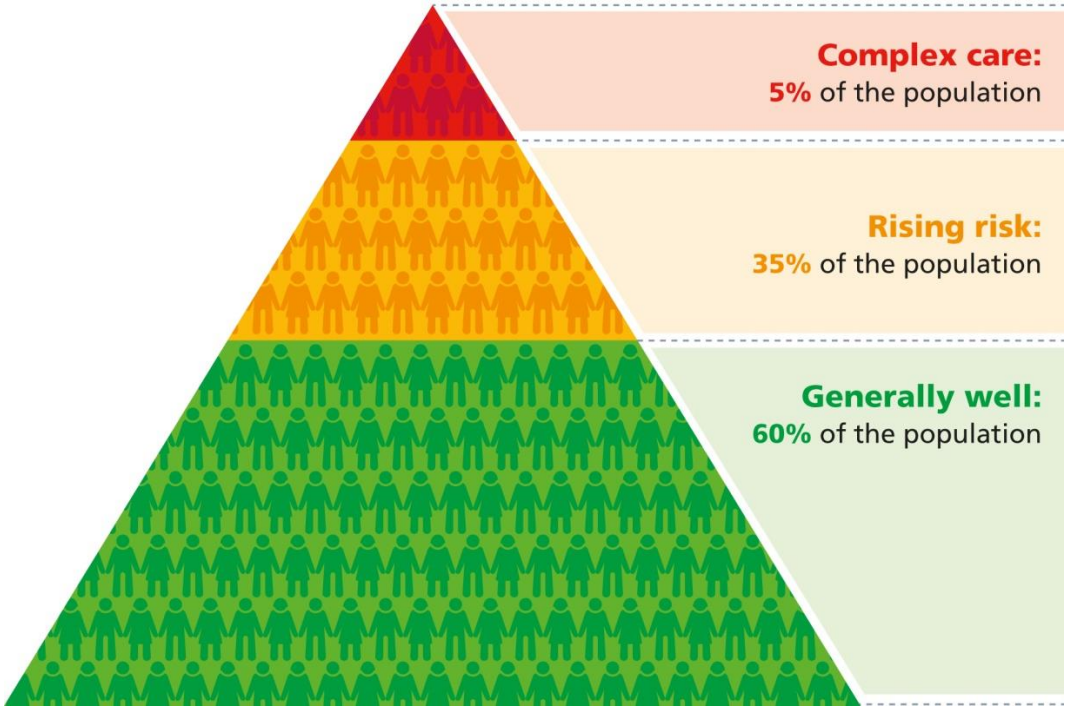
An ageing society will mean more people living with combinations of long-term health conditions. This needs increasingly proactive and well-coordinated care in primary and community settings to ensure continuity of care for those who need it, with specialist secondary care clinicians supporting local teams.

For WCHC, this builds on our services that already support people throughout their lives. These include universal provision for children and families as well as many other nursing, therapy and medical services, and both health and social care services.

We recognise significant potential to better integrate or ease transitions between our health and care services with mental health, primary, secondary and community & voluntary sector provision. Our services will become simpler to use, with one point of contact enabling bespoke combinations of services based on individual need. This will achieve better and safer outcomes for people as well as utilising NHS and social care resources most effectively.

Given the need to reduce or delay future demand for health and care services we intend to develop our services to meet needs across the 'triangle of complexity':

- Where people are generally well, encourage and support wellbeing
- Where people have developing needs or are at risk, we will use a 'case finding'[3] approach to support independence, self-care, effective condition management and healthy behaviours
- Where people have complex and ongoing needs, proactive integrated teams will provide effective care and support



[3] Case finding is actively searching systematically for people at risk, rather than waiting for them to present.

Truly joined-up services will provide more proactive, personalised health and social care close to where people live, meaning reduced need for unplanned secondary care. The proportion of urgent care, where it represents a failure of planned care, should reduce.

For when it is needed, urgent care will be provided more responsively and effectively - and with greater continuity of care - by providing stronger connections between primary care and the wider care system.

WCHC has identified the following core areas of strategic development and innovation for 2018-2021.

5.1 Integrated Neighbourhood teams

More integrated teams at Neighbourhood and practice level will provide more efficient and person-centred 'joined-up' care. They will support people proactively, reducing system pressures caused by reactive, episodic management.

These teams will be formed by aligning existing community-facing services with GP practices and Primary Care Networks to develop integrated Neighbourhood teams. They will include mental health, social care providers and the VCF sector, closely supported by secondary care teams, reducing complexity and improving people's experience of care.

Local leadership and coordination will balance increased autonomy and local service developments to meet specific community needs with use of best practice and reduction of unwarranted variation.

