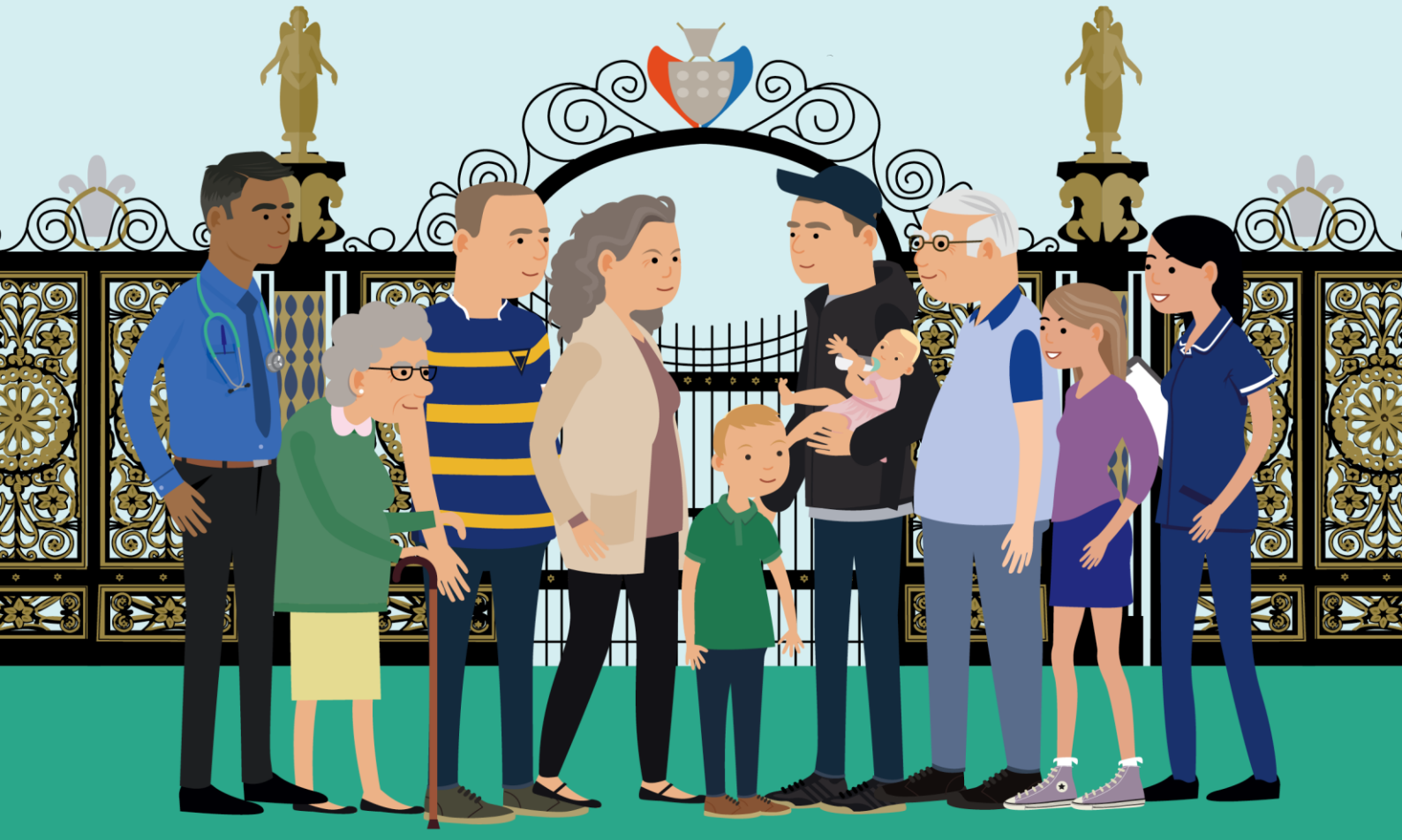
Together we...
Are improving health and social care in Warrington

Our Vision and Strategy for Health and Care Transformation in Warrington

"We want to make people's lives better, helping them to live longer, healthier lives."



1. Introduction

Like all other towns and cities across the country, over the next decade Warrington will see a growing demand for health and social care services.

This rise in demand is a result of demographic changes and there will be a steep rise in the number of old people, and as we know old people have a larger number of long term conditions than the rest of the population.

In addition to the increase in our older population, across Warrington we have a growing number of families and individuals who are struggling and in need of help and advice.

At the same time as the increase in demand for services, we are facing major financial pressures and significant reductions in our funding.

The NHS will be approximately £30 billion short of funds by the end of this decade whilst local authorities have had cuts imposed by central government of more than 30% in recent years. Taken together the impact of the funding squeeze affects the financial viability of the system.

Clearly, in order to sustain health and social care services we will need to adopt a different approach, one which will enable people to have the very best health and care and will ensure that we spend the available money more efficiently.

