The Wigan Locality Plan for Health and Care Reform

The Wigan Integrated Care Organisation
Population of Wigan about 320,000

Nearly 98% of Wigan's population are White British:

- 50.9% of adults are physically active, significantly worse than England average
- Higher than average rates of obesity
- 65% of the borough population are of working age.
- 23% of residents have long term illness.
- There are nearly 34,000 carers of which 3,000 are likely to be children.
- Nearly 100,000 people in the borough are living in the most deprived quintile.
- Rates of homelessness are high 3.63 per 1,000 households compared to 2.48 per 1,000 for England.
- Smoking prevalence is currently 18.7% & Manual Class prevalence is 24.4% which is below Eng Av of 26.5% (PHE 2015)

Our population aged 65+ will increase by 30,000 over the 20 years.
The picture in Greater Manchester

£56 Billion GVA
Fastest growing LEP in the country

2.7 Million People
Growth of 170,000+ in the last decade

104,000 People Unemployed
7.8% (above UK average of 5.5%)

77.7 Male Life Expectancy
England average: 79.3

81.3 Female Life Expectancy
England average: 83.0

112,000
People on long-term sick and inactive

10 Local Authorities

12 Clinical Commissioning Groups

15 Trusts and FTs: Acute, Mental Health, Community and Ambulance
The Public Health Outcomes Framework provides indicators that relate to the absolute health within Wigan Borough. The key indicators below show that health in Wigan Borough is improving and the gap with England is reducing.

### Challenges
1. To reduce the gap in health experience between areas across the Borough.
2. To help people make lifestyle choices that improve their health.
3. To focus on what individuals and communities can do to improve health.

### Health Outcomes

#### Healthy Life Expectancy
- **Wigan**: 62.5
- **England**: 61.1
- **Difference**: 1.4 years

#### Cardiovascular Mortality (under 75)
- **Wigan**: 58.1/100,000
- **England**: 133.7/100,000
- **Difference**: 75.6/100,000

#### Cancer Mortality (under 75)
- **Wigan**: 137.8/100,000
- **England**: 169.1/100,000
- **Difference**: 31.3/100,000

#### Suicide (All ages)
- **Wigan**: 15.9/100,000
- **England**:
- **Difference**: 53.2/100,000

*Each suicide is a tragedy. However, as the number is small for women (6 deaths a year), Public Health England has not calculated a rate.*

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**Health & Well-Being Strategy 2016-18**

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Cancer Deaths (age < 75)
(Observed and expected relative to England 2012 - 2014)

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<tr>
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<th>Males</th>
<th>Females</th>
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<tr>
<td>Wigan - Actual</td>
<td>102</td>
<td>86</td>
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<td>Wigan - England rates applied</td>
<td>107</td>
<td>89</td>
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Average number of deaths per year (2012 - 2014)

Source: Health and Social Care Information Centre
Principles of Reform for Public Services in Wigan and GM

• A **different** conversation with residents leading to a better understanding of their interests and assets and not their deficits and needs;
• Working **with** – rather than doing to or for;
• Taking an **asset** based approach and building on community, family and individual’s strengths;
• Working with the **whole** family in a joined up and coordinated way;
• Utilising **evidence** based interventions and developing an **evidence** base for new interventions;
• Understanding and supporting the **assets** of a community;
• People in **control**, not passively receiving services
Aligning Reform Across Sectors in GM

**H&SC TRANSFORMATION**

1. **RADICAL UPGRADE IN POPULATION HEALTH PREVENTION**

2. **TRANSFORMING COMMUNITY BASED CARE & SUPPORT**

3. **STANDARDISING ACUTE & SPECIALIST CARE**

4. **STANDARDISING CLINICAL SUPPORT AND BACK OFFICE SERVICES**

5. **ENABLING BETTER PUBLIC SERVICES**

   The creation of innovative organisation forms, new ways of commissioning, contracting and payment design and standardised information management and technology to incentivise ways of working across GM, so that our ambitious aims can be realised.

