Complex Governance Proposal for ICA/BCF

This paper outlines a proposal to bring together the Better Care Fund Programme of work and the development of the Wolverhampton ICA into one manageable programme of work to avoid duplication and make best use of the resources available

1 Better Care Fund Programme (BCF)

The Better Care Fund Programme in Wolverhampton is a well-established programme that has been running since 2014. The programme is underpinned by a Pooled budget between Wolverhampton CCG and the City of Wolverhampton Council and brings together key organisations to work collaboratively on a number of projects with the main aim of streamlining pathways for patients, providing a more individualised approach and delivering Care Closer to Home.

1.1 BCF Workstreams

There are 5 workstreams that sit within the BCF programme, each with a number of projects that they are responsible for delivering:-

Adult Community Care	People Living With Frailty Programme, Review & Redesign of Integrated Community Services, GP Home Visiting Service, Redesign of Community Model for EoLc, Night Comfort/Re-positioning Service, Admission Avoidance, Emergency Care Passport, Social Prescribing/Community Connections, Primary Care Multi-Disciplinary Team Meetings
Mental Health	Prevention - mapping of services, Community pathways for patients with a mental health condition to prevent crisis
Dementia	Implementation of the Wolverhampton Dementia Strategy
CAMHS	Implementation of the CAMHS Transformation strategy which aims to transform our local system by developing care pathways, services and initiatives across health, education, criminal justice and social care with a unified set of values. Ensure children and young people are seen at the right place, at the right time and by the right person, Increase capacity and capability across the system so everyone can support CYP and their emotional mental health and wellbeing, Clear pathways across all areas of the system for CYP and across all commissioned services including specialist, Ensure CYP who require inpatient beds can access beds quickly and in an appropriate location.
Integration	Information Governance, IT, Estates, Monitoring and Reporting and Finance

The future of BCF is unclear post March 2020 as the national planning guidance for 2019/20 is yet to be published and there is a national review of the programme underway.

2 Development of the Wolverhanpton Integrated Care Alliance (ICA)

The development of the Wolverhampton ICA has been ongoing for approximately 12 months.

There are 2 Oversight Groups, the ICA Governance and ICA Clinical Pathways groups. Within each of these are a number of sub-groups which are shown below:-

2.1 ICA Governance Sub-Groups

ICA Governance BI/IG/IT	Ensure that the ICA has the right information to inform its clinical pathways, To ensure/enable appropriate information sharing between organisations, Find solutions to issues that arise regarding IG/IT
ICA Governance Commissioning and Contracting	To develop a contracting mechanism which aligns the clinical pathways to the principles of the ICA
ICA Governance Outcomes	To develop and agree a set of outcomes for which the ICA clinical pathways can be measured, and also to measure the success of the ICA

2.2 ICA Clinical Pathways sub-groups

ICA Clinical Frailty	Development of frailty pathway pathways that focus on the whole system to capture those living with mild/moderate and in partnership with the End of Life group, those who are classed as severely frail. This includes pathways redesign, workforce analysis, process redesign and the development of person centred success measures,
ICA Clinical Mental Health	Focussing on Primary care (PCN's) aligning workforce and mapping pathways, Physical Health/Mental Health interfaces, Accessing timely care, current processes and systems and some service re-design
ICA Clinical Palliative Care & End Of Life	Development, commissioning and implementation of a transformed Wolverhampton End Of Life pathway across the whole system, including an electronic shared care record.

ICA Clinical Children and young people	Standardising parent and clinician facing processes and information around the Wolverhampton "Big 6" which will support a reduction in NEL admissions to hospital, the implementation of joint clinics in Primary Care, and the review and redesign of community paediatric services

3 Interdependent Programmes

3.1 Community Transformation

It should be noted that there is also a **Community Transformation programme** being undertaken at RWT which is mainly reviewing its model of delivery of community services across the City. The 10 year plan placed Primary Care Networks (PCNs) clearly in the spotlight for revamping current models of care and revitalising General Practice Primary Care. Core to the PCN approach is ensuring that there is an appropriate Community Nursing infrastructure which is wrapped around these PCN, which makes for greater multi-disciplinary and cross agency team working to ensure the prevention and admission avoidance agenda can be delivered against.