We believe that by working **together we** can do things differently, creating a new integrated care system, built around the needs of local people. We want the people of Warrington - children, adults of a working age, and older people, to feel more in control of their lives and able to draw upon their own personal resources, and those of the community, not only when health and social care problems arise but to prevent these problems happening.

We recognise that we need to do much more to support people to be well and independent so that they do not require the intervention of expensive services. In health, we know that the current model, where the majority of funding is spent on acute hospital services. – The most expensive part of the system - is unsustainable and has to change.

This document describes our vision in more detail, the context in which we have developed this and our plans for making it happen.

Building on the town's Health and Wellbeing Strategy, our plans will require large scale transformation of the way that care is delivered in across the town.

We do not underestimate the scale of this challenge which will require the commitment of all of the main health and social organisations across the town.

Most importantly, transforming our public services needs to be truly person-centred. And aligned to the principles expressed in Warrington's Health and Wellbeing Strategy:

- Tackling inequalities
- Promoting prevention
- Providing care closer to home and enabling self care
- Strengthening communications and improving engagement
- Personal responsibility
- Ensuring consistent safe and quality care
- Investing in integration
- Promoting safety and improved quality of life
- Providing high quality integrated services

The support of staff working across health and social care and the views of local people are equally important, therefore the overall transformation programme will be supported by inclusive, two way communication and engagement.

Looking to the future, we are going to grasp this unique opportunity to change the way in which we work and firmly believe that by working **together we** can make people's lives better.

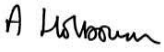
Professor Steven Broomhead
Chief Executive - Warrington Borough Council

Dr Andrew Davies
Chief Clinical Officer - Warrington CCG

Mel Pickup
Chief Executive - Warrington & Halton Hospitals NHS Foundation Trust

Colin Scales
Chief Executive - Bridgewater Community Healthcare NHS Foundation Trust

Simon Barber
Chief Executive - 5 Boroughs Partnership NHS Foundation Trust



Alison Holbourn
Chief Executive - Warrington Health Plus Community Interest Company

2. Our Vision

Our Vision is simple; *we want to make people's lives better*. Helping people to live longer, healthier lives, supported by sustainable services, wrapped around individuals – not buildings or organisations.

We can do this by working together to change the way in which health and social care is delivered. Our vision is shared across all the agencies that work together to secure and deliver public services across Warrington. We work for Warrington, not the individual agencies that employ us.

Our focus is to build a health and social care system in Warrington that is **person-centred**, supports people to stay well and provides the right care, in the right place, at the right time.

Our system vision will be delivered through a large scale change programme which aims to improve services and outcomes for local people, moving from a hospital based system of unplanned care to a preventative, anticipatory, whole person approach to their care, health management and treatment.

Our Vision of the future for our care services is illustrated in ***Figure 1.***

Together we...

Are improving health and social care in Warrington

Right Care, Right Place, Right Time.

3. Our Case for Change

We believe the case to transform health and social care is overwhelming. The Town's health economy like many across the NHS in England faces a series of challenges and opportunities that if not addressed have the potential to impact the sustainability, delivery and outcomes of local services, and therefore worsen the health and wellbeing of local people.

Increasing numbers of patient and service users are also pointing out the sometimes fragmented nature of their health and social care. Whilst many are receiving elements that are very good, the whole pathway of care can at times appear disjointed.

When we asked local people about their experiences… this is what they told us:

"We didn't know who was responsible for what"

"Waiting for medications takes up a bed for patients being discharged"

"Health and social care don't communicate with each other; we have to tell different people the same story all the time"

"Need support and appropriate equipment for disabled people in emergency care"

"I want my child to have the right care by the right person and in the right place"

"Dad wanted to come home and we wanted him home, but it took ages"

Together We can change this...

By working together we can improve the way in which care is delivered, not just hospital care, but care in GP practices, mental health services and social care.

Work to reshape some care services is already underway - integrated health and social care is an emerging reality and there is work being undertaken on how we better deliver care in our communities.

However, this change needs to go further, with more improvements in primary care, greater access to GPs, more support for people to manage their own care, better illness prevention and some services moving from hospitals into the community.

Primary and community-based care services, GPs in particular, are often the gateway to health and social services and the main source of advice for patients. So transformation of primary care is the cornerstone of a changed health and social care system.

By strengthening the primary and community care pathways we will enable people to stay healthier and independent for longer and also reduce demand on hospitals services.

The three examples illustrate the difference that more joined up care could make to people living in Warrington…

Mrs Anne Warrington

Anne is 78 year old lady with osteoarthritis, hypertension and mild congestive heart failure. Anne has had bilateral hip replacements and can only walk short distances. Unofficially cares her husband, 82 year old Derek Warrington

Anne had a holistic assessment of her needs undertaken by her GP. The assessment identified that she would benefit by having a care coordinator who would help her navigate the health & social care system.

Recently Anne's congestive heart failure deteriorated, her primary care team arranged for Anne to be seen in the acute medical unit, where she received care and was discharged home within 12 hours with the support of the collaborative care team.

Anne continues to enjoy her time at home with her husband… surrounded by the care she needs.

