

Integration Director's Report

4 June 2019

Three wavy lines in blue, green, and pink/magenta colors that sweep across the bottom of the page.

Agenda Item No: 8.3

Trust Board	
Meeting Date:	4 June 2019
Title:	Integration Director's Report
Executive Summary:	This report provides the Trust Management Committee with an update on the Integrated Care System developments in Wolverhampton
Action Requested:	Receive and note
For the attention of the Board	This report provides an update of the Integration activity to date and summarises on-going developments
Assure	
Advise	Appendix 1- ICA clinical pathways update May 19 Appendix 2- Clinico Informatics update May 19 Appendix 3 – ICA Communications and Engagement Plan
Alert	
Author + Contact Details:	Sultan Mahmud Director of Integration Tel 01902 695963 s.mahmud@nhs.net
Links to Trust Strategic Objectives	<ol style="list-style-type: none"> 1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	Revenue: None Capital: None Workforce: Additional capacity for Primary Care Services Team Funding Source: Central funding
CQC Domains	<p>Safe: patients, staff and the public are protected from abuse and avoidable harm.</p> <p>Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.</p> <p>Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.</p> <p>Responsive: services are organised so that they meet people's</p>

	<p>needs.</p> <p>Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.</p>
Equality and Diversity Impact	None identified
Risks: BAF/ TRR	
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	Non-Executive Directors
References	<p>Next steps on the NHS Five Year Forward View 2018/19 Planning Guidance NHS Long Term Plan (published 7th January 2019)</p>
NHS Constitution:	<p>In determining this matter, the Trust Management Committee should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details

1

Integrated Care System Update

Background

It is the stated ambition of the Trust to strongly support the development of an integrated care placed based system in Wolverhampton.

Our aims are:

- To become a fully integrated provider of primary, community and acute services
- To take further responsibility for management of the overall population health of the city
- To blur the distinction of the purchaser-provider split in Wolverhampton. In practical terms it would focus on individual relationships with providers, the procurement of services, sub-contracting, and the management of the provider chain against specification and performance criteria. This would usually be focussed on the short-term and annual cycles. Connections with the population are based on a locality/neighbourhood approach.

2.0

Integrated Care Alliance (ICA)

The ICA comprises, Wolverhampton CCG, Wolverhampton City Council, The Black Country Partnership, Royal Wolverhampton NHS Trust, GP groupings and Healthwatch Wolverhampton.

The remit of the ICA is design the new healthcare system in the Wolverhampton place to ensure enactment of the NHS Plan. The work is being undertaken by the following groups:

- Wolverhampton Integrated Care Alliance (ICA) Clinical Development group
- Overarching Wolverhampton Integrated Care Alliance (ICA) Governance Group

2.1

Clinical Development Group Update

Strategic Planning in the EOL and Frailty Work Stream Sub Groups is now sufficiently developed and these plans are now at the stage of translation into operational delivery programmes which will be taken forward by primary care networks and community services transformation teams. The CYP and MH Sub Groups are also making good progress. The Governance Sub Groups will provide the enabling infrastructure to allow this to happen e.g. contractual changes,

financial arrangements, risk share agreements etc.
Appendix 1 contains an implementation update on each of the Work Streams.

2.2 Bringing the Transformation of Community Nursing into the Integrated Care Alliance

2.2.1 Summary

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 specially 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

2.2.2 The 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 oversight group 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. 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 work streams 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 Community Nursing and the PCN infrastructure to accommodate these changes.

2.2.3 The current status of the Transformation of Community Services Programme

Significant work is being undertaken to support the ICA Work Streams in changing Community Services care models with a particular focus on EOL and Frailty.

There is now an established Task and Finish Group meeting bi-monthly and this has wider representation from primary care, community services teams, commissioners, Compton Care and other key stakeholders. This is currently a Division 3 work programme aimed at bringing together a re-designed proactive and responsive community service delivery teams with the ICA and PCNs development. The diagnostic phase is underway alongside a detailed workforce

analysis. The Clinical Chair for this work – Dr Helen Ward recently attending the LMC to provide a high level overview and is intending to undertake the same for the PCNs in the coming weeks.

2.2.4 The way forward

The manner in which Community services are commissioned and described can be found in the table below. They can be broken down into a number of areas with which has a degree of commonality around them:

- Services which should be part of the PCN solution (recognising that some of these should still be delivered on a city wide basis i.e.RITS & Wound Care)
- Services that address different specialities
- West Park rehabilitation and Neuro services

Community Nursing	Specialist areas (a)	Specialist areas (b)	West Park & Neuro
CICT Rehab	Community Childrens Nursing	Diabetes	Care of the Elderly
Community Matrons	Community Falls Prevention Team	Foot Health	Neuro_Rehabilitation
District Nursing	Community Paediatricians	Hearing Services	Community Neuro Rehabilitation Team
EOLC (Palliative Care)	Falls Assessment Clinic	INR	Community Stroke Co-ordinators (Stroke)
Hospital at Home (CICT)	Occupational Therapy	Speech & Language Therapy	Community Stroke Co-ordinators (TIA)
Rapid Intervention Team	Oral Nutrition		
Wound Care	Phlebotomy		
Continence	Physiotherapy		
Heart Failure Service (Nursing)			

The Community nursing component needs to be addressed as part of the PCN solution, recognising the co-dependencies with the EoL and Frailty programmes of work in the ICA. They are mutually dependant and should not be treated exclusively.

