Agenda item 8b

The Wolverhampton 'Place'

1. Background

Over the last 24 months, Wolverhampton CCG has pursued a collaborative solution to develop a place based alliance in which the equality of all the Provider partners is paramount. We have been cognisant that clinical leadership is central to success and that primary care working alongside secondary care and social care breaking down traditional barriers will be essential as we move forward. It is a partnership model in which clinicians are pro-active, engaged members in addressing the burgeoning challenge of increasing multiple long term co-morbidities, an ageing population, and increasing personalisation and self -help. All research evidence suggest that the core of evolving and instituting successfully new models of care has, as a core requirement, positive and trustful working relationships

To implement new models of care, the CCG acknowledges that there must be a shifting of the resource to increase investment in Primary Care, something which has fallen consistently over the last few years as a proportion of NHS spend. In addition there needs to be a much stronger relationship between GP Primary Care and Community Services along with additional investment in Community Services.

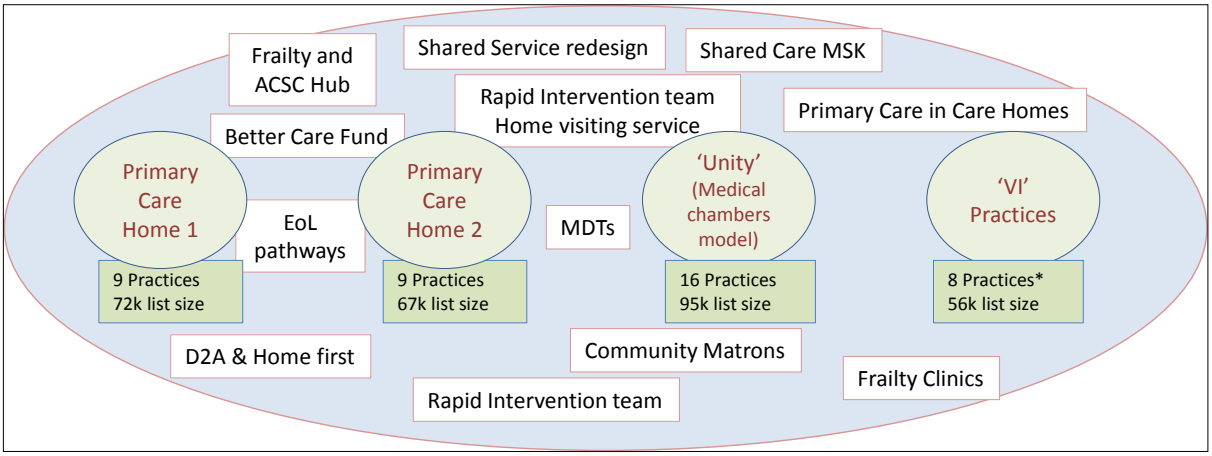
2. The Strategy

The Strategy has a number of imperatives:

2.1. An agreed, collaborative shift in patient care to ensuring that those patients who can be cared for in a non-hospital setting, are
2.2. 'Bend' the demand curve for acute activity ensuring more pro-active primary and community focus with the accompanying financial resources to support this
2.3. Institute positive, aligned and collaborative working relationships with and between all Providers (Primary, Acute, Community, MH and LA) in the Wolverhampton health economy
2.4. Ensure the alignment of all GP Practices into collaborative groupings, (recognising that there is a mixed model in Wolverhampton of PCH, Medical Chambers and VI)
2.5. Ensure that Multi-Disciplinary teams are grouped around clusters of GP practices to ensure the delivery of pro-active community care
2.6. Discard the perversely incentivised Acute PbR contract
2.7. Agree a collaborative new contract solution with the Acute/Community provider and a virtual contract (compact) between stakeholders with improved allocative efficiency to respond to changing health challenges, while ensuring that the Acute provider remains financially viable
2.8. Ensure that the LA are part of the solution
2.9. Craft the right solution as emerging thinking and regulatory directions of travel emerge (rather than adopting an 'a priori' hard dogmatic approach)
2.10. Appropriate public consultation and engagement

3. From Strategy to Plan

3.1. All practices are clustered into groupings. This is summarised below and additional detail is provided in appendix 1.



3.2. A key output of the preparatory work was an agreed 'Propectus' signed by Dr. H Hibbs and Mr. D Loughton on behalf of the CCG and RWT respectively. This had already been agreed and approved by the CCG Governing Body. This is attached as appendix 2.