We intend to work towards integrated assessments, shared care plans and appropriate real-time information about the people we care for, across different parts of our system, i.e. not just NHS organisations but social care and potentially other providers, supporting individuals to achieve their personalised outcomes.

How	Measures of success
• Alignment of many nursing, health visiting, social care and therapies staff to Primary Care Networks and practices. • Identification and implementation of leadership and management structures that promote local identity whilst providing effective professional leadership and supervision, and satisfy governance needs, with minimal unwarranted variation. • Development of information sharing and coordination capacity, using IM&T, working towards a fully integrated assessment and care plan per person • Build relationships and coordinate / integrate services with social care and independent / VCF sector providers.	Increase services provided as close to a resident's home as possible. Improved experience and outcomes of health and care services (people and carers) Staff report greater job satisfaction Implementation of shared records, integrated assessments and care plans Reductions in non-elective admissions and readmissions within 30/90 days

5.2 More integrated pathways and services

Realising the potential of integrated Neighbourhood teams depends on proactively identifying and assessing people's needs, informed by effective risk stratification. This facilitates early intervention and supports individuals to adopt a strength based approach which promotes independence and improved wellbeing.

More effective, holistic and person-centred pathways of care, particularly for people with complex needs, depend on everyone involved in care having the ability to share information and coordinate effectively.

This will include proactive, multidisciplinary care with rapid response, proactive case finding and management and timely transitions to and from community care, improving system flow.

How	Measures of success
• Proactively work with partners to identify priority pathways, using data-driven analysis and evidence to inform revision/creation of models. We expect these to include: – Implementation of better integrated, multidisciplinary care at practice level for people with current complex needs, e.g. frailty, multi-morbidity, based on Buurtzorg principles – Identifying and implementing a model of case finding and support for people with multiple long-term health conditions • Realising benefits of health and social care integration through development of integrated service provision • Combining physical and mental health pathways, recognising that needs in one area often lead to needs in another, and these cannot be separated. • Further development of a Single Gateway for referrals and service coordination for both public and professionals • Ensuring development and better coordination of wider children and families services, scoping the transfer of services where this will improve provision • Collaborating with partners in general practice and secondary care to provide a new model of Urgent Care in Wirral	People are able to stay independent in their place of choice for longer. Reduced number of care home placements Reductions in non-elective admissions and readmissions within 30/90 days Reduction in Delayed Transfers of Care (DToCs) Reduction in unwarranted variation in practice People with long-term conditions routinely have their mental and emotional health needs assessed and are connected to sources of support

5.3 Focus on promoting health and wellbeing

Supporting physical and mental wellness, considering social as well as clinical needs, will help people maintain quality of life and independence and avoid or delay use of more formal, costly services.

Our staff, and those of partners, have untapped potential to positively influence people's lifestyles and help them connect with supportive groups and services. Meanwhile, we can help our own staff better manage their own health and wellbeing, both for themselves and to enable them to better support patients and service users.

Build organisational capacity to promote health and wellbeing, so that staff are consistent in using every contact to support people to live healthier lives.

This will include proactively identifying people who need extra support, due to physical, mental or social factors. Staff will support people to have access to, and links with, their advocacy and support networks in the community.

It also means a continued and more systematic focus on staff wellbeing, both work-related and lifestyle factors.

How	**Measures of success**
• Development of training programmes in Brief Interventions / Making Every Contact Count and Motivational Interviewing; potential for use across wider system • Incorporation of person-centred assessment into service delivery models • Use risk-based approach to identify people who will benefit most from being connected to other services and groups • Ensure staff have easy access to information to connect people to groups and services. • Systematic focus and plan to increase staff wellbeing	Improvement in years of healthy life expectancy Reduction in disparity between different parts of Wirral in years of healthy life expectancy More people who use our services are connected with sources of social support Reduced staff sickness absence rates and improved staff retention; greater reported work satisfaction

5.4 Social Value and WCHC's role as an Anchor Institution

As a major employer and buyer of goods and services as well as a service provider, WCHC plays a very significant role in the economic, social and environmental development of its communities as an 'Anchor Institution'.

By making a conscious effort to ensure that these effects are positive, WCHC adds social value by contributing to the long-term wellbeing and resilience of individuals, communities and society in general. This is in areas as diverse as carbon reduction, provision of work placement and apprenticeship opportunities and supporting people to live healthier lives.

During 2019/20, WCHC will be adopting a systematic approach to measuring and increasing its social value.