It is proposed therefore that the Community Nursing components of the agreed schedules of service which would be expected to be an inherent part of PCN multi-disciplinary and multi-agency working be treated separately to the rest of the Community Transformation programme and be brought under the governance of the ICA with shared delivery management of delivery between the Trust and the CCG.

2.3

Data and Information Sharing across the Wolverhampton Place

The Trust with local partner is undertaking the preparatory Information Governance work in line with the NHS provider legal obligations to enable phase one initiation for a unified care record and analytics system for the Wolverhampton place. Progress has been made in the following areas:

- Each data producing (provider organisation) is undertaking a Data Privacy Impact Assessment (DPIA).
- Defined Data-Set for sharing (Tier 1 - limited data-set) is nearing completion and moving to the legal ratification stage.
- Partners have agreed that the Graphnet Commercial Relationship will sit with RWT as a statutory NHS anchor organisation.

The Project Management resource required to undertake DPIA and DSA has been agreed and identified.

Work has also commenced with voluntary GP Groupings across the city to receive and share data based on the VI data-set whilst ensuring all IG and GDPR requirements are met. This will allow:

- Further integration opportunities
- Harmonisation of care delivery
- Understanding of patient flow analytics across the system
- Contribute towards clinical and operational workflow mapping across the Wolverhampton place

The work towards sign off of DSA's is in the final draft stage. The following outlines the elements of progress towards this.

2.3.1

The Structured Clinical Data Set

This is progressing well and the key partners have provided a comprehensive data set.

There is a Data Sharing Agreement in place with all GP Practices.

A sub data sharing agreement with 2 non RWT PCN practices will be completed by next week which will permit sharing the same primary care data set and the further evaluation of the "GP complex care" system.

The full data set will become more complete and indeed grow over time.

There will be sufficient data to provide significant intelligence and drive new systems pathways and transformation on behalf of the ICA.

2.3.2

Framework strategic document

It is the view of the IT/IG/BI/Informatics Sub Group that this will be an NHS First in terms of a fully GDPR compliant DSA for delivering a health-economy wide multi

partner programme.
Further guidance is now being provided nationally.

2.3.3 Data agreements

With the agreed data set now to hand, with agreed clarity of use and purpose, with agreed governance, all as described in a detailed framework document each partner will undertake a DPIA, This will inform and permit a joint data controller agreement, followed by the Data Sharing Agreement (DSA).

2.3.4 Data housing

Graphnet is the current repository (there are other options). We are in the process of a contract transition to be held by the data controllers, as a data processor. Graphnet is the shared care record provider across Walsall and all of Staffordshire and is being used by WMAS. It is interoperable with Dudley and Sandwell systems and so implementation supports the STP Digital programme and clinical strategy. This is being progressed.

2.3.5 Data quality management

There may be issues here in relationship to data integration and NHS number use. It will be a function of IT/IG/BI/Informatics Sub Group to manage that and avoid error and risk.

2.3.6 Data use

This will be agreed and governed by all partners within in data governance GDPR compliance.

The use of the data within the Structured Clinical Data Unit (SCDU) will be used for primary (individual clinical care), secondary (cohort clinical care, service delivery) , and tertiary (pseudo anonymised) population health analysis.

3.0 Clinico Informatics Developmental Work

Evidence based approaches that have succeeded in high performing systems have relied heavily on clinical informatics, strong evidence base and a departure from standard approaches in managing patients with long term conditions.

The trust is testing new evidenced based approaches based on its integrated care dataset in the following areas:

- End of Life Care pilot.
- Huddle- Red to Green currently being piloted in ward 2 in West Park.
- GP MDT Pathway
- Learning from Death
- Frailty
- Coding

Appendix 2 contains updated further information on progress.

4.0 ICA Communications and Engagement Plan

The Trust Board asked for a comprehensive ICA Communications and Engagement Plan. This can be seen Appendix 3.

5.0

Joint Prevention and Population Health Unit

The joint (RWT and Council Public Health) Prevention and Population Health unit launched on 1st May 2019, putting the Trust in a strong position to deliver better care through the use of Population Health Management. The team will be using epidemiology, statistics and systems thinking to help managers and clinicians to better understand patterns of health and disease in the population, so that the Trust can be a system leader in delivering better outcomes for the whole population. Examples of the work programme include:

- Epidemiological profiling of frailty, looking at population prevalence, usage of healthcare services, and where to focus interventions to reduce future demand and improve patient defined outcomes

A smoke free programme focussed on de-normalising smoking, supporting quit attempts including people choosing to vape, and reducing second-hand smoke exposure in the environment

- Analytical support to validate data driven care models, which flag up candidates for clinical review based on patterns of healthcare activity and other risk factors
- Public Health data science capabilities digital innovation projects

We are in the process of establishing full data access for the team.

