The Wolverhampton Context (1)

- Wolverhampton is an area with ca. 250,000 residents living within the city boundary
- There is one Local Authority
- There is one Mental Health Trust which also serves other parts of the Black Country (BCPFT)
- There is one integrated Acute and Community services provider which also provides acute services to other areas of the Black Country and Staffordshire
- The Acute Trust also provides tier 2 specialised services
- There are currently 42 GP practices
- There is a long history of collaborative working across the city
- In 2012 Community Services, as part of the TCS programme, migrated from the PCT to the Acute Trust.
- Also as part of TCS, Mental Health & Learning Disability services migrated to Black country Foundation partnership trust - a specialist Mental Health provider.
- The PBR tariff for Acute services and Block arrangements for Community and Mental Health have provided a disincentive for the local health economy to move services closer to peoples' homes
- Over the years the 'connectivity' between GP Primary Care and Community Services has suffered as well as the connectivity between GPs and 2^0 care consultants (leading to fragmentation of services and care pathways)
- Social Care which is integral to many health care pathways has also suffered from often working in isolation from health services.
- Primary Care has been historically under-invested in Wolverhampton

The Wolverhampton Context (2)

- Around 20% of all practices in Wolverhampton are either single/double handed and up to 16/17 there had been little history of practice collaboration
- Great strides have been made over the last two years with regard to collaborative working in primary care. Following some recent movements, all but two practices are aligned to collaborative GP groupings. These are:
  - Primary Care Home 1: 8 practices, 60k list size
  - Primary Care Home 2: 8 practices, 55k list size
  - Medical Chambers: 15 practices, 77k list size
  - VI (Vertically integrated) practices: 9 practices, 61k list size*
  - Unaligned: 2 practices, 23k list size
- Over the last 3-4 years good working relationships have been developed with the LA and the BCF has been a positive vehicle for community based delivery over the past three years

*1 practice leaving VI asap, list size 8k

The Wolverhampton Context (3)

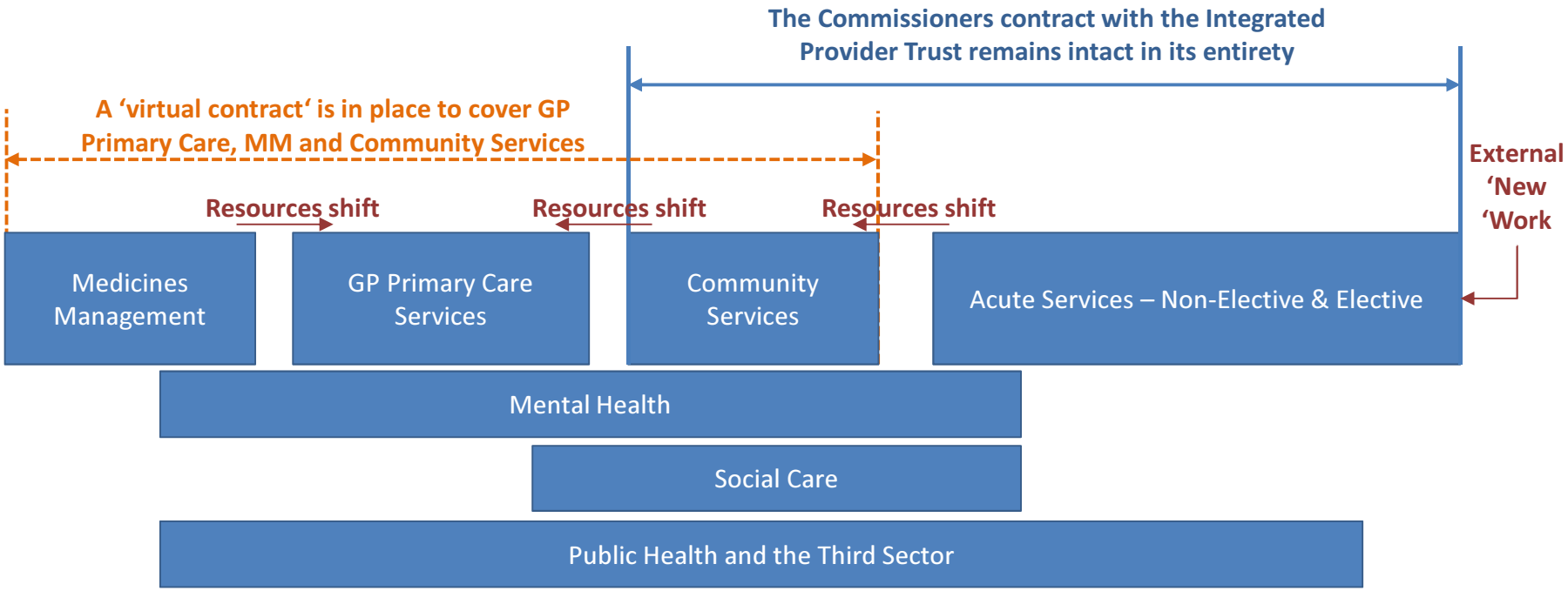
- The core patient centred strategy jointly signed up to by all organisations in Wolverhampton is to deliver care closer to home where appropriate and to invest in capacity and capability in Primary and Community care settings. This is informed not simply by national policy but also by Public commissioning engagement events held by the CCG over recent years.
- There is substantial and strong collaborative working programme already in place and the Better Care Fund over the past three years has been the vehicle for delivery for :
  - MDTs in community/primary settings
  - Joint Health and Social Care teams to support admission avoidance as well as facilitating supported post acute home living
  - Mental health planned and unplanned Care pathways
- The intent of our local programme of work is to create and 'architect' the environment where a collaborative solution is the answer – this means working with our GP practices and with provider colleagues and the local authority to co-design the local solution
- There is no appetite locally for adversarial relationships but rather for developing and working in a high trust environment
- We are clear this may mean difficult conversations are needed as we progress but this will only further cement a joint solution