6 Enablers

Achieving the ambitions described above will depend on having in place an organisational structure and support services that most effectively:

- Provide the tools, information and analysis for staff to deliver transformed services
- Directly support individuals, teams and divisions to provide high quality, sustainable services
- Deliver the project management and quality improvement infrastructure to enable well managed change
- Lead and influence an evolving health and care system

6.1 Information Management & Technology (IM&T)

Delivering Place-Based Care will depend on having the IM&T infrastructure and tools that enable straightforward information sharing and care coordination, with easy to use IT systems that make life simpler for our staff, particularly when working remotely.

This work has begun with the development of the Wirral Care Record, with interoperability across different IT systems to provide a shared longitudinal record, supporting population health analytics, a combined view of a person's care information (Health Information Exchange) and 'Registries' for particular health conditions that promote and record best practice provision.

There is also significant potential in

- health platforms and telehealth technologies to support people to manage their own health and to maintain independence
- enabling people working in different organisations to share non-clinical information and collaborate

This is likely to require investment in innovative technology and development of positive relationships with major technology providers. It will also need investment in IT infrastructure and management.

6.2 Business Intelligence and Population Health Analytics

Reducing unwarranted variation in service provision, whilst increasing service quality and efficiency, needs effective Business Intelligence tools that are embedded within our Trust and our partner organisations.

The Trust's Information Gateway (TIG) has begun to demonstrate the value of both analytical tools and accessible information to inform service development.

Future service planning will be based on an analysis of population health need and a holistic assessment of the Acuity and Dependency of individual people.

A data-driven approach (using person-centred outcome measures) will enable us to understand and demonstrate the effect of our services on people's wellbeing and independence, alongside their quality and efficiency, plus the system-level effects of enhanced health promotion, early intervention, crisis prevention and improved transitions in community care settings.

6.3 Development of System Infrastructure

A further area of significant focus will be to work with partners to build the infrastructure to manage place-based care. This means the development of a virtually or partially integrated provider function that can:

- Deliver a capitated, long-term population health contract, or work within an alliance contract framework that promotes Place-Based Care and population health
- Plan, implement, manage and monitor complex service changes
- Make use of effective governance for decision making and assurance
- Engage communities and staff in developing new models of care
- Develop and maintain a clear understanding of population needs and service performance
- Ensure different parts of the provider system are resourced appropriately, enabling a transition to more proactive, community-based care and support

This work will be done by the Wirral Integrated Commissioning function and by providers working as the Wirral Provider Alliance.

7 Governance and Board Assurance

Given the dependencies between internal transformation and strategic development, we will expand our programme management systems and governance to include all strategically important programmes, alongside Cost Improvements and Transformation.

In 2018/19 we implemented Programme Management Board (PMB) to provide assurance regarding the delivery of programmes and projects associated with delivery of Trust strategy, as well as cost improvement projects and oversight of capital projects planning and expenditure.

Reporting into OMB, this provides a systematic and integrated approach to monitoring, reviewing and evidencing of progress against our Organisational strategy and related plans.

The Trust's Quality Impact Assessment process, reporting into PMB, ensures that the effects on patient care of planned transformation projects are fully understood, with schemes that are detrimental to care quality are either not progressed or amended, and their effects monitored.

We recognise the risks and challenges of delivering multiple transformation programmes in a complex provider environment. Strategic risks are regularly reviewed by Board and embedded in our Board Assurance Framework.

We are operating in a rapidly changing environment and our strategy will flex and respond accordingly, being regularly reviewed by Board.

8 Equalities Impact Assessment

In order to demonstrate ‘due regard’ for the General Duties of the Equality Act (2010) the Trust has developed a robust and consistent approach of undertaking Equality Analysis.

The General Equality Duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The functions of a public authority include all of their powers and duties. This means everything that we are required to do as well as everything that we are allowed to do. Examples include: policy decisions, budgetary decisions, public appointments, service provision, statutory discretion, individual decisions, employing staff and procurement of goods or services.

An Equality Impact Assessment is a fundamental part of the rigour with which WCHC sets about developing new services and pathways.

Appendix A 10 design principles for community services

The King's Fund, Reimagining Community Services (2018)
www.kingsfund.org.uk/publications/community-services-assets

- Organise and co-ordinate care around people's needs
- Understand and respond to people's physical health, mental health and social needs in the round
- Make the best use of all the community's assets to deliver care to meet local needs
- Enable professionals to work together across boundaries
- Build in access to specialist advice and support
- Focus on improving population health and wellbeing
- Empower people to take control of their own health and care
- Design delivery models to support and strengthen relational aspects of care
- Involve families, carers and communities in planning and delivering care
- Make community-based care the central focus of the system.

NB in this paper, community services are defined in their widest sense, including GPs, social care providers, community and voluntary sector services etc.