Mr Derek Warrington

Derek is an 82 year old man with COPD and heart failure. He has rheumatoid arthritis and dementia and unable to perform personal care tasks. Propensity to wander out of the house, leave the gas on unlit and cannot be left alone.

Derek had a holistic assessment undertaken of his needs at the same time as Anne. Derek was allocated the same care coordinator as Anne to help her access the health & social care system as Derek's main care giver.

Derek receives outreach support for his dementia from 5 Boroughs Partnership. Recently he was suffering from a urinary tract infection which made his confusion worse. The care coordinator pulled in additional support from the collaborative care team, who put a package of care together to enable him to be managed at home.

Derek didn't have to go into hospital and continues to enjoy his time at home with Anne his wife.

Mr Paul Warrington

Paul is the 45 year old son of Anne and Derek. He lives across town from his parents. Paul lives alone, smokes 15 cigarettes a day, drinks between 30-35 units of alcohol per week, eats lots of fast food and additionally has suffered from depression following his divorce.

Paul was invited to the surgery following a recent short stay in hospital with a suspected heart attack. The hospital stay together with his lifestyle triggered the primary care appointment for an assessment.

Paul was advised about the risks associated with his diet, smoking and alcohol intake and offered some lifestyle advice in relation to his alcohol use. Paul was signposted by his primary care provider to some community support services that would support him to make changes to his lifestyle including smoking cessation services.

Paul is supported and has the tools he needs to make lifestyle changes to improve his health… helping him to help himself to live a longer healthier life.

The case for change doesn't stop at just the issues relating to the way in which organisations work, the systems and process, but also reflects the need to address the killer issues in our town:

- Smoking related deaths are significantly worse in Warrington than in most other parts of the country
- A fifth of the local adult population are overweight
- Life expectancy within Warrington varies considerably with men in our most affluent communities living more than 10 years longer than those in our most deprived areas

It is wrong, we believe, that people in Warrington have poorer health than elsewhere in the UK and that life expectancy is so varied. Our aim is to change that, largely through integration. By this we mean **person centred coordinated care** rather than structural change.

In practice that will mean:

- People are the focus of delivery, regardless of the organisations providing or commissioning
- Outcomes for people take priority over output or process targets and measures
- Frequent users of public services are encouraged to make better choices and contribute to their communities through the development of services designed to encourage and facilitate responsible behaviour
- Multi-agency provision of services, across sectors, is the norm. Service silos and duplication are eliminated
- Technology will transform our ability to predict need, provide advice and deliver service

3.1 The Challenges for Warrington - why we need to change

Lifestyle-related health issues, health inequalities and health outcomes

People in Warrington experience a range of worse health outcomes in comparison with similar towns in other parts of the country.

True transformation in Warrington will be dependent upon people taking greater responsibility for their own health. Adult obesity, alcohol misuse, smoking related deaths and cardio vascular illnesses caused by these are all significant factors affecting the health of local people.

In general, health outcomes are worse in the more deprived areas of Warrington; these tend to be in the central wards in Warrington (Bewsey & Whitecross, Fairfield and Howley, Latchford East, Orford, Poplars and Hulme, and Poulton North).

For the time period 2009-2013;

- Life expectancy in Warrington was 78.4 for males and 82.0 for females (a difference of 3.6 years). At ward level, male life expectancy ranged from 73.2 years in Fairfield and Howley to 83.6 in Hatton, Stretton and Walton (a difference of 10.4 years). Female life expectancy ranged from 78.5 years in Fairfield and Howley to 87.2 in Appleton (a difference of 8.7 years).

- Mortality* due to Cardiovascular Disease was highest in Latchford East ward and lowest in Appleton; the rate in Latchford East was almost double that in Appleton. “Premature” CVD mortality (in people aged under-75), was highest in Bewsey and Whitecross ward and lowest in Appleton; the rate in Bewsey and Whitecross was almost 4 times the rate in Appleton.
- Mortality due to cancer* was highest in Poplars and Hulme ward and lowest in Culcheth, Glazebury and Croft; the rate in Poplars and Hulme was almost double that in Culcheth, Glazebury and Croft. “Premature” cancer mortality (in people aged under-75), was highest in Bewsey and Whitecross ward and lowest in Appleton; the rate in Bewsey and Whitecross was more than twice the rate in Appleton.
- Mortality due to respiratory disease* was highest in Bewsey and Whitecross ward and lowest in Hatton, Stretton and Walton; the rate in Bewsey and Whitecross was more than 3 times the rate in Hatton, Stretton and Walton. “Premature” cancer mortality (in people aged under-75), was highest in Fairfield and Howley ward and lowest in Appleton; the rate in Fairfield and Howley was more than 9 times the rate in Appleton.

*Directly Standardised Rate – i.e. standardised to account for the different age structures of the populations in different wards

Population Change

Warrington’s population is changing; the total Warrington population is projected to grow by 9.7% by 2021. This trend is evident across all ages up to 2021 by which time there will be 11% more children and almost 5% more working age adults living in the town.