**WIDER REFORM ACROSS GM**

1. **EARLY INTERVENTION AND PREVENTION: IMPROVING OUTCOMES FOR GM**

2. **TRANSFORMING LOCAL SERVICE DELIVERY: PLACE BASED INTEGRATION**

3. **RECONFIGURING SPECIALIST SERVICES: DRIVING CONSISTENCY OF STANDARDS & OUTCOMES**

4. **IMPROVEMENT AND EFFICIENCY: GM STANDARDS AND SHARING SERVICES**
Wigan’s Health & Wellbeing Strategy

1. Creating a Culture of Health & Well-being (based on Robert Wood-Johnson Foundation framework)

2. Delivering Further Faster Towards 2020 (Locality Plan)

3. Creating & Sustaining Resilient Communities (The Deal)

4. Addressing Wider Determinants through Maximising the Potential of Growth & Reform (Wigan’s Economic Prospectus)
Wigan Locality Plan for Health and Care Reform

Track Record of Delivery
- Reducing Non Elective Admissions
- Reducing Health Inequality
- New model of social Care
- Award winning Integrated Neighbourhood Teams
- Prime Ministers Challenge on primary care access success
- Best performing GM system in 2015/16 winter
- Benchmark for place based public service reform in GM

Transformational Programmes
- Population Health Gain
  Heart of Wigan
- Transformed Community Based Care
  The Wigan Integrated Care Organisation
- Standardisation of Acute Services
  WWL standards based horizontal alignment

Place based integrated working
A number of place based MCPs built from Primary Care Clustering and used as the default place based setting for the implementation of existing reform programmes/business cases:
- Community Nursing and Therapies
- Outpatients
- Reformed Adult Social Care
- New integrated children's model
- Place based PSR addressing wider determinants

Outcomes
- Financial Sustainability
- Reduced Acute Activity
- Reduced Institutionalised Care
- Improved Care Outcomes
- Residents well and independent
- Public Services Orientated towards prevention not crisis

Enabling Better Care
- Estates Strategy
- Workforce Reform

Aligned Commissioning
- Share to Care
Heart of Wigan

1. North Karelia Whole System CVD Prevention
2. Heart Start from Seattle
3. Lessons from Heart of Mersey
4. RSPH Health Improvement Level 2 (Heart Champions)
5. Community Defibrillator roll-out
6. NHS Health Checks ..plus Vascular Dementia risk
Heart of Wigan Phase 3

HWBS Priority 1. Increase Physical Activity
• Review targeted early intervention and prevention, and universal physical activity offer.
• Develop programmes targeting key cohorts (Learning & physical disabilities, mental health etc).
• Review the weight management offer across clinical and community programmes – across start live and age well
• Launch “Wigan on the Move” as part of Wigan WellFest (3rd-11th Sept 2016)
• Borough-wide roll-out of Daily Mile in all primary schools

HWBS Priority 2 Finding the Missing Thousands
• Expand Health Check screen to include depression and anxiety
• Expand Health Improvement Service offer to develop and include effective level 1 alcohol reduction and wellbeing offer.
• Develop and implement appropriate and adaptable wellbeing programme to be delivered by and for WWL staff groups
• Embed routine NRT provision within pre-operative process for elective surgery
• Vascular dementia risk awareness programme and support developments of Dementia united and dementia friendly communities.
• Maximise the potential of new technology for Health Improvement eg. Wellness kiosks, Quit-it app, mobile support offer.

HWBS Priority 3. Increasing Independence & Resilience
• Ensure Health Improvement outcomes are incorporated into Deal For Communities (including ‘Get Wigan Moving’ allocation).
• Strategic placement and registering of defibrillators.
• Expansion of CPR training and Heart Champion programme.

HWBS Priority 4. Transport and Planning
• Borough wide strategic cycle plan.
• Develop & agree local criteria on Section 106/community levy investments.
• Broaden the scope of the current ‘greenspace offer’.
Wigan Digital Council of the Year- We’ve got An App for it!
Physical Activity is the Most Effective Drug

- Overall economic & social cost of inactivity in Wigan Borough is estimated at £21,779,819 per 100,000 population, per year.
- On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual.
- Referral into physical activity is embedded within the NHS health check
- Diabetes pathway redesign - more emphasis placed on early intervention and self-care, aiming to increase referrals to lifestyle services
- Integrated Community Nursing and Therapies Services and the Older People’s Pathway developments - Early intervention and prevention and self-care are at the heart of these new approaches
- CQUIN for 2016-17: referrals from treatment room staff into Early intervention and lifestyle services
Building on Track Record of Success

- Emergency Admissions – a net decrease of 5% over the last five years compared to a net increase of 9% nationally;

- The greatest improvement in healthy life expectancy for both men (37 months) and women (18 months) in all the GM districts in the period 2009/11 to 2011/13;

- CVD deaths under 75s reduced by 27% for women & 25% for men over last 5 years & gap between Wigan & England reduced by 50% & 40% respectively;

- A&E – a net decrease of 2% over the last five years compared to a net increase of 8% nationally;

- A&E – we were the only system in GM to achieve the 95% waiting standard in 2015/16;

- Reduction (budgets reduced by 25% since 2011/12) in the cost of adult social care through supporting more people to be independent whilst absorbing demographic pressures.
The Wigan ICO

“The ICO will be a new alliance of providers working together to improve integrated and joined up services based around primary care, focused on prevention and early intervention, bound by a common narrative and approach, and with a stake for each organisation (including the local hospital) in the scaled reduction of demand.”