In order for this to happen, the transformation of Community services needs to be especially addressed with a sense of considered and planned urgency and accelerate, in particular, those services which would be part of the multi-disciplinary PCN infrastructure. Clearly there needs to be synergy in any newly designed delivery model with the work being undertaken in both BCF and ICA.

3.2 STP

In line with the NHS Long Term plan, the Black Country and West Birmingham STP is working towards becoming an Integrated Care System (ICS). The STP plans recognise the importance of building the Black Country wide ICS on locally developing arrangements such as the ICA. There will also be further interdependencies with specific STP clinical workstreams that may impact on the local ICA development which need to be considered.

3.3 Primary Care Networks

3.3.1 The current Primary Care Situation in Wolverhampton

Six PCNs have been agreed by the CCG, with an average size of about 50,000 patients. The current PCN clinical leads are also representatives on the clinical and governance oversight groups of the Integrated Care Alliance (ICA) in Wolverhampton which is the mechanism to drive collaborative and joined up working as part of the longer term structural plan to create a local Integrated Care Provider (ICP) approach.

4 Opportunity

As can be seen by the information above there are a number of duplications in both the projects within each programme which presents a risk of conflicting approaches to clinical pathways. There is also duplication with the individuals involved in both programmes of work which creates demand on an already stretched workforce resource.

Substantial preparation and engagement has been invested in creating collaborative working between Primary and Secondary Care clinicians as part of this and a number of workstreams are active and have developed preliminary clinical models. The leading ones are:

- Frailty
- End of Life (EoL)

The Commissioner has committed to invest additional community based funding into these areas to address the service and quality improvement of community based solutions for these cohorts of patients.

There is a common and strongly held view by clinicians and managers that the value of the investment (reduction in admissions; improvements in quality of care; better experience for patients) will be enhanced through ensuring that the community nursing infrastructure is appropriately delivered with PCN collaboration to ensure service clarity, integrity and quality.

The Commissioners have re-written the service specifications for core Community Nursing and the PCN wrap around infrastructure to accommodate these changes

All of this preparatory work creates an opportunity to address the common deficits we have as a 'system' in the ICA and the BCF programme of work i.e. the ICA is mainly clinically driven and has a deficit of operational representation/delivery resource; the BCF is mainly operationally led and has a deficit of clinical input; the LA are integral to the success of both the BCF and the ICA but are more engaged within the BCF Programme They are for the major programmes of work clearly part of the solution (Frailty, EoL, Adult MH); health front line teams are not actively engaged in operationalising the new ICA models. The BCF workstreams could become the delivery vehicles for the ICA (and can be rebranded as ICA delivery vehicles). The programme and project documentation used by the ICA and the BCF are similar so little would need to be transferred over. The resources (people) are largely the same working in those areas and the attached analysis clearly shows where and how the deficit could be closed. There is limited project management resource in the BCF workstreams.

5 Current Programme Resource

As an established programme, the **BCF** has a PMO that consists of:-

BCF – Programme Manager / Lead (permanently funded), CCG Project Manager (permanently funded), CWC Project Manager (funded for 2 years), (Joint CCG/CWC) Project Support Officer (funded until March 2021).

In November 2019 there will be a Graduate Management Trainee working at the CCG and aligned to the BCF Programme as a Project Manager/Delivery Lead.

The ICA has not identified additional Programme support and is currently supported by existing members of staff from CCG (one for Clinical pathways and one for Governance) and a full time Integration Manager from Royal Wolverhampton Trust. There is no dedicated Project Manager or Project / Admin support other than a PA who schedules meetings and distributes papers.

An initial mapping of projects can be seen in section 9.

6 Proposal

In order to reduce duplication, identify gaps and to make best use of the resource available it is proposed to merge the two programmes (BCF and ICA) to enable the clinical review and redesign of pathways and to facilitate the operational delivery of the programme of work.