6.0

Overall Integration Programme Risks

The risk and issues associated with integrated care development are as follows:

- The integration programme is complex and requires radical thinking and new approaches to managing patient cohorts across organisational boundaries. Communicating the iterative changes in governance and care delivery requires further work across the health economy and a structured plan.
- Care Summary Record Information Governance Risks
- There is a risk that the benefits from integrating health and social care do not accrue fairly to all organisations. To mitigate this risk, proposals for monitoring performance, targeting service improvements and sharing costs and benefits will need to be closely scrutinised.
- The expected shifts out of acute and into community must be planned as part of the ICA to include associated investment and disinvestment plans, with transition funding to be jointly agreed via the appropriate ICA governance groups with risks shared appropriately across the health economy. The provision of a fit for purpose community based information system will be pivotal to achieving these plans.

7.0

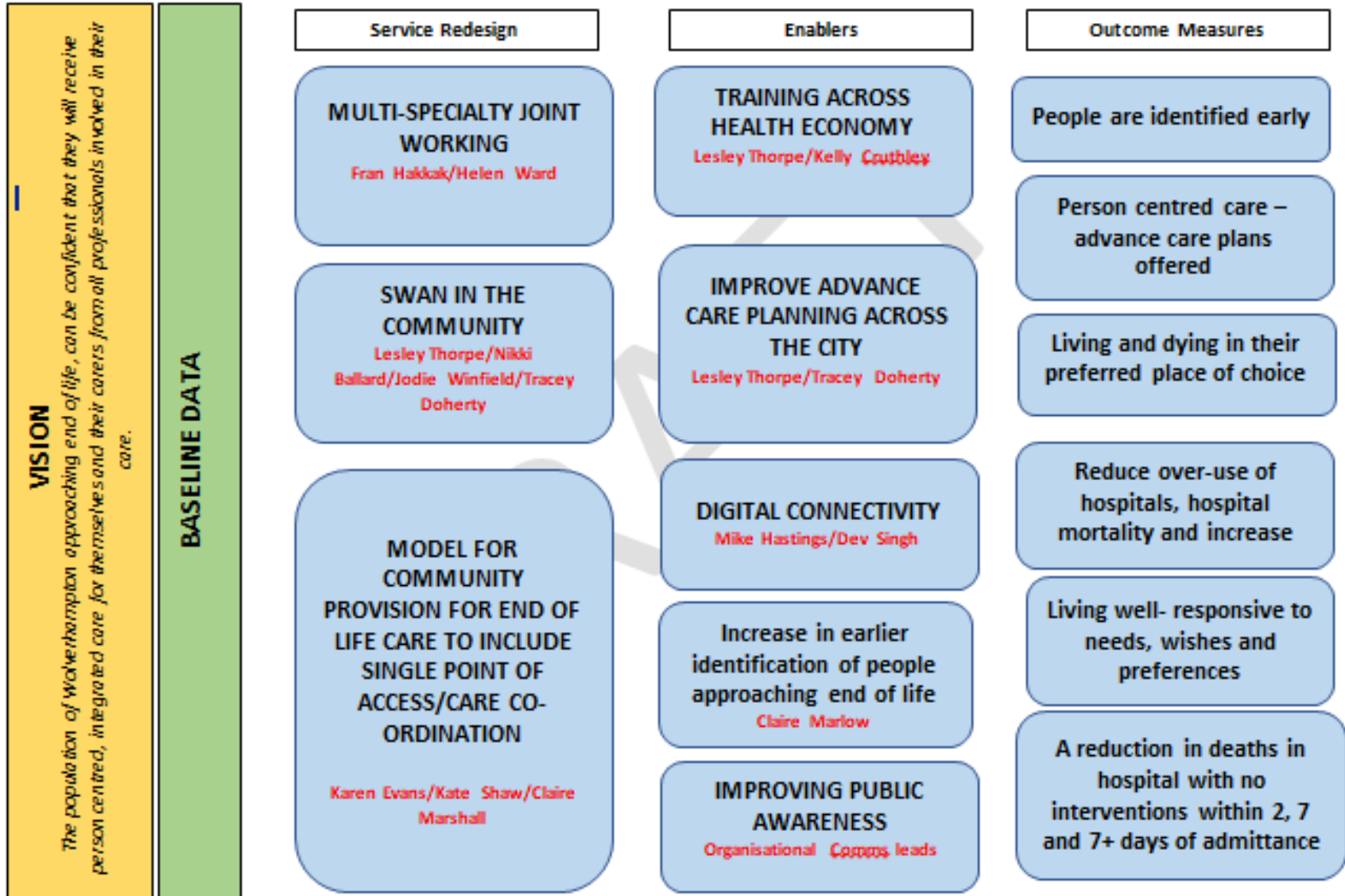
Conclusion

The Board is asked to note the contents of this paper.

ICA- Clinical Plans on a Page

May 2019

End of Life - Plan on Page



End of Life Implementation Progress

- Revised set of Outcomes with metrics agreed and will be agreed/ratified by the Outcomes group
- Mapping of Wolverhampton position against National six ambitions for palliative and end of life care underway
- Breathlessness Service Action Plan and Business case to May meeting of the Sub Group
- Implementation of Swan in the Community underway with full training programme on track
- Business case drafted for education and training on Advance Care planning
- Re-designed model for community end of life care completed in draft form on plan for the June meeting.