Moreover, people are and will be living longer with an expected 27% growth in the numbers of people aged 65+ years by 2021 and 60% by 2030. Significant growth in those aged 70-75 and 85+.

Frail older people occupy around 70% of acute hospital beds (with up to 60% of over 65’s in our hospital having a dementia co-morbidity), and are associated with around 46% of total NHS and around 55% of social care expenditure. Frailty is the underlying cause of death in 25% of the population.

In addition to this growth in the population, changes in the age profile within the population will impact heavily upon health and care service delivery. As the population ages there will be more people living with health conditions and often multiple needs, placing greater demands upon our health and social care system, both in community and in hospital care settings.

Long term conditions currently account for 70% of overall health and social care spend with a projected increase related to lifestyle and age profile demographics. The average annual cost to health services of a person with one long term condition is £1,000 and this rises to £8,000 for a person with three or more long term conditions.

We need an approach to change that is clinically and practitioner led, sustainable and appropriately resourced.

In essence, the 'prescription' for a healthier Warrington is the whole-system working together.

Primary Care

Demand has increased significantly in primary care, however funding for primary care has reduced in proportion to total NHS spend. The scale of the challenge faced by general practice is illustrated by the figures below:

- GPs provide 90% of NHS contacts with only 9% of the budget[1]
- Consultations in general practice have increased by 75% between 1995 and 2009[1]
- There has been an increased clinical workload in general practice of over 40% since 2008

Additional pressures driving change in primary care include:

- Growth in new technologies, providing patients with greater access to information and enabling greater involvement in their care
- Innovation in treatments enabling care closer to home
- Increasing patient expectations
- Increasing demand for GP appointments
- Increasing pressure for general practice to resume responsibility for out-of-hours care
- Workforce pressures, such as ageing workforce, insufficient trainees to meet future need and demands on GP time to support clinical commissioning

The current primary care system will not be able to deliver effective care with the rising disease prevalence, ageing population and associated rising costs. The increasing demand on primary care requires a change in how it is delivered and that:

- Responds to the increasing demands of complex clinical needs
- Promotes effective care coordination and system integration based around both the needs of patient groups (for example the frail elderly or children/adults with complex disabilities) and also based around the personal needs of individual patients within those groups
- Seeks to provide care to communities that reach beyond the traditional core primary care offer
- Optimise skills and resources provided by wider primary care workforce (dentists, opticians, pharmacists)

Social Care

Social care responds to a wide range of need - from an 18 year old with autism who needs support to leave home; to an 80 year old with dementia who needs protection as well as personal care. Social care touches the lives of almost a fifth of the adult population.

There has been good progress in developing different models of care that enable people to live as independently as possible. For example, through rehabilitation and reablement that avoids dependency on long term care and traditional services, developing recovery models in mental health services, and through supporting people with learning disabilities or mental health needs to engage in employment and leisure.

There are many examples of innovative local services aimed at earlier intervention and prevention. Investment, however, has inevitably suffered due to the scale of the financial challenge to the health and care economy over a number of years.

However, where there is agreement for whole system investment, there remains considerable scope to achieve better outcomes for people through the further development of services along with the right mix of housing-based support, telecare and other technologies. The provision of information and advice, which is a key element of the Care Act, will become more important in supporting individuals to manage their own health and care needs and access the right help.

Many people with care and support needs are clear that they want a holistic approach to enable a quality life, not just a short term intervention of a service. In pursuing closer integration of health and social care, care will be needed to avoid an over-medicalised approach to those people whose need are not primarily clinical.

The mainstream use of personal budgets is improving the choice and control individuals have over their care and support, and their lives. Extending these arrangements so that people can access a combined budget covering health as well as social care needs ('Integrated Personal Commissioning') creates the potential for integrated care to be driven as much by individuals as by organisations.

Acute Care - Sustainability of our hospital services

With a population reach of 313,000, Warrington and Halton Hospitals NHS Foundation Trust operates on the lower end of the scale for a full range of District General Hospitals which is ideally a 450,000 - 500,000 population base.

It is vital that Warrington has clinically and financially viable hospital services for the future, it currently costs more than there is available to run some clinical services. The scale of activity for some of the Trusts specialties is in the lower quartile when compared to Trusts across the country.

Collaboration with other health and social care providers locally will be required to ensure a sustainable future for locally based hospital services.

Better Links between Health, Social Care and Voluntary Services

Warrington has many voluntary, community and social enterprise partners. We recognise that our ambitions for improving the health and wellbeing of local people are more likely to succeed if our models of health, care and support services reflect all aspects of health and wellbeing and operate as a strong and integrated part of our health and care system.

Many voluntary organisations have a detailed understanding of specific local needs, high levels of trust and engagement with local communities and the ability to work across multiple services to provide care for individuals. For example, within the context of an ageing population, the Voluntary Sector has a crucial role to play in addressing social isolation as well as harnessing the power of the local community.