6.1 BCF Programme Board

Under national policy the BCF Programme Board has to be retained and therefore will continue with a role to monitor and review the Pooled Budget and BCF National conditions and metrics. The BCF Programme Board will continue to meet on a monthly basis (as the Partnership Board) with key membership from CWC and WCCG, and with BCPFT and RWT provider partners as attendees. As the purpose of this group will change to purely a monitoring role, representatives from Housing, Health watch and the voluntary sector will be stood down from the BCF Programme Board, but subsequently invited to the relevant ICA groups for their valuable input into the design of pathways, structures and outcomes of the ICA. Chairing of the BCF Programme Board will remain the same with co-chairs from WCCG and CWC

6.1.1 The BCF Integration workstream

This workstream will continue to support the BCF Programme Board with financial issues, national and local reporting and Estates, whilst the IT and Data sharing elements will move into the BI/IG/IT sub-group for ICA.

6.1.2 BCF Adult Community Care workstream (ACC)

The ACC will become the mobilisation and delivery group for the current projects sitting within it and for the outputs of the ICA clinical priority groups – Frailty, End of Life and Community Nursing.

Sitting within the Adult Community Care workstream is a D2A project. This project has been implemented and an evaluation is currently underway with a proposal being drafted to ensure that the project becomes business as usual within the next 3 months. It is recommended, therefore, that this group continues to complete this piece of work and will then cease upon project closure.

6.1.3 BCF Mental Health Workstream

This workstream will be merged with the ICA Mental Health group (?) to facilitate the design of clinical pathways and subsequent implementation and delivery.

6.1.4 BCF CAMHS

The CAMHS BCF work stream already reports directly into the CAMHS Transformation board and as the Children and young people ICA group is mainly prioritising physical health it is proposed that the CAMHS workstream is removed from the BCF Programme

Associated budgets will be removed from the BCF Pooled budget

6.1.5 BCF Dementia workstream

It is acknowledged that Dementia cuts across all of the ICA clinical pathways (with the exception of CYP) and therefore consideration of this should be taken into account in the development of pathways in these areas with the appropriate sources of knowledge included in the design. The Dementia BCF Workstream is responsible for implementing the Joint Dementia Strategy and therefore will remain with this single remit and will report into the ICA Clinical priorities group.

6.2 Integrated Care Alliance (ICA)

6.2.1 ICA Oversight Groups

The ICA Governance Group and Clinical oversight group will continue in their current form but will merge into one meeting with a split agenda. There is currently a number of people who sit on both meetings and there is a duplication of information and discussion, for example when the Governance Group receives updates from the Clinical group. Having a split agenda will enable a single discussion and for those clinicians who only wish to be part of the clinical group to leave at an appropriate juncture in the meeting.

6.2.2 ICA Governance Sub Groups

The ICA Governance sub groups will continue to support the development of the ICA and also the projects within the Mobilisation and Delivery Groups which will include some projects which were previously within the BCF Programme only. For example; data sharing agreements for MDTs and IT solutions etc.

6.2.3 ICA Clinical Sub Groups

The ICA clinical sub-groups will continue to develop clinically led design of pathways and services and will feed into the Mobilisation and Delivery groups for operational delivery A full list of projects will be presented to the clinical groups and overarching clinical pathways.

The exception to this will be the Mental Health workstream which will go forward as one clinical group with the membership reviewed to ensure that the most appropriate people are involved that can influence the operational delivery. The main reason for this is that there are a number of Mental Health meetings/forums outside of the BCF and ICA and this is an opportunity to rationalise meetings.

6.2.4 Reporting and Monitoring

Within the BCF Programme each workstream produces a monthly highlight report which is presented to BCF Programme Board. These reports will be reviewed to include a brief update for each project, risks and issues and slippage escalation within each workstream and will be presented by the clinical leads to the Clinical Oversight Group.