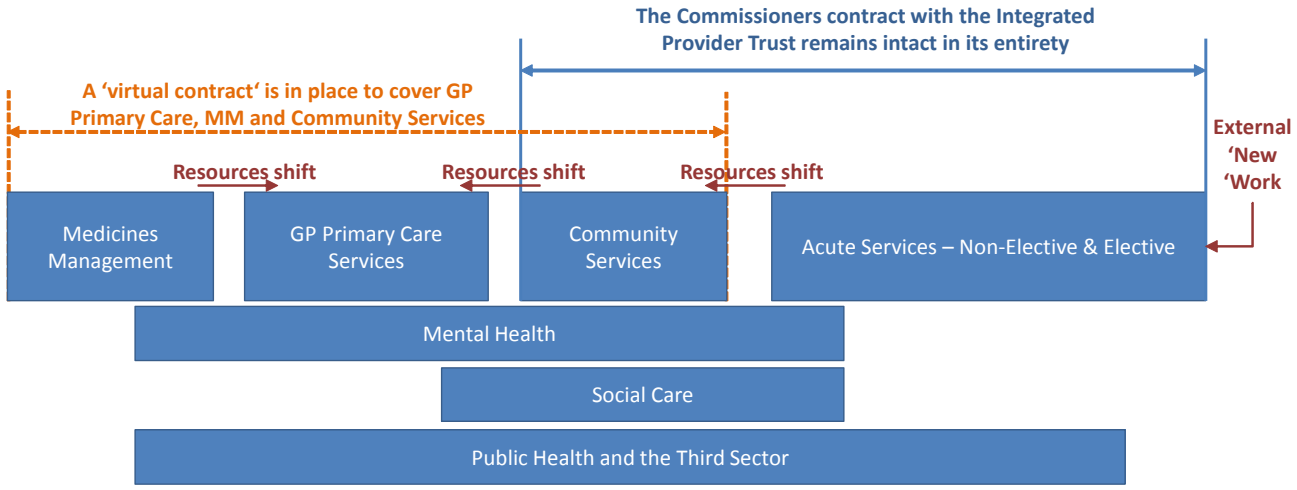
3.3. A new model has been developed to move from the current PbR method of contracting to a mixed model of contracting. This is made up of a number of components:

Fixed Cost (i.e. block):	This is predominantly non-elective activates
Risk/Gainshare:	This is predominantly for elective activity
Cost & Volume:	This covers a number of areas incl. A&E
Cost Reduction:	This is predominantly Medicines

(Exploratory discussions are ongoing with the Trust currently). Further details are laid out in appendix 3. It is anticipated that a full F&P and Governing Body approval will be sought for the new contracting arrangements

Areas	18/19 Plan Activity Annual	Plan Price Annual	% of contract
Segment 1 - Risk/Gainshare	366,009	£60,342,915	37%
Segment 2 - Cost Reduction	3,094	£9,045,150	6%
Segment 3 - Fixed Cost	31,529	£52,243,808	32%
Segment 4 - Fixed income	-	£7,373,630	5%
Segment 5 - Cost and Volume	606,868	£34,412,215	21%
Totals		£163,417,718	100%

3.4. Work has been ongoing to develop and articulate the new model for the new system model of care (the Wolverhampton place). This has been presented on several occasions to the Governing Body, is summarised below and the full presentation is laid out in appendix 3



- The Commissioners contract with the Trust and moves from PbR and Community block to a combined payment mechanism which has 4 'buckets':
  - → Block
  - → Gainshare
  - → Cost and Volume
  - → Cost reduction
- In order to 'realise' the shift in resource allocation and services into Community and GP Primary Care, all parties have to work together behind a commonly aligned clinical strategy (Cohorts, Disease groups, Pathways). All parties recognise the co-dependence in the delivery in activity and cost shift
- The virtual contract is run on an open book to create the positive debate and tension for the deployment of resource and staff to realise the activity and resource shift
- In the development stages, the contracting relationship for the Wolverhampton place for MH does not change
- The BCF pool continues to be the vehicle for delivery and shared risk with the LA