We will work to ensure we know which voluntary care services are in our communities to enable us to signpost people appropriately to get the support they need when they need it.

Financial position

The need to improve outcomes and the experience of care is a fundamental part of why we are pursuing this programme of change. We also know that we must change to address the scale of the financial pressures that is facing our health and social care economy.

The scale of savings required over the next three years is a step change even from the demanding saving requirements of recent times. In this context, we cannot maintain the quality of services currently provided to local people if we continue to deliver them in the same way. In order to continue and improve the quality of services, we must radically transform the system in which they are delivered.

Service variability

Outcomes across Warrington for local people are unacceptably variable. This is being experienced in primary care, community care and in our hospital. This can manifest itself in a variety of ways, including differing referral rates for cancer, high admission rates to hospitals, variances in hospital length of stay and clinical outcomes.

Similarly patient experience and quality of service delivery across Warrington can vary significantly. Such variations have to be tackled. We will work to a future where services are delivered consistently to the highest standards in a fair, sustainable and equitable manner.

New approaches to care

Against the backdrop of significant health and social care challenges, we are continually improving our understanding of the best approaches to maintain health and provide better treatment for people who need care.

There is strong evidence that for some conditions, developing more specialised hospital care can result in better outcomes for patients through the concentration of highly-effective technology along with the most highly trained and specialist staff.

Empowering local people

It is clear that significant opportunities exist to improve health outcomes through empowering patients to be in control in decision-making about themselves and their loved ones' care. In this way we can improve outcomes by addressing the whole person, rather than focusing on single facets of their health and social care needs.

Too many people report negative or unsatisfactory experiences and for too many people there are barriers to accessing care in a straightforward approach. Putting a people first will therefore underpin our approach to achieving a healthier Warrington.

4. Our Ambition

We believe that our ambition to make the people of Warrington's lives better is achievable. By working together we can improve the way in which care is delivered, not just hospital care, but care in GP practices, mental health services and social care.

The NHS five year forward view sets out the NHS plan for the coming five years alongside a number of potential models of care. It is clear that quality of care can be variable. Preventable illnesses are widespread, health inequalities are deep rooted and alongside changing population needs, new treatment options emerging, particular challenges such as mental health, cancer and support for frail older people; service pressures are building and a different model of local health and social care services is required.

Some critical decisions need to be made regarding investment, public health measures and local service changes. Decisive steps need to be taken to break down barriers in how care is provided between family doctors and hospitals, between physical health and mental health and between health and social care.

The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health and care needs. The health and care system must take into account the needs of the entire person, rather than addressing just one particular element of what may be a complex range of health and social needs.

In reality, this means being prepared to set aside traditional approaches which may suit the health and social care system's traditional organisational needs but do not best serve the needs of the individual.

This new model of care means that the different tiers of the health and care system must connect better.

In practical terms, specialists and other staff will break traditional organisational boundaries and work in different locations and different settings, centred on the needs of people and communities.

In the future we want a model of care that is built around three 'settings' of care:

- **SUPPORTING** people to self-care and equipping them with the knowledge and resources to take healthy lifestyle decisions.

- **DELIVERING** care in communities across the town, including GP practices, schools, health and community centres, pharmacies, people's homes and residential care facilities. Our intention is to bring as much care as possible closer to home.

- **ENSURING** that, in future, our hospital will be used for only those services which absolutely must be delivered in this setting, because of the complexity of the service or the seriousness of a person's illness.