The Governance Sub groups will report into the ICA Governance oversight group. The Clinical Development sub groups will report into the Clinical Pathways Oversight Group

The Mobilisation and Delivery Groups will report into the Clinical Pathways Oversight Group and the Governance Group.

6.2.5 Requests for Funding

On occasions business cases are presented to the BCF Programme Board for funding of projects. These would need to go to the Clinical oversight group for clinical approval to ensure that they are aligned to the pathways and then to the ICA Governance group to determine approval and source of funding.

7 Programme Resource

The combined resource outlined in Section 5 could be allocated to support the Oversight and mobilisation and delivery groups. However, given the significant number of projects within both programmes, prioritisation will be needed to be undertaken, ideally by the Clinical Pathways oversight group, to ensure delivery.

It is proposed that Project/Delivery Managers will be aligned to a specific pathway i.e. End Of Life and manage the delivery of that pathway, ensuring that the clinical proposals are linked to the Governance groups with regard to developing Outcomes and enabling funding and activity flows etc.

There will still be a need for dedicated Project Support/Admin to support the programmes and the demand on this role will increase with the merging of the programmes and therefore additional resource will be required.

Strategic Direction and Overview Care Pathways and Governance	RWT	1.0 WTE
Strategic Direction and Overview Care Pathways	WCCG	0.4 WTE
Strategic Direction and Overview Governance	WCCG	0.4 WTE
Project/Delivery Manager	WCCG	1.0 WTE
Project/Delivery Manager	CWC	1.0 WTE
Graduate Management Trainees	WCCG	2.0 WTE (until July 2020)
Project Support	WCCG/CWC	1.0 WTE

The successful delivery of the BCF Programme and the successful development of the Wolverhampton ICA is dependent upon the appropriate resourcing being made available. Even with the resource outline above being available, it will still be necessary to prioritise projects and the resources allocated to them.

8 Risks

- Capacity to deliver against timelines – prioritisation will be needed across existing BCF projects and ICA delivery
- Project management and support capacity – medium and long term
- Interdependencies with STP programmes of work

9 Mapping of Projects

BCF	ICA Clinical / Governance sub groups							Mobilisation and Delivery Groups				
ACC Workstream	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Frailty												
Evaluation of Primary Care Frailty Clinic		√			√	√		√				
Evaluation of OT in Primary Care		√			√	√		√				
Approval for implementation of Healthy Ageing Coordinators		√				√	√	√				
Implementation of healthy ageing coordinators		√			√		√	√				
Evaluation of carer support into frailty clinics		√			√	√		√				
Roll out of carer support model in frailty clinics & ED (and other opportunities)		√			√	√	√	√				
Woundcare												
Further development of woundcare business case			√		√	√		√				
	End of	Frailty	Community	Mental	BI/IG/IT	Outcomes	Commissioning	ACC	D2A	MH	Dementia	Integration

	Life		Nursing	Health			and Contracting					
Final approval of woundcare business case			√				√	√				
Roll out of redesigned woundcare service			√		√	√	√	√				
Evaluation of redesigned woundcare service			√		√	√		√				
Re-design of Community Nursing												
Review and redesign of Community Nursing Services to align with PCN's			√		√	√	√	√				
Develop updated specification for District Nursing Service			√		√	√		√				
CV amended specification into contract			√				√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Develop update specification for Community Matron service			√		√	√		√				
CV amended specification into contract			√				√	√				

Redesign of CICT services to align with PCN's			√		√	√	√	√				
CV amended specification into contract			√				√	√				
Integrated Working												
Evaluate co-location of North Locality Teams		?	?		√	√		√				
Develop framework for measuring success		?	?			√		√				
Based on outcome of evaluation - develop Business case for roll out of model		?	?		√	√		√				
Obtain resources to roll out model							√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Identify suitable location												√
Floor Plans and costs												√
Approval of suitable premises												√
PM estates / refurb												√