Frailty – Plan on a Page

VISION

The older people of Wolverhampton, and their carers have timely access to and benefit from a patient centred integrated model of care that is equitable across the City whilst being responsive, meeting the needs of our local communities and individuals

BASELINE DATA

Service Redesign

Systematic and standardised identification and clinical assessment of frailty across pathways and services

Drs King/ Elckayappa/ Claire Morrissey

Integrated frailty pathways to facilitate better patient experience and care – 4 pathways out of Acute into Community and social care

Drs King/ Elckayappa/ Claire Morrissey

Healthy Ageing Coordinator in primary care

Drs King/ Elckayappa/ Claire Morrissey

Increase referrals to relevant prevention and early intervention services (i.e. falls prevention, memory clinical, physical activity)

Drs King/ Elckayappa/ Claire Morrissey

Enablers

Standardised electronic templates across primary, community and secondary care, improving quality of data collection for secondary purposes

Drs King/ Elckayappa/ Claire Morrissey

Education and Training of health and social care professionals

TbC

DIGITAL CONNECTIVITY
Shared electronic patient record

Mike Hastings/Dev Singh

IMPROVING PUBLIC AWARENESS

TbC

Outcome Measures

Older persons outcome star/ PAM licences focussing on 4 key asset based domains (baseline and follow up at 6 months)

Ankush Mittal

STP level frailty dashboard ~~inc~~ falls and dementia

Ankush Mittal/ Tina Gallagher

Prescribing Costs for eFI cohort

Ankush Mittal

Improve early identification of End of Life Care

Ankush Mittal

Frailty/Ageing Well Implementation Progress

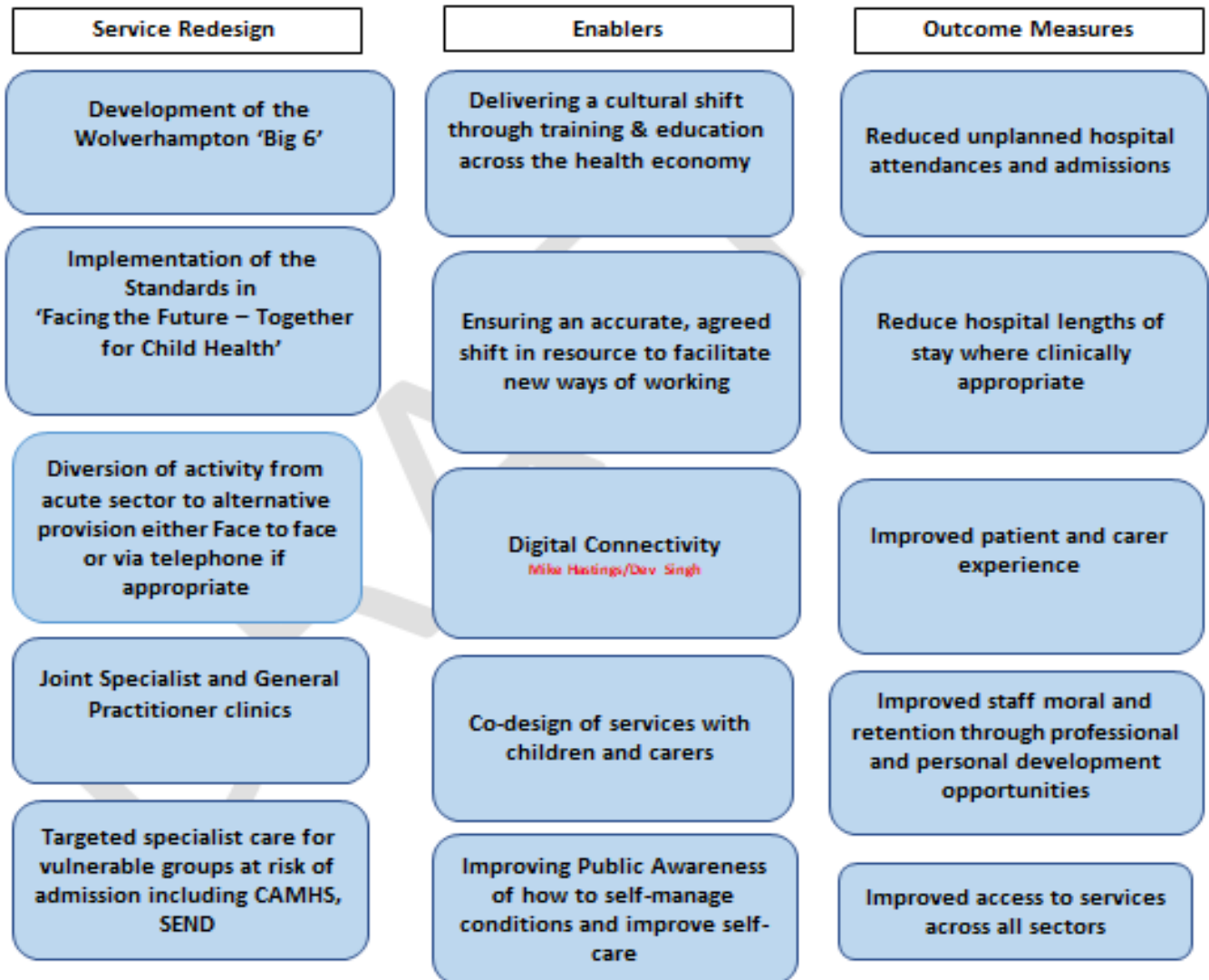
- Task and Finish Group focussing on implementation of the Ageing Well Co-ordinators in Primary Care (funding agreed 1 per PCN)
- Developing models of anticipatory care including a Primary Care in-Reach Team (PiTs) to care homes and proactive case management
- Deterioration Project and FREED Assessment Tool being trialled in 5 Nursing Homes and evaluated for roll-out.
- Evaluation of Frailty Clinic pilots in Primary Care commenced x 2