The Wolverhampton Local Model – Integrated Care "Alliance"*

- The local model will deliver the agreed core strategy which must be realised in a financially constrained environment, in which all parties 'buy into' the common delivery and financial challenge
- The voice of the Wolverhampton citizen and patient will be central
- In order to deliver the core strategy there will need to be a different contracting and payment mechanism agreed with providers
- The model recognises that the Acute Trust is having ever increasing demands placed on it from neighbouring health economies (Staff, Telford & Shropshire, Walsall) as well as increasing activity from Spec Comms. Therefore the Trust needs room to expand and appropriate activity therefore has to shift to Primary and Community Care settings
- As activity shifts resource needs to shift
- The Transformation programme to the 'ICA' in Wolverhampton will allow all of these articulated pressures to be realised

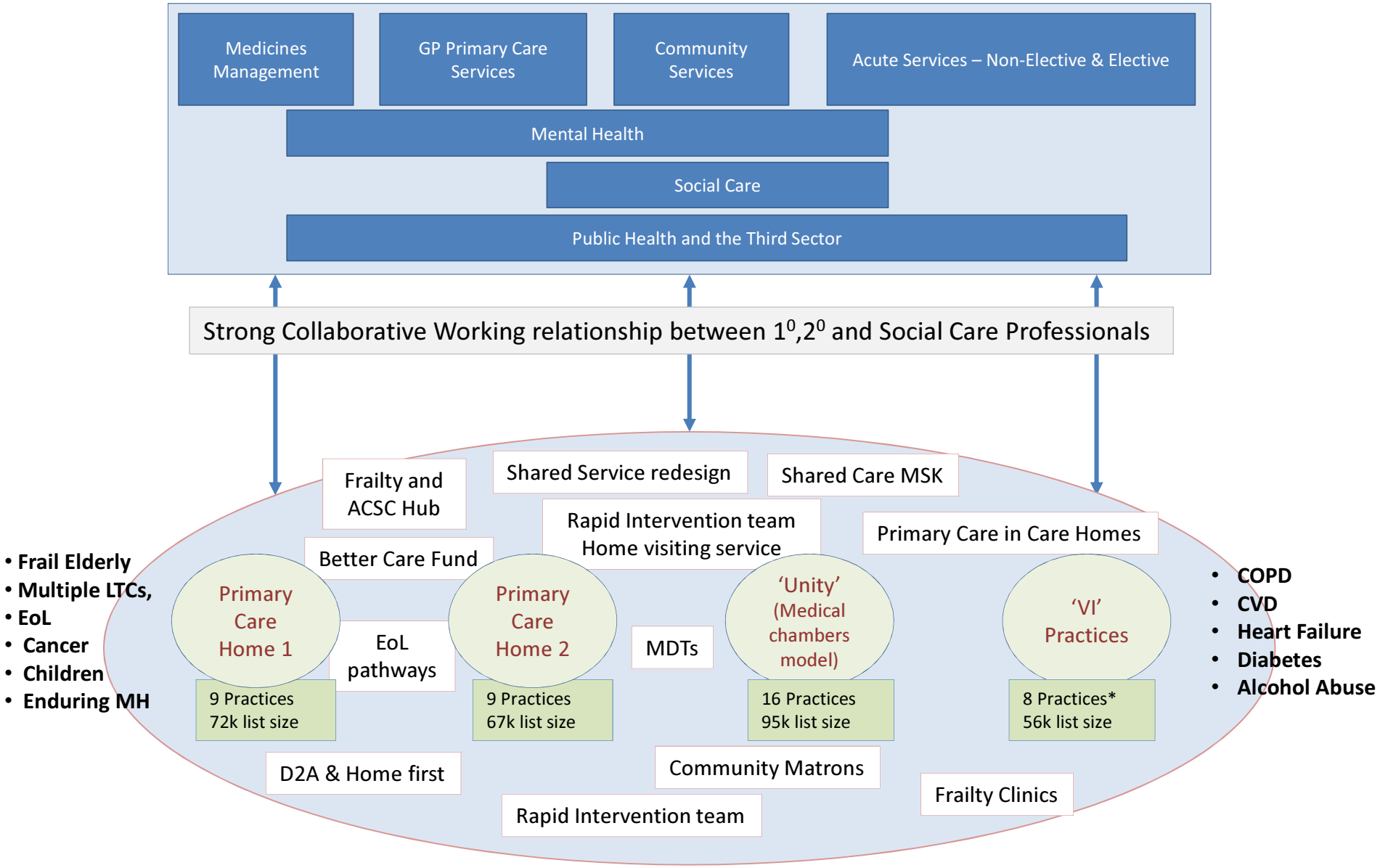
*"Alliance" reflects the developmental stage of the collaboration