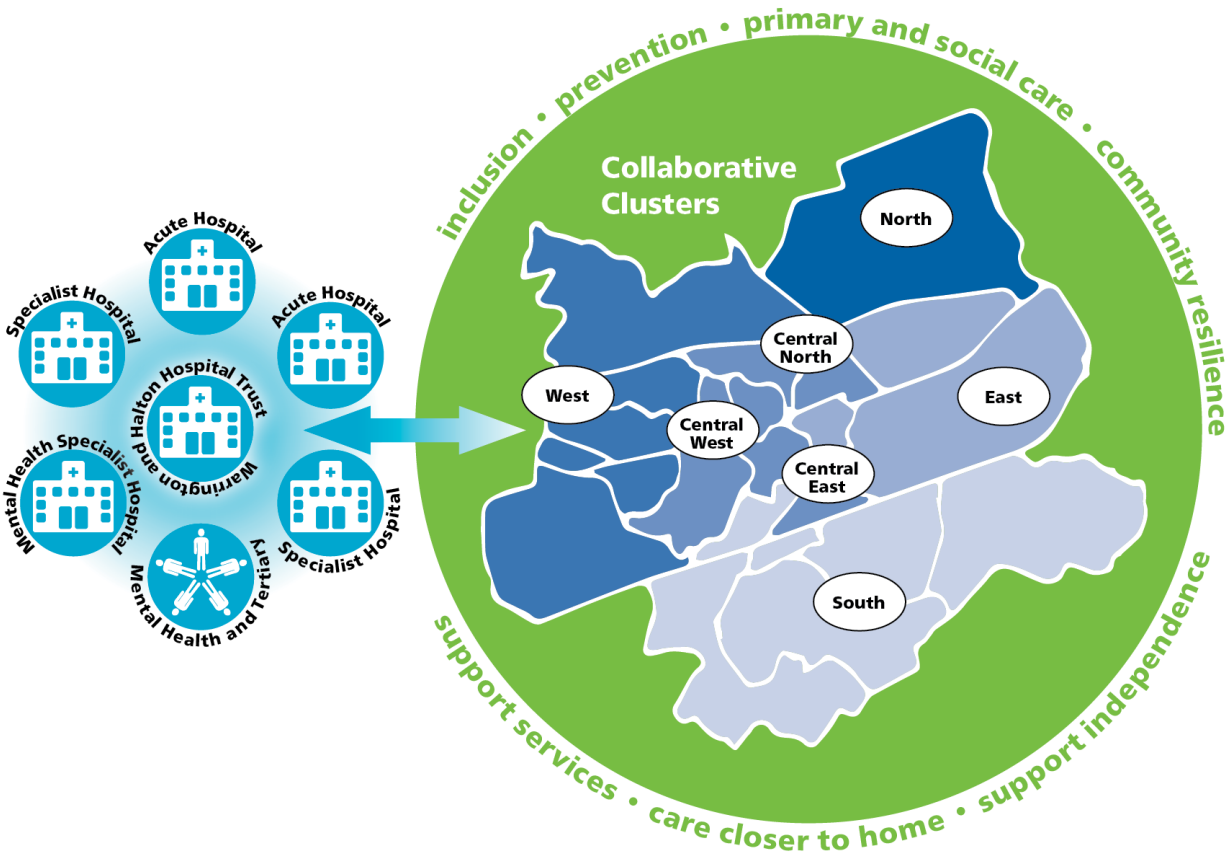
This may mean that in order to provide the very best specialist services, our local hospitals will work together in an alliance partnership, offering possibly different, but highly specialised services.

Work to reshape some care services is already underway – integrated health and social care is an emerging reality and there is activity is being undertaken to scope how we better deliver care in our communities.

However, this change needs to go further, with more improvements in primary care, greater access to GP services, more support for people to manage their own care, better illness prevention and some services moving from a hospital setting into the community.

Improving primary and community care will enable people to stay healthier and independent for longer and also reduce demand on hospitals.

What the proposed Model of Care might look like in Warrington



5. Redesigning Our Approach

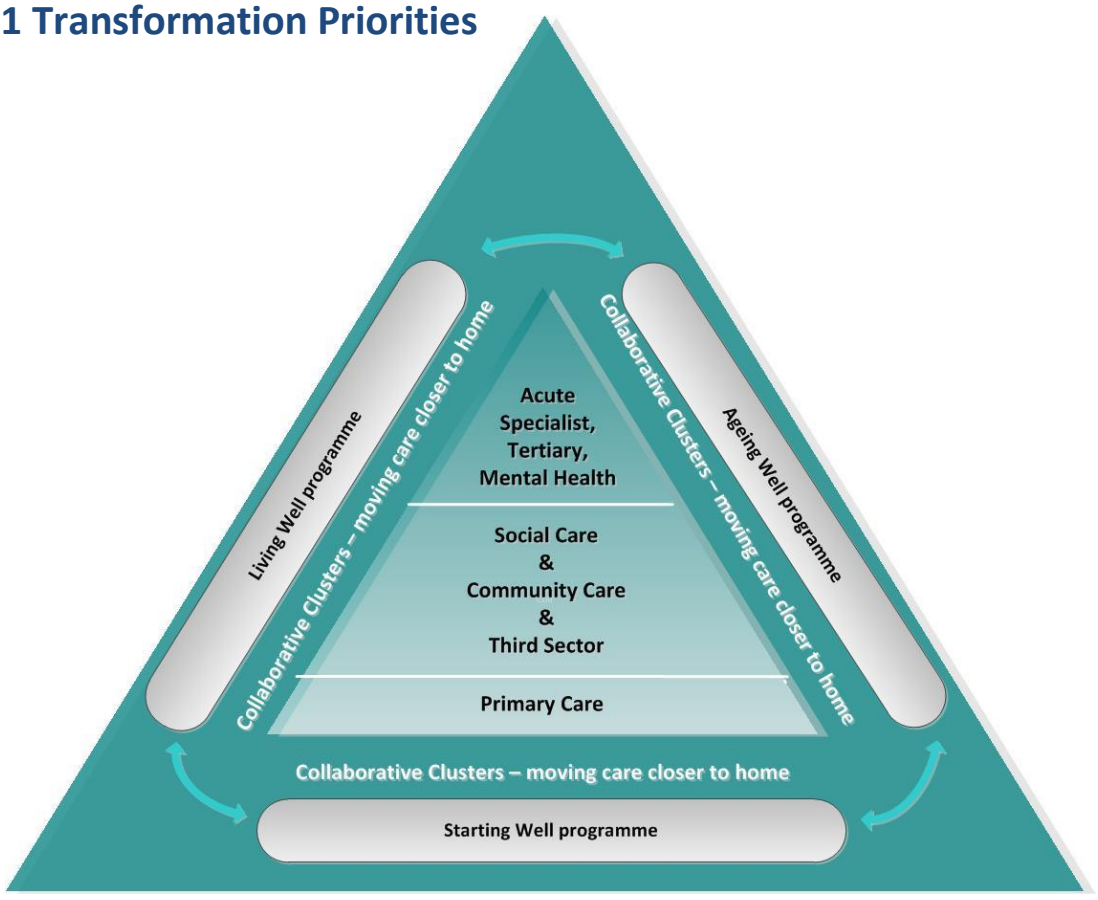
The multiple demands on our NHS and social care system mean that in planning for the future we have to manage competing priorities and make decisions that will give us the best chance to achieve the ambitious improvements in health outcomes of Warrington people.