PM move/change management												√
Palliative & EoL care												
Develop redesigned model for Community End of Life care service	√				√	√	√	√				
Develop specification for redesigned Community EoL service	√				√	√		√				
Obtain approval for Community EoL redesigned service	√						√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Ensure resource is approved for shift of activity into Community EoL service	√						√	√				
Roll out redesigned model for Community EoL	√				√			√				

service												
Evaluate new Community EoL service	√				√	√		√				
GPHV Service												
Evaluate 6 month Pilot of GP Home Visiting Service			√		√	√		√				
Amend specification for service based on evaluation findings			√		√	√	√	√				
Based on evaluation and Board approval - roll out service across the City			√		√			√				
Evaluate 12 month Pilot of GP Home Visiting Service			√		√	√		√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
MDT's												
Engage with Primary Care to ensure all practices are ready to initiate this new way of working		?	?		√			√				
Roll out prototypes			√					√				

as per individual practice preferences												
Align MDT Coordinators to Localities			√					√				
Work with Practice to wrap MDT's around PCN populations			√		√	√		√				
Amend MDT's to align with PCN populations			√		√	√	√	√				
RiTS												
Develop model for RiTS service 24 hrs per day			√		√	√		√				
Develop Business case for amended model			√		√	√		√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Obtain resources and approval for redesigned service			√				√	√				
Develop implementation plan for redesigned service			√					√				
Implement new			√		√			√				

model												
Evaluate new model			√		√	√		√				
Emergency Care Passport												
Undertake Scoping Exercise of current uptake and usage			√		√			√				
Develop roll out plan to improve usage			√					√				
Monitor improvement in usage and impact			√		√	√		√				
D2A (temporary Delivery Group)												
Evaluate D2A process					√	√			√			
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Evaluate Care Home Trusted assessor					√	√			√			
Evaluate Trusted assessor documentation									√			
Evaluate impact of D2A on Community					√	√			√			

Services												
Social Prescribing												
Develop preferred model for Social Prescribing attached to PCN's												
Obtain appropriate approval for preferred model												
Roll out preferred model												
Community Connections												
Profiling the WV10 area, understanding need and demand		?	?	?	?			√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Analyse maps and identify areas of high need and demand		?	?		√			√				
Testing out ways of connecting people with each other and their		?	?					√				

communities												
Run a number of "Love your community" events		?	?					√				
Develop and establish regular Talking Points in a variety of settings		?	?					√				
Identify and agree indicators for identifying where lonely and isolated people might live		?	?		√	√		√				
Trial a scheme to reduce loneliness and social isolation		?	?					√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Telecare												
Evaluate the impact of new Telecare Response Service with SJA and it's impact on admission avoidance					√	√		√				