'ICA'– Wolverhampton Place – *Developmental phase*



- 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

Wolverhampton Localities



Source: Governance work stream – draft for discussion July 2017

Principles of the Wolverhampton 'ICA'

- The Wolverhampton 'ICA' is not a 'procured' hard solution. It is a collaborative approach based on shared vision and clinical alignment
- On 10th May (2017), NHS leaders in Wolverhampton agreed to explore the further development of an accountable care approach. Key principles agreed were:
  - Our strategy must be **clinically led**. The clinical workforce must be deployed effectively across the health system, removing artificial distinctions between "primary" and "secondary" care clinicians. We will support the professional development of all existing staff. There is strong clinical support across the health system to work in this way
  - We will create a **shared governance system** across the parties which will provide system leadership
  - We will provide a clear vision for our system that will be a joint public commitment, and hold ourselves **mutually accountable** for delivering this
  - The alliance partnership work will be **patient-centred**. We will focus services around the patient, developing innovative unified pathways that provide a more consistent quality of care across Wolverhampton
  - We will **shift resources** from hospital to out of hospital services so that more patients are supported proactively in their home and communities
  - We will focus on health developing our approach to **health promotion and disease prevention** to support the wellbeing of our communities alongside the care that we already provide
  - We must be **financially sustainable**, making the best use of the resources that we have collectively. This will mean amending the current funding flows as they do not always incentivise best practice

Leadership and Shared Governance principles

- Our 'ICA' will be clinically led and managerially supported
- The clinical strategy will be informed by clinicians from across primary and secondary care
- Clinicians will be involved in the governance ***and*** the formation, delivery and ongoing evolution of the clinical strategy
- ***All*** partners will be part of the cross organisational leadership team
- A management team will be responsible for enacting the vision and plans agreed at system level and for ensuring the open and transparent operation of the virtual contract mechanism
- Patients and public will be involved from the earliest stage

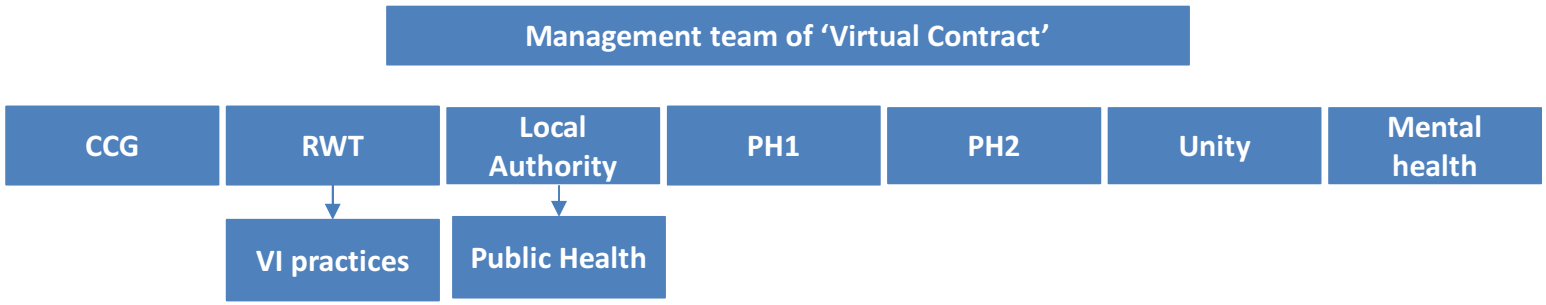
Source: Agreed prospectus
CCG/RWT August 2017