Appendix B Partner selection criteria

Transforming the way we promote health and deliver health and care services will require new partnerships between health and social care providers and other parts of the independent and community and voluntary sector.

Characteristics that would be looked for in other bodies with which we could develop formal relationships would include:

- Alignment of culture and values
- Shared organisational aims and intended outcomes
- Complementary business models, enhancing and sustaining both organisations' development and service provision
- Due diligence with respect to:
    - Financial security
    - Probity
    - Historical performance (both service quality and contracted activity)
    - Reputation
    - Skills and resources

We recognise that we will sometimes be required to enter partnerships with organisations whose culture, values and aims are different from our own, in the interests of system transformation and providing people with the most effective care and support.

Appendix C Place Based-Care improvements

Canterbury, New Zealand

Canterbury, New Zealand has, for over a decade, focused on greater coordination and alignment across health and care services and increased investment in primary and community care. As a result, their health system is supporting more people in their homes and communities and has moderated demand for hospital care, particularly among older people. Compared with the rest of New Zealand, Canterbury has lower acute readmission rates; shorter average length of stay; lower emergency department attendances; and lower spending on emergency hospital care.[4]

Encompass, Kent

The Encompass Multispecialty Community Provider (MCP) in Kent reports that they have achieved significant reductions in secondary care activity by implementing a range of measures, with Multidisciplinary Team working reported as most influential. This has included reductions in Emergency Department minor (i.e. walk in) attendances (6%), emergency admissions (8%) and short stay admissions (33%). Their MCP, across a population of circa 180k has reduced activity by the notional equivalent of £3.4m, which would scale to £6.2m in Wirral.

Local Government Association research

Research for the Local Government Association into opportunities for greater integration of health and social care suggests that savings of up to 10% may come from increasing resources for integrated community services with benefits for both users and the wider system.[5]

[4] https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf
[5] https://www.local.gov.uk/our-support/efficiency-and-income-generation/care-and-health-efficiency

Appendix D SWOT analysis

There is significant overlap between WCHC's strategic aims and those of the wider Wirral system. High level Strengths, Weaknesses, Opportunities and Threats are identified below.

These are regularly reviewed by Board and influence the development of the Board Assurance Framework

Strengths	• Organisational focus and strong track record on safety and clinical effectiveness • Open and honest culture, proactive focus on supporting the wider system • Organisation providing both community health and social care services, well placed to join up different parts of the health and care system • Support people through all stages of life, including through universal services for children and families • Position of influence within System and positive relationships with other providers • Wirral wide infrastructure and links into Cheshire system via 0-19 service • Ability to link WCHC staff into integrated care teams within 9 localities • A track record of achieving quality objectives • Consistently good performance against contractual KPIs • 90% of our patients, on average, recommended us to family & friends • A positive, open culture and score well for overall staff engagement
Opportunities	• Development of partially Integrated MCP with GPs and other providers, or deliver functionally similar offer under alliance contract • Alignment of infrastructure with GP Fed(s) to strengthen primary-community care offer to commissioners, and offer scale and expertise to practices • Utilisation of organisational reach and scale to improve health promotion and positively influence development of integrated care teams at local level • Supporting the secondary care provider through even more effective management of transitions of care and proactive support for wellbeing and independence and crisis prevention • Development of stronger links with providers within the social care and community and voluntary sectors, and social housing providers • More integrated provision of physical and mental health services to improve quality and value • Development of consistent community care model across Cheshire and Wirral (with CWP)

	• Demonstration of value added by investment in primary and community care
Weaknesses / Threats	• Limits to ability to deploy necessary transformational / developmental capacity, both within current systems and new areas • Capacity to change culture within organisation and system with the speed required to support new ways of working • Ability of Information Management & Technology (IM&T) to allow appropriate information sharing and facilitate single assessments and care plans • Challenge of increasing efficiency whilst maintaining quality and delivering transformation • Workforce availability in medium to longer term to deliver care due to demographic change; availability of social care workforce • Across system, planning within silos, particularly workforce • Disparate views amongst GPs and limited track record of delivery of transformational change within wider Wirral system • The development of Primary Care Networks (PCNs) may disrupt the ability to coordinate services effectively • System financial deficit may lead to short term decision-making, preventing transformational change and redistributing funding to primary and community settings • Place-Based commissioning may reduce opportunities for bringing expertise to areas outside of Wirral • In the absence of additional funding, pooling of NHS and council commissioning funds may increase pressure on NHS budgets • Place-Based Care may put additional expectations on primary and community providers but without the additional resources necessary to provide good quality services • Current regulatory environment, by focusing on individual organisational performance, hinders change across whole system (although also limits pressure on WCHC to reduce required surplus)