CYP – Plan on a Page 0-18

VISION

Our Shared Vision – for Children and Young People to receive care and interventions in the right location. Self care-empowering parents to take responsibility by working in partnership

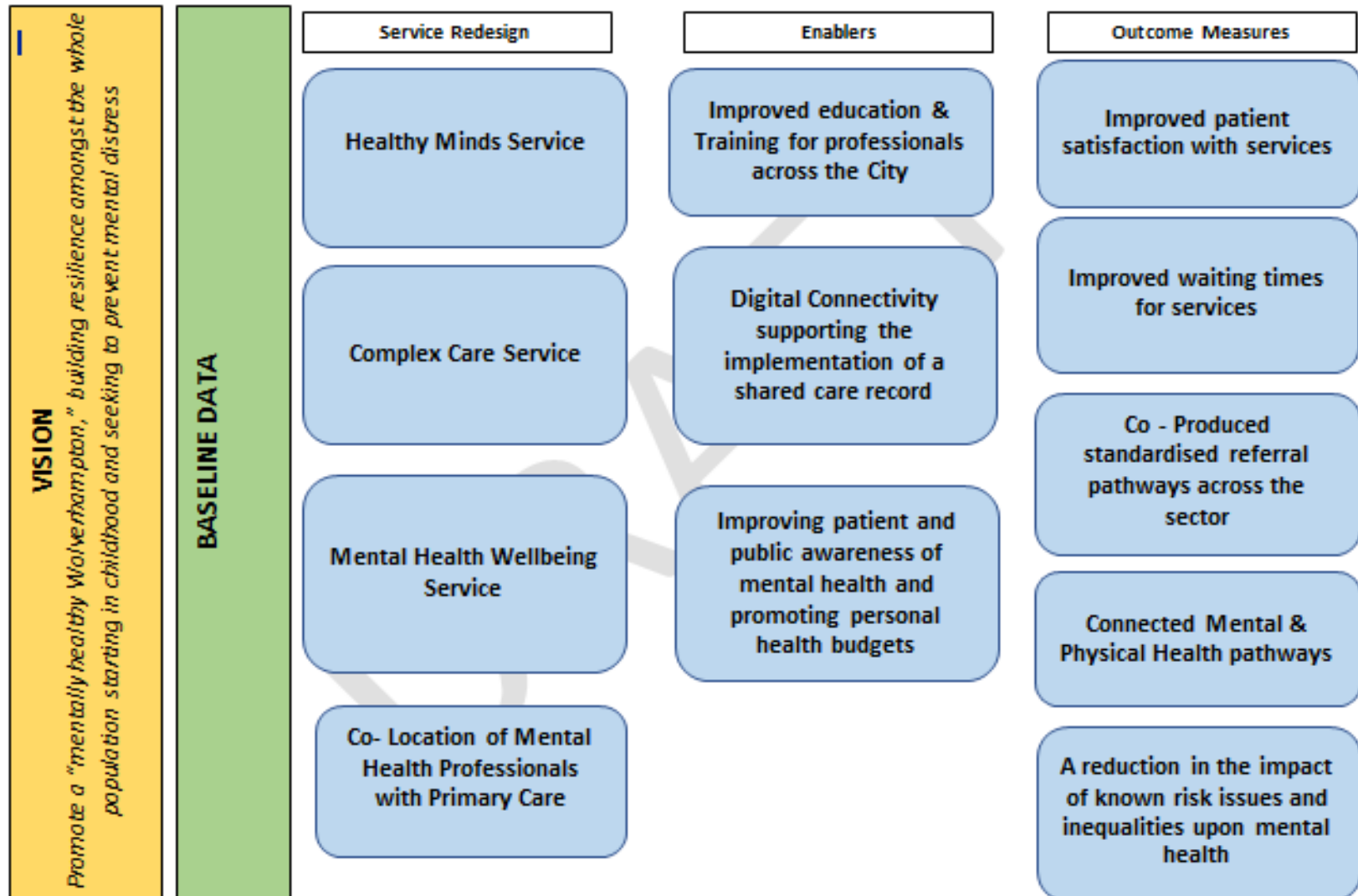
BASELINE DATA



CYP Implementation Progress

- Implementing the 12 Standards in 'Facing the Future Together for Child Health'
- Direct helpline to Paediatric Consultant for GPs to seek expert advice and guidance is live
- Trialling joint specialist and general practitioner clinics at West Park Surgery

Mental Health – Plan on a Page



Update on Mental Health Work Stream

- Clinical Lead Co-Chairs Identified
 - Dr Vishwanathan
 - Dr Ram
- RWT Clinical Representative being identified by Dr Odum once work programme is clear
- Aligning the Wolverhampton Mental Health Strategy priorities to the ICA Work-Streams
 - IAPT/Dementia/Early Intervention/others
- Meeting to be held on 15th May 2019 to determine priorities for this Work Stream