We have examined a wide evidence-base, including the Joint Strategic Needs Assessment, to identify our priority areas of transformation, aligning to Warrington's Health and Wellbeing Strategy, which we believe will make significant impacts to achieving our strategic vision of moving from a reactive hospital based system of unplanned care to a preventative whole person centred approach to care.

Through effective re-design and focused investment, these will drive improved health outcomes. There are cross cutting groups and enabling functions which will all be relevant parts of our transformation programme.

This does not mean that other areas will be neglected; we will continue to improve all health and social care services, but we are prioritising these key areas, as evidence indicates that we can achieve the biggest improvement in health and social care outcomes by transforming the way that these areas are designed and delivered.

5.1 Transformation Priorities



5.2 Starting Well programme

Transformation priority: Prevention model

Care closer to home preventing avoidable hospital attendances and admissions for children and young people.

This is particularly relevant to those with complex or long term health conditions and also those presenting with mental health problems or drug and alcohol issues, both of which are disproportionally represented from our wards of greatest social deprivation.

The National reforms for Children and Young People with 'Special Educational Needs and Disabilities' (SEND) are reflected in the work partners have undertaken locally to implement Education Health and Care Plans, improve care coordination, implement personal budgets and establish the 'Integrated Services' model on the Woolston Learning Village site for children and young people with additional needs.

The commissioning and provider landscape for children and families is complex. In order to ensure a continuum of care that provides a graduated response to need and good educational health and social outcomes a Joint Commissioning Strategy Plan for Children &Young People has been developed.

The work highlighted during the development of this strategy identifies the need to meet the emotional health and wellbeing needs of children and young people where we have established shared outcomes, aligned investment and engaged providers to collectively ensure services are integrated and deliver timely access to high quality care so as to produce good commissioned outcomes.

Through the continued integration and alignment of commissioning and provider services. We will identify further opportunities to deliver high quality sustainable and innovative services that deliver prevention and manager on-going complexity.

5.3 Living Well programme

Transformation priority: Urgent Care model

The future delivery of urgent and emergency care is being considered as part of a national review of major trauma services and also because of the challenges being experienced due to current service pressures across Warrington.

Our approach to determining the future shape of urgent and emergency care is being informed by a number of individuals and organisations working towards developing an agreed set of outcomes to compliment the proposed model of care. A series of workshops with leading clinicians involved in the delivery of urgent and emergency care will be held to explore the current delivery and configuration of services, explore and develop the clinical standards for the future delivery of care, and to shape what the provider landscape could look like.

We have not at this stage sought to identify individual options for future provider sites in detail, and we will need to focus on the clinical standards we expect patients should receive to deliver the best urgent and emergency care.

We believe urgent and emergency care will be best served in future by a delivery model that sees patients benefit from services delivered locally with access to major trauma services when required (NHS England, 2015). In essence, an emergency centre comprises hospital-based facilities that are able to receive the full range of emergency patients and which provide for resuscitation, diagnosis and onward referral where appropriate.

The objective for the Urgent Care Programme is to provide an integrated urgent care service comprising of and Accident and Emergency department, Acute Medical Assessment, Ambulatory Care, Primary Care 24/7 that incorporates urgent care streaming and out of hours.

The programme has the following aims:

- To develop an integrated community, primary and secondary care approach to deliver front line care for our population who present with emergency needs
- For those people with urgent care needs, including people experiencing mental health crisis, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in settings with the very best expertise and facilities in order to maximise the chances of survival and a good recovery
- To co-ordinate care around the patients' needs
- To deliver urgent care efficiently, safely & on the same day whenever possible avoiding admission to hospital
- To deliver improvements in the system's ability to address urgent care need
- To ensure a seamless service for the patient irrespective of which organisation is providing the care or how they enter the system

5.4 Ageing Well programme

Transformation priority: Integrated Out of Hospital Service ("step up/step down")

Warrington Clinical Commissioning Group (CCG) and Warrington Borough Council are working together to improve Out of Hospital Services in Warrington. Our ambition is to deliver first class outcomes for patients and carers. These services are provided to patients – generally older – to help them avoid going into hospital unnecessarily, to help them be as independent as possible after discharge from hospital and to prevent them having to move into residential or nursing homes until they really need to.