Design principles include:

- Reduces demand on public services by promoting independence and prevention;
- Treats people in the home and community for as long as is possible and appropriate;
- Incentivises providers to work together to meet the needs of the whole person;
- Reduces dependence on oversubscribed and specialist resources;
- Allows all members of staff to be trained in conversations with residents and patients that focus on assets rather than need.
Presentation of Wigan ICO

• The ICO is at the centre of the Wigan Locality Plan. The ICO recognises that, in order to deliver truly effective and efficient out of hospital health and social care, providers need to work together as part of a new collaborative model which has clear and robust governance structures with the power and ability to reshape care delivery.

• An agreed vision for the ICO has been committed to by partners including through the establishment of a provisional outcomes framework and scope of services. A high-level organisational model for the ICO has also been agreed, based around the Multi-speciality Community Provider model.

1 Health and social care outcomes for Wigan population are commissioned through place-based integrated commissioning.

2 New provider or partnership (with organisational form to be determined) is accountable for delivering outcomes agreed.

3 Neighbourhood teams (built around MCP model) provide an integrated set of services determined by local priorities and supported by common standards of governance, operations and decision-making.
Shifting The Balance To Early Intervention And Prevention

Working in collaboration to support our population and improve outcomes

- Thinking about cumulative impact rather than single service planning
- Identifying and addressing demand before it escalates
- Supporting individuals and families collaboratively, working across organisational boundaries
- Reducing demand on expensive, reactive services

Local NHS
Wigan Council
Public Services
Residents/Patients
Voluntary/Community Sector
Addressing The Wider Determinants Of Health And Care Demand

• 40% of children in Wigan are not school ready for reception (80% in some places);
• 1 in 4 of the children in one of our primary schools lives in a house with a reportable incidence of domestic violence in the last 2 years;
• 40% of residents at highest risk of unplanned hospital admission are adults of working age – often with complex dependency on public services;
• Only 54.6% of adults are physically active
• Significant proportion of activity in our GP practices is socio-economic – debt, domestic abuse, loneliness, access to work, cold homes;
• Loneliness is a major determinant of hospital admission for older people;
• Access to quality work for adults of working age is a health protective factor.
Community Link Worker Case Study

Sue

PROFILE
Sue is 62. She met her husband when they were both working night shifts at the Holiday Inn - she was on the desk and he was on the door. She suffered a minor stroke 2 years ago whilst on holiday in Egypt, for their wedding anniversary. She has since been suffering from the physical and psychological symptoms of the stroke. Over this period she saw her GP and specialists regularly who all made her feel like she was inventing her symptoms. Her husband left his job to become her carer and they found their savings were quickly disappearing, exacerbating the tension that had been emerging in their marriage...

IMPACT
Impact of the CLW service on Sue's life
Through the CLW, Sue and her husband received two emergency food packages from the foodbank. She has also received equipment that is helping her to better manage her condition at home and will be attending a tribunal for her benefits assessment alongside an advocate from Citizens Advice.

All of this has had an impact on Sue and her husband’s relationship. They are no longer consumed by the challenges they face and are much more content knowing where to go for help. Once she feels stronger, she plans to start volunteering at the foodbank as she feels it is her turn to give back.

Sue’s use of services:
- 4 visits to CLW, ongoing catch up calls
- No longer visiting her GP regularly
- Her husband has been back to A&E since his stay
- Accessing regular support from a community nurse

SUE’S JOURNEY
Returns to Egypt for wedding anniversary

Mar'16

-CLW refers her to Fall Clinic, the community nurse, and Think Ahead Stroke
-Second meeting with CLW visits the foodbank
-Meets CLW - registers husband as a carer
-Meets CLW in the hospital who refers her to a primary care CLW

April’16
-“A young girl appeared by my bed and asked if I needed anything - all of a sudden things changed.”
-A tax letter comes through the door, instead of kicking off, her husband calls the CLW

Sue’s hopes for her future

"If you’re unsure, then it will be a good thing to come"
Community Link Worker Case Study

Dave

PROFILE

Dave is 32. He was drinking 6 times a day and was told he didn’t have long to live. He knew that alcohol was linked to most of the problems he was facing, but was convinced that no one would be able to help. He has accessed many different services over time, most recently failing to complete the Leigh Recovery Partnership programme. What he really wants is to be able to see his children and for them to see him as a role model. He has suffered acute episodes of medical issues linked to his alcohol and being attacked one night when drunk in Leigh.