Clinico Informatics Projects Update

As at 13/05/19

Project	Description	Outcomes	Progress	Next Steps	Time Scale
Huddle - Red to Green System	Developing a system and process to identify 'Red' and 'Green' days in hospital wards for every patient every day. Capturing this data will result in rich data intelligence informing the Trust of where the bottlenecks are in the Trust in terms of patient flow. A dashboard will be created displaying the status of delays across the Trust	Identification of 'Red' delays in hospital Proactive discharging of patients length of Stay Ward Live View of patient status Capturing Actions list for Delays Integration with EOL Pathway Integration with Frailty Pathway	System now in use at Fairoak, West Park and now C41 (Gastro)	Other wards to be including Respiratory ward	31/05/2019
EOL	Developing a data driven care system and process to identify End of Life Patients earlier. Centered around allocating care plans in a more efficient way - reducing paper work and improving care quality	Earlier identification of EOL patients Preferred Place of Death Gold Standard Care Plans EPAACS Record completion Reduction of A&E Attendances Reduction in Emergency admissions Patient priorities monitoring	System and Model of Care developed and is functional. Integration with Clinical web portal documents also complete	Clare Marlow and her team are testing system and are providing feedback, Ward C41 was identified so that system can be complimented with the Huddle system	31/05/2019
GP MDT Pathway	Developing a data driven care system and process to risk stratify patients for each VI GP Practice which will capture assessments and patient actions more formally. Patients escalated further will be discussed in a virtual MDT	Better screening of health needs of population base Formalised MDT Pathway Structured patient Actions Monitoring of Actions Reduction of A&E Attendances Reduction in Emergency admissions Integration with EOL Pathway Integration with Frailty Pathway	System rolled out to Warstones GP practice. Risk escalated patients are being Triaged by Dr's	DSA to be extended to include NON VI GP practices	31/05/2019
Learning from Death	Developing better systems and processes in being able to undertake reviews of hospital deaths in a more efficient way. The current system is heavily reliant on disaggregated steps which need to be joined up. The Trust is investing in a newly developed system in the future, however, the current processes can be improved in the interim.	Streamlining Administrative tasks in collating information Automation of worklists between various stages of Mortality Review Quicker turnaround of each Mortality Review	Meeting with Governance dept took place and access has been granted to current system. Meeting with IT also took place request 'back end ' access to data	VK to assess current processes and identify areas which can be tweaked easily	31/05/2019
Frailty	Developing a data driven care system and process to identify Frail Patients earlier. Centered around allocating care plans in a more efficient way - reducing paper work and improving care quality	Better Identification of Frail Patients Better Care Management Plans Integration with EOL Pathway Reduction of A&E Attendances Reduction in Emergency admissions	Initial discussions have taken place with Dr Liz King to ascertain requirements	VK to develop basic model and present to Dr Liz King and Prof Singh	TBA
Coding	Improving Integration of Clinical Coding between primary care and the Trust and making this better accessible via the Clinical Web Portal	Better summary of Individual Patient Coding Integration of Primary Care and Hospital Coding	N/A	Meeting to be arranged between Prof Singh, Head of Coding and VK	TBA

Communications & Engagement Strategy

Developing an Integrated Care Alliance in Wolverhampton

1. Executive Summary

In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population. NHSE and NHSI are now using the term 'integrated care system' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'.

The updated 2018/19 planning guidance made it clear that integrated systems will become increasingly important in planning services and managing NHS resources in the future. The 10 Integrated Care Systems (ICS) already operating in this way will prepare a single operation plan and take responsibility for a system control in 2018/19.

This document gives a clear message that we need to adapt to take advantage of the opportunities that new technologies offer and evolve to meet the population and financial challenges that we now face.

Other key legislation including the Care Act 2014 set the scene for public sector. This document sets out expectations of a care service fit for the 21st century, and the tightest squeeze on public finances since the 1970s.

More of the population now have a mixture of needs that involve medical care as well as social care support. These exceed the separate responsibilities of individual organisations making it impossible to consider how we meet these challenges in isolation, for organisations across Health & Social Care our futures are intertwined.

The challenges set out nationally can be summarised as people are living longer, with more complex health issues and financial pressure on public services. These are mirrored locally. The local health and care system recognises that to really meet these challenges we must take a longer view, they are not things that can be fixed overnight and we need to look at new ways of thinking and doing to make the difference that we have not been able to make to date. This requires changes to the way that we provide services to meet the changing needs and wants of our population.

Wolverhampton is an area that has risen to that challenge. We are working differently to make the changes required, to think about solutions and make them happen, regardless of the traditional barriers that exist. We are refining organisational boundaries and are working towards establishing teams without walls who focus on the person and their care needs.

We also know that we cannot address these challenges without a fresh look at our relationship with the people and the communities of Wolverhampton and in turn the relationships that those people and communities have with each other. We also need to consider how we utilise community assets.

This plan sets out our ambition to involve, inform and inspire key audiences to work in new ways and develop an Integrated Care Alliance which is truly person centred.

It articulates our approach to engagement and gives a clear message that our ambition to work together to develop a new model of care is not achievable unless we take people, communities and staff with us.

Introduction

This strategy has been written by members of the Communication Team supporting the Integrated Care Alliance.

This is a document which outlines our plans on engaging and communicating effectively with our patients, public, partners, staff and stakeholders over the next two years.