Governance of the Wolverhampton 'ICA'

Building from the broader principles, new governance arrangements that support new ways of working together will be established:

1. Work collegiately to develop coherent plans for the Wolverhampton health and care system
2. Work by consensus. No-one can be over-ruled on any matter. However, once a decision has been made we will all support it
3. Be transparent and open with regard to the challenges we face and have an open book approach to finance, contracting and performance
4. Take no unilateral actions that potentially result in a cost or workload shift to other organisations, without prior review and agreement in the Alliance Leadership Team
5. Commit necessary resources and support to the accountable care alliance, including participation in the Alliance Leadership Team and supporting groups

To support our alliance approach we will formally agree a set of 'joint working principles and behaviours' that we hold ourselves mutually accountable to uphold. We will also develop a dispute resolution process to help us maintain a consistent approach to these principles and behaviours



Financial Management Principles

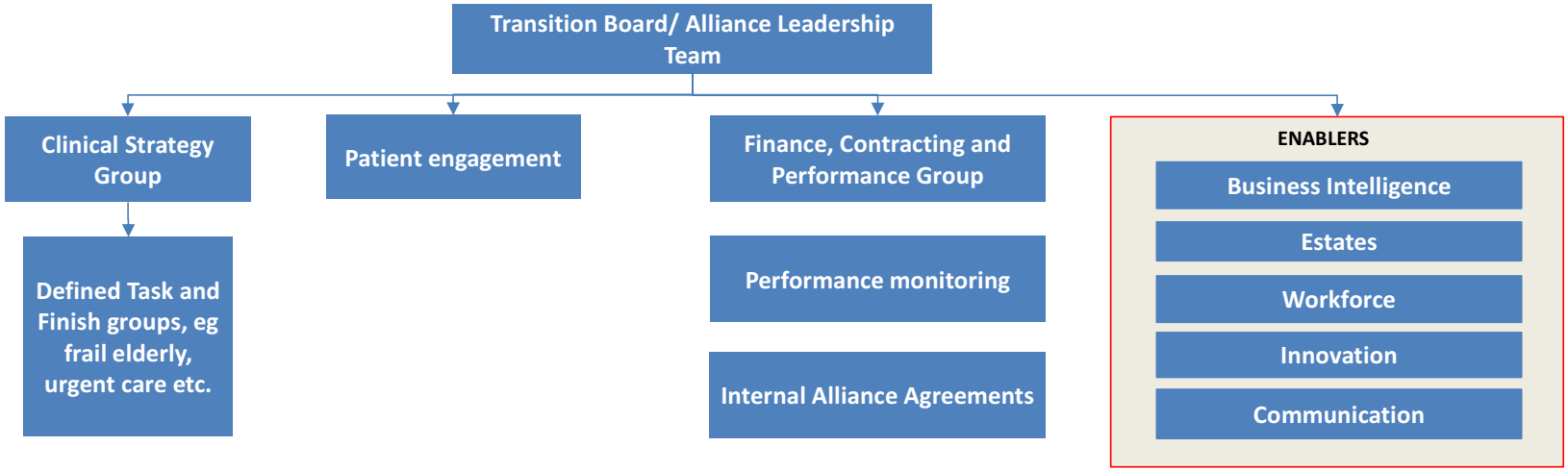
- Strong financial controls will be put in place
- New contracting methodology will be explored as part of a shadow running year 18/19 and fully enacted FY 2019/20
- Organisations will work together on cost savings plans to ensure a financially sustainable system (CIP and QIPP alignment)
- No work will move from Acute to Primary and Community care without appropriate resource
- Organisations, whilst needing to ensure their own financial controls, will also look to ensure joint working enables financial balance across the system ***and*** we will not work to the detriment of each other

Health Promotion, Prevention and Outcomes

- The system will agree a series of outcome measure at individual, practice group and population level.
- All national require outcomes will be worked to as part of this programme, in addition to the locally agreed outcomes
- Constitutional standards will be upheld
- Where possible health care will be preventative rather than purely reactive and interventional
- Population data and risk stratification will be used to aid clinical delivery and outcomes
- Open culture of data sharing

Transition

- A transition programme structure will be put in place which will address the some of the key enablers to the solution
  - Estates strategy
  - IMT strategy
  - Joint health and social care records
  - Business intelligence



Transition Schedule and Key milestones

Decision making layer - ***Decide and delegate***

Supporting layer - ***Inform and deliver***

Infrastructure layer - ***Enable and 'informatise'***