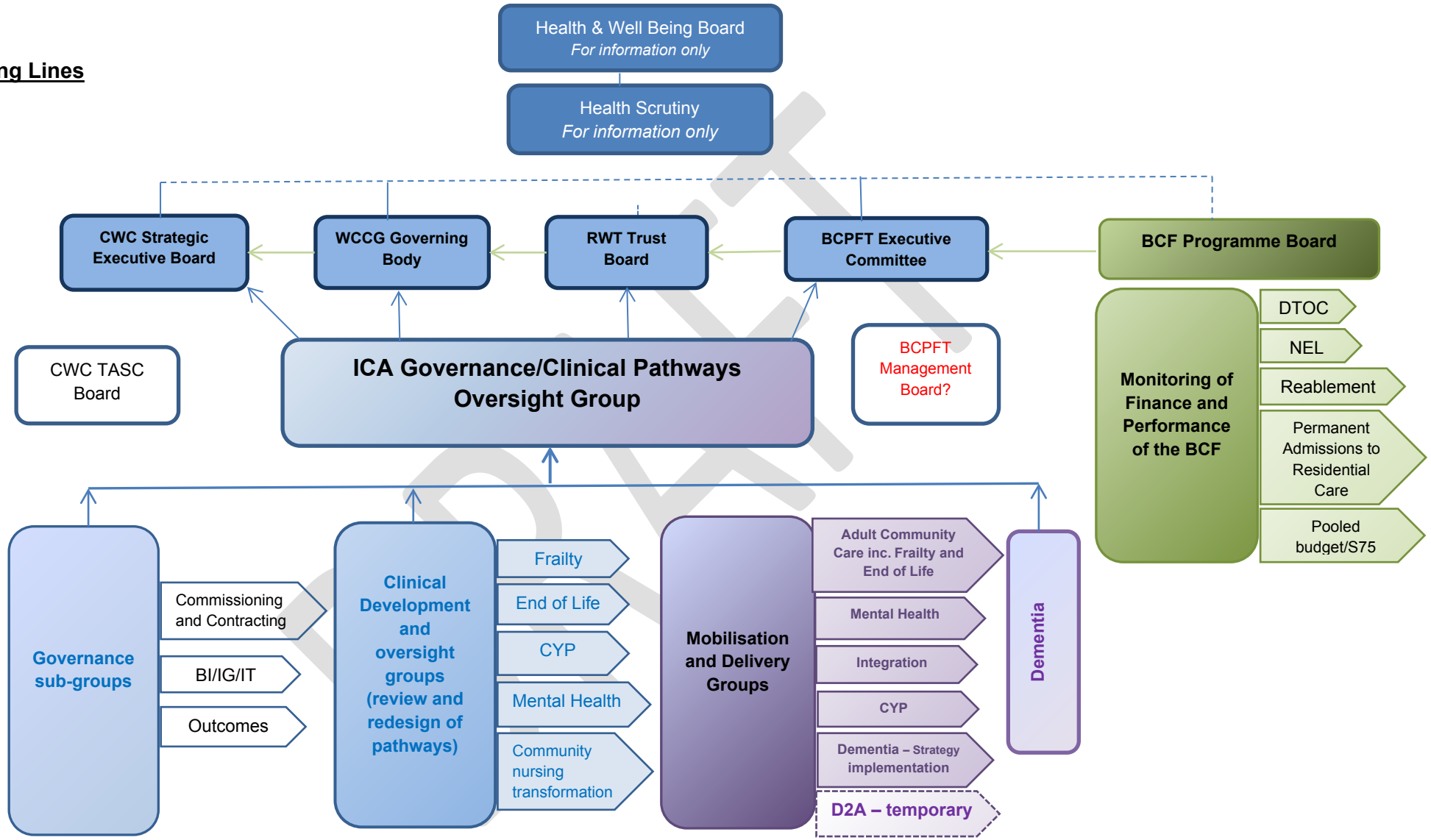
Increase the number of referral for Telecare (free for 6 weeks) within D2A and Admission Avoidance Services	√	√	√					√				
Develop a digital Telecare service offer which does not relay on a landline telephone					√			√				
Scope the demand for urgent Telecare packages 'out of hours					√			√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Explore the possibility for a proactive telecare telephone welfare check call service to support D2A						√		√				
Explore the benefits of using a connected care					√	√		√				

platform to support D2A/reablement												
Fibonacci												
Set up steering group					√							√
Further development of model to localise templates					√							√
Development of roll out plan to other users								√				
Roll out across other identified users								√				
Red Bag Scheme												
Obtain resource for Project Support (post to be advertised)		√					√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Develop milestones for delivery		√						√				
Mental Health workstream												
Prevention - mapping of services,										√		
Community pathways for										√		

patients with a mental health condition to prevent crisis												
Dementia workstream												
Implementation of the Dementia Strategy											√	

The table below maps the current BCF work programmes and offers a suggested “home” within the ICA structure

Reporting Lines



Current Resources

Programme Manager BCF – Andrea Smith
Programme Leads – ICA Governance (Andrea Smith, Steph Poulter) and Clinical Oversight (Karen Evans, Steph Poulter)
Project Management/Delivery Leads – Michael Holden, Sheeba Mir (until December 2019), Graduate Managament Trainee (from October 2019), Graduate Management Trainee (from November 2019)
Project Support – Cate Chislett