The demands on health and care resources are rising year on year – Wolverhampton people are living longer with ever more complex conditions; continuing progress in treatments and medical techniques comes with new costs and expectations; and modern lifestyle issues such as obesity are causing an increase in long term conditions.

For the future, we must transform services to adapt to these rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources.

Our vision, which is jointly signed up to by all organisations in the Wolverhampton Integrated Care Alliance, 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 of this. 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. This demands a whole-system transformation in the way we commission and provide health and social care.

Communication, involvement and engagement need to be at the heart of these changes in order to make them sustainable for the future and responsive to the needs of the Wolverhampton population; in other words, the patient voice needs to be at the heart of everything we do.

2. Profile

To respond to this the focus of our model of care builds on a joined up network of GP-led, community-based multi-disciplinary teams which enable staff from health, social care and the voluntary sector to work better together focussing on the holistic needs of the person.

The support for developing and implementing this model is also underpinning our work towards a complementary process of developing standardised best practice pathways of care. Through this we will ensure that all services provided outside of the ICA are commissioned in a way which incentivises optimum outcomes for the patient, maximises efficiency and enables effective communication back with the GP.

3. National context

The new care models programme, Primary Care Networks, is an integral part of the NHS Five Year Forward View and the Long Term Plan sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care

at the right time in the optimal care setting. The focus shifts to prevention in order to help people to stay healthier which in turn will reduce the need for unnecessary GP appointments, A&E admissions and pressures on other services, ensuring that people only use the NHS when it is really needed. The Primary Care Networks will be the 'bedrock' of integrated services ensuring they are built around the needs of patients in that network.

A continuous priority for the NHS is to have quality care for patients and improve outcomes. For all major conditions, results are now measurably better than a decade ago. Cancer survival is at an all-time high, deaths from cardiovascular disease have halved since 1990, and male suicide is at a 31-yr low. The Long Term Plan goes further on the NHS Five Year Forward View's focus on cancer, mental health, diabetes, multimorbidity and health aging, including dementia. The plan extends its focus to children's health, cardiovascular and respiratory conditions, and learning disability and autism.

Workforce is also a growing concern for the NHS. The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. However, the staff are feeling the strain, partly because the workforce growth has not kept up with the increasing demands on NHS services. The NHS needs to become more flexible with its approach to its workforce in order to attract and retain staff.

4. Partnership and Programmes Principles

The priorities of tackling the health, care and finance gaps are achievable only by fundamentally changing the NHS's relationship with people and communities.

Locally our program is being delivered in line with the principles set out in the GP Five Year Forward View of clinical engagement, patient involvement, local ownership and national support.

We are developing a new health system which is built with patients and the health and care system, clinical leadership is central to all the activities.

We recognise that fundamental to our success is the new way of working being shaped by those affected by change. Our programme is supported by significant organisational development support to ensure that any local changes are designed in partnership with staff and those using services.

5. Programme Governance

Accountability for oversight and steering of the ICA Programme is delegated to the ICA Clinical Pathways Oversight Group and the Governance Oversight Group with representatives from each partner organisation.

In total, there are four clinical workstreams within which all the activities of the programme should be delivered. These projects are as follows:

- Frailty
- End of Life Care
- Children and Young People
- Adult Mental Health

Urgent Care is considered as a cross-cutting theme across all four work programmes. These four workstreams report into a clinical pathways oversight group. This reports into an overarching Governance Group structure.

The Head of Communications at The Royal Wolverhampton NHS Trust and Communications Manager at NHS Wolverhampton Clinical Commissioning Group are members of the Governance Group and will ensure appropriate messaging.

The communications and engagement is one of the cross cutting, enabling functions to support delivery of all of the workstreams.

At each Governance Group there is a standard agenda item for communications & involvement. An update is provided routinely through the programme report and this representation at partnership board is an opportunity to shape messaging, review public feedback and have a full Board discussion on any communication or involvement topics.

There is also a need to ensure that the public voice is heard at these meetings. Healthwatch Wolverhampton is members of the Governance Group and Clinical Pathways Group to reflect the patient voice.

6. Strategic aims

The NHS Long Term Plan was published in January 2019 and points towards a number of key developments:

- Primary Care Network Contracts (30-50,000 patient population) creating genuinely integrated teams of GPs, community health and social care staff, likely to be a requirement for GP Primary Care additional funding share of £4.5 billion by 2023/2024.
- Major reforms to the NHS' financial architecture, payment systems and incentives, including £700 million in reduced administrative costs across providers and commissioners both nationally and locally.
- Widening digital access to services – wide ranging and funded programme to upgrade technology and digitally enabled care across the NHS.
- Likely amendments to primary legislation related to the 2016 Health Bill order to accelerate processes for service integration with Integrated Care Systems in place across the country by 2021.