IMPACT

Impact of the CLW service on Dave’s life

Through support from the link worker and other services, Dave has been able to stop drinking completely over a period of about 6 months (although he is still smoking cannabis regularly). Through the peer support group that the link worker referred him to, he met his girlfriend who has also recently become sober.

Stopping drinking has been particularly difficult for his social life: he is no longer able to go out with some of his friends for fear of being tempted to drink. His new lifestyle has, however, given him the chance to meet up with old friends from school and work and to improve his relationship with his parents and children.

The link worker has been very important to him, listening and giving him time to talk about his challenges. He sees the link worker as a friend and hopes they will continue working together.

Dave’s use of services

- Interview and dates of appointments with his GP suggest a reduction in Dave’s use of primary care services
- 10 meetings in total, ongoing informal contact with CLW
- Continued involvement with the Leigh Recovery Partnership
- Continued hospital attendance due to ongoing health issues

DANE’S JOURNEY

Dave’s hopes for his future

*Dates of GP appointments taken from interviews and clinical records
Primary Care Clusters

• GP clusters have formed based on place;

• Cluster working is a focus for the resilience and sustainability of General Practice within the context of the ICO;

• The clusters will be at the centre of the service delivery footprints within the ICO;

• Each cluster has a seat on the ICO Partnership Board;

• Clusters actively engaging with wider partners – including mental health, children’s and wider public service reform.
Three Stage Programme Of Work For Designing The ICO

What will it deliver?
- What is the vision for the ICO and what outcomes will it achieve?
- What is the scope of services and geography to be covered by the ICO?
- What capabilities are required to implement an ICO and how ready is Wigan to provide these?
- How do we need to engage patients and citizens in the design?
- How should the ICO be governed?

What will it look like?
- What are our options for creating a new model of provision?
- How can commissioning arrangements best support the new model of joined up provision?
- What are the enabler requirements? e.g. workforce, IT, estates
- What is the financial case for the ICO and what investment is required?
- What does the implementation roadmap look like?

How do we get there?
- What should be the length of contracts and what payment models should be employed?
- What due diligence will providers and commissioners need to perform?
- What does the detailed implementation plan look like?
- What are the impact and transition plans for “ICO Member organisations”
- How does this align with NHS planning guidance and contracting rounds?
Integrated Nursing and Therapies Service

• Foundation of ICO;
• Reform of service – delivered via prime vendor contract with Community Provider & Hospital;
• Based on success of Integrated Neighbourhood Teams – using risk stratification;
• Asset-based approach at the heart of service;
• Single point of access established – co-location of health and social care staff.
ICO Progress

- Broad agreement on Scope of ICO – comprehensive out of hospital services across life course;
- Finalisation of GP Clusters as focal point for service delivery footprints;
- Appointment of Partnership Director for the ICO;
- Emerging agreement on governance of partnership behaving as if it were an organisation;
- Joint Commissioning Executive (CCG/Council) modelling ICO in shadow contract form from 1st April 2017 with 'go live' of April 2018.
## ICO - Key Issues

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<th>Key Considerations</th>
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| **Scope**           | • Full population coverage – based on registered list  
• Stakeholder feedback is that almost all out of hospital services in scope – plus housing and leisure.  
• Further work needed on which acute services should be in scope;                                           |
| **Primary Care**    | • Governance of clusters needs to be developed;  
• Management capacity & capability in clusters;  
• Agreement that primary care functions should be in – but not core contract at this stage;                                                      |
| **Governance**      | • ICO Partnership Board in place with clusters represented;  
• ICO to act as partnership ‘with teeth’ in first instance – shadow year 2017/18;  
• 1\textsuperscript{st} April 2018 – ‘go live’ of ICO (although full range of services may not yet be ready) with potential to become ACO by April 2019 |
| **Commissioning**   | • Joint Commissioning Executive in place – CCG and Council;  
• Active discussion at JCE on commissioning of ICO – looking at option of strategic, place-based commissioning function – CCG/Council |
| **Capability to Deliver** | • ICO PMO established with dedicated capacity;  
• Partnership Director appointed                                                                                                                                       |
Thank you for Your Time

Any Questions?