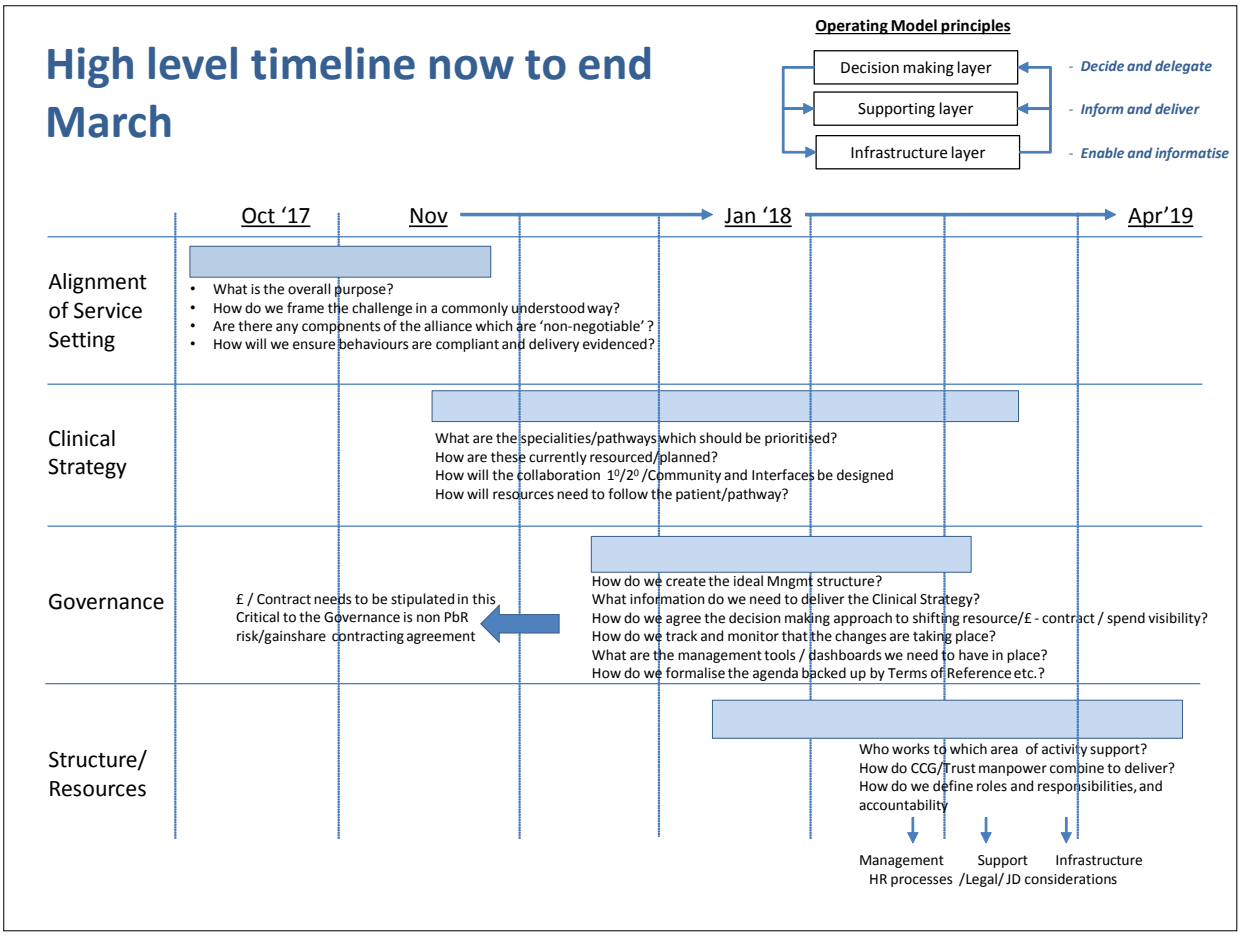
Attached, as appendix 4, is the financial overview of the agreed areas in scope of the 'virtual contract'.

A key consideration in the development of the Wolverhampton place is ensuring that clinical strategy and alignment is at the heart of the new models and that GPs are equal decision makers in the allocation and application of resources. Substantial development time has been invested in the alignment of the GP groupings, the agreement of the clinical areas to focus on and the development is now moving into how the decision making of virtual contract areas of responsibility will play out.

It needs to be recognised that the Local Authorities and the Mental Health Provider are also equal partners in the way forward.

Next steps necessarily move onto how the resources in the CCG are deployed under the new models of care/system and how we can make the best use of informatics to support decision making and prioritisation

The overall schematic approach and headline timetable for the development is laid out below



The full side is attached as appendix 5

4. From Plan to Implementation

4.1. A detailed implementation plan has been drawn up to deliver the outline schedule. This includes:

4.1.1. The initial set of clinical pathways for patient cohorts has been determined and Task and finish groups have commenced work

4.1.2. Timings for the final contractual approach to be in place (overall main contract and the virtual contract)

4.1.3. Dedicated resource has been set aside in the CCG to support and lead the different areas of work

4.1.4. The planned completion date is April 2019 but it is likely that the cohort/identification and clinical development work will continue beyond this

4.1.5. Overall governance and how/where this will fit in a 'system' has yet to be determined but what is clear is that the integrity of current statutory bodies will not be compromised nor their governance responsibilities of that statutory body

4.1.6. Attached as appendix 6 is the detailed GANNT chart for development

5. Public and Patient engagement

The Wolverhampton place strategy builds on all of the Commissioning Cycle engagement and the 'You said we did' feedback which has consistently stated that patients want greater care closer to home and stronger relationships with Primary Care.
Nevertheless, a full engagement approach will be developed for discussions with PPGs and members of the public (The Healthwatch AGM on 04/07/18 is the first step in this). The Governing Body will be sighted fully on the engagement plan as it is firmed up over the next 6 weeks

6. Risks

There are a number of risks of not moving forward as well as a number of risks associated with moving forward.

6.1. There is a degree of uncertainty with regard to the evolution of strategic commissioning in the Black Country Not endorsing and officially adopting the strategy in sight of full governance could lead to a shift /complete change in the collaborative approach that has been adopted in Wolverhampton – ostensibly to deliver a similar result but based on a forced, rather than a collaborative decision
6.2. The programme fails to progress to the required timescales through non engagement of the Acute provider in either the clinical strategy development or the transparency of spend across the agreed cohorts
6.3. Disentangling and providing transparency across the 'longitudinal spend' lens proves to be too difficult and the role of the management team becomes dissipated and engagement in the new model of care drops away
6.4. Not all of the GP groupings buy into the new model of care solution and there is not full participation in the way forward
6.5. Disruption to staff could lead to a lack of focus on delivering the CCGs core agenda and its staying in financial balance