With a growing older population and increasing pressures on the system due to an increase in the number of people living with long-term conditions, demand for Out of Hospital Services in Warrington is expected to continue to rise.

A recent review of Out of Hospital Services set out a number of recommendations which identify how delivery of the service could be improved. The review highlighted that currently there are a number of service providers, providing different elements of care provision.

The current providers range in size and composition, however, no single provider has the lead role for out of hospital services intermediate and this can lead to inefficiencies or may restrict the quality of service that can be achieved.

The overall goal of the programme is to transform the pathway for out of hospital services such that it becomes a seamless, supportive, rehabilitative journey for the patient or service user. To support this aim, an outcomes based contract is being developed in co-production with people who have used the service or may require such services in the future to ensure that the aims of the service reflect the outcomes that people would wish to achieve. The service is expected to be provided under one single contract by one single Provider entity which will be responsible for the delivery of all the services in the out of hospital pathway(s), rather than, as now, several individual contracts with a number of individual Providers.

The aims and objectives of the programme include:

- Aligning the delivery of services to outcomes which are based upon patients' needs
- Stronger partnership working
- Improved co-ordination of service delivery through the alignment of incentives across the out of hospital care pathway(s); and
- A long-term sustainable health economy, improving value for money through increased efficiency and reduction of perverse incentives

5.5 Transformation Priority: developing Collaborative Clusters - care closer to home

The 'collaborative cluster' programme is a key enabler to delivering and supporting the transformation processes at the pace that will be required to realise the five ambitions for primary care. The 'collaborative cluster' is accountable for a registered population of around 30,000 - 50,000. There are seven clusters being implemented across Warrington, which together will provide care coordination, extended primary care, and advanced access.

The 'collaborative cluster' offers a chance for professionals to integrate when is necessary to increase their range of activities, to allow for different access solutions and expand primary care in a population unit 'beyond the Practice walls', without breaking down existing practice units. Such an approach could also allow for commissioners to ensure that both health and social care, and care coordination professionals can integrate at the primary care home level.

The ‘collaborative clusters aim to provide:

- Extended access
- GPs with specialist skills
- Nursing specialist assessments
- Separates acute and complex care, manages complex care proactively with multi-disciplinary team input
- Shared care coordination resources (key workers or care coordinators) incorporating health and social care
- Active Case Managers
- More diagnostics available in real time
- More ambulatory care available dependent on the needs of that population
- Expanded community based mental health services
- Shared care home services
- A home for dedicated medicines management
- Greater scope for self-management and primary prevention support, integrating with social care and third sector services

The concept can deliver on the potential of community based professionals, building continuity of care and strong relational working.

Thus a group of Practices in a community, with common characteristics, continue to provide essential medical services but are able to work beyond the boundaries of the ten minute appointment and beyond the practice walls enhancing the ability of all of the multidisciplinary teams to deliver around the known requirements of the population.

The move towards collaborative working in clusters from a number of providers requires significant transformation, restructuring and adaption of the workforce from not only primary care but community, social, and acute care, maximising opportunities to work with the third and independent sector.

Our ambition is that our local hospital will be smaller, as more services traditionally delivered in a hospital setting are delivered within the collaborative clusters/primary care home.

6. Moving Forward - The Future

We have a real opportunity to transform the way that health and social care services are provided across the town. We want to see a local economy where the people of Warrington get the right care and support they need, in the right place at the right time.

When people need a response from services, this will be a joined up, targeted response built around the needs of the individual, involving them fully in decision and drawing on their personal strengths and those of their community.

Clearly, a transformation of this scale and pace will require fundamentally different ways of working across the whole system and we call on all those involved in the delivery of services in Warrington to work together to deliver our vision.

We intend to build on the detailed planning that is already being undertaken on how to deliver integrated services in Warrington. Given that there is a need to look at how health and social care services are designed, organised and provided, there will be a need for public engagement and we will therefore, support a period of engagement with stakeholders to seek their views and together develop the best possible options for service development.

7. Measure of Success

We will know that we have improved the Warrington health and social care system if together we:

- have increased the number of people having a positive experience of care
- have reduced health inequalities across Warrington
- have ensured local people can access care to the highest standards, at the right time and are protected from avoidable harm
- have ensured that all those living in Warrington will be supported by new, better integrated, joined-up community services
- have increased the proportion of older people living independently at home and who feel supported to manage their condition
- have improved the health related quality of life of people with one or more long term conditions, including mental health conditions

Above all we will ensure that we listen to people of Warrington. Local people will be the best judge of whether we are achieving our ambitions to be truly person centred and outcome focussed. This will be demonstrated by an increased number of our residents who say:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Author: Amanda Risino, Director of Transformation

Togetherwe...

Are improving health and social care in Warrington