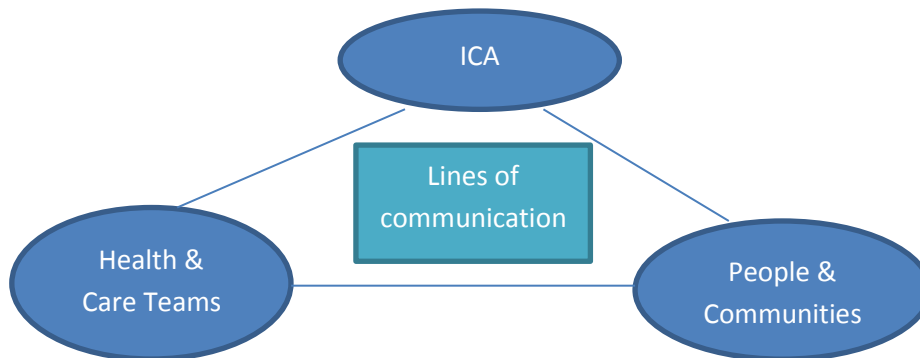
With this in mind the partners are working to develop a new, person centred, place-based models of care which:

- understands the position, needs and motivation of people and communities;
- works with people and communities to hear their voices;
- engages with people and communities to build relationships and offer genuine opportunities for influence;
- embraces the assets of people and communities to create opportunities for co-production, building collaborative relationships that recognise that different roles and perspectives are a constructive force for change;
- empowers staff to lead service changes to benefit people;
- enables people and communities to put themselves at the centre of their care - so that they can make informed decisions about their health; be supported to manage their conditions and stay as independent and in control as possible;
- creates an environment to support people using health and social care to drive change themselves.

Taken together, these approaches will improve health outcomes and allocate resources more efficiently to areas of need and want – especially for those with long term conditions and complex care needs.

Given our vision for maximising the potential of:

- The individual (in their community)
- Our staff in supporting the individual
- Our staff working effectively with each other



This strategy also plays a key role in connecting those staff to the communities they serve.

Our overall strategic aims are therefore to:

- 1. design and produce person centred care with people and communities in the City of Wolverhampton**
- 2. ensure teams can effectively connect to their local communities to deliver person centred care.**

7. Delivering our strategy

We have developed 4 stages to guide delivery of the above aims.

1. Developing a collective understanding of the context, scope and boundaries of what the integrated care alliance is; and of the motivations, assets, needs and constraints of our leaders, teams, local people and communities.
2. Supporting our leaders and teams to develop skills, knowledge and confidence to:
 - a) communicate effectively using common key messages and information
 - b) listen to what people say and understand how to share what is heard
 - c) carry out consultation appropriately and inclusively, and involve people and communities in influencing decision making through clear, transparent processes
 - d) facilitate co-production of health and care services
3. Monitor and evaluate the effectiveness and impact of our communications and involvement of people and communities.
4. Draw out and share learning from evaluation and apply it to ongoing communication and involvement activities.

8. Objectives

The strategic objectives are detailed below across the 4 stages of strategy delivery.

Strategic Stages	Objectives
1. Developing a collective understanding of the context, scope and boundaries of what the integrated care alliance is; and of the motivations, assets, needs and constraints of our leaders, teams, local people and communities.	<ul style="list-style-type: none"> • Identify and analyse our current and future stakeholders • Understand what is important to local people, communities and teams • Manage and maintain stakeholder expectations • Have a shared understanding of how things will be different in the future
2. Supporting our leaders and teams to develop skills, knowledge & confidence to:	
a) Communicate effectively using common key messages and information	<ul style="list-style-type: none"> • Raise the profile of the integrated care alliance and inform key audiences • Share successes to inspire teams • All ICA partners using consistent messages • Ensuring that information regarding the ICA is readily available if needed • Ensure all staff understand their role in the ICA
b) Listen to what people say and understand how to share what is heard	<ul style="list-style-type: none"> • Patient voice is integral to plans of all partners • Staff inspired to lead and encouraged to shape the future care model
c) Carry out consultation appropriately and inclusively, and involve people and communities in influencing decision making through clear, transparent processes	<ul style="list-style-type: none"> • Listen and share successes • Create appropriate engagement opportunities with real opportunity to influence for people, communities and staff
d) Facilitate co-production of health and care	<ul style="list-style-type: none"> • Make real changes for person centred care • Steps are taken to move towards more and more services being co designed and co-produced
3. Monitor and evaluate the effectiveness and impact of our communications and involvement of people and communities.	<ul style="list-style-type: none"> • Create an evaluation tool • Ensure that patient voice and lived experiences form a key part of the overall programme evaluation • Ensure that staff experiences are reflected in the new model
4. Draw out and share learning from evaluation and apply it to ongoing communication and involvement activities.	<ul style="list-style-type: none"> • Organisations commitment to the communication principles and engagement pledges • working together to use the knowledge and insight they have to inform the programme direction

9. Situational analysis

In order to inform our strategic aims, consider areas for improvement and of opportunity, we have taken a 'snap shot' of the current state of affairs. Looking at communications and engagement activities along with any other relevant areas we have undertaken a situational analysis.

A SWOT (strengths, weaknesses, opportunities and threats) and PESTEL (political, environmental, social, technological, environmental and legal) and stakeholder analysis have been carried out and are included in full in **appendix 1, 2 & 3**.

Overall the Wolverhampton Health and Social care economy is in a good position to achieve the changes proposed. We have political support for the direction of travel and whilst we have significant risks and challenges, presented by the financial and social climate, these present us with a perfect case for change.

We recognise that things cannot continue as they are with,

- 1 in 4 people in Wolverhampton have a limiting long term illness
- A quarter of early deaths (under age 75) are due to smoking, obesity, cardiovascular disease and lack of physical activity
- In two decades time there will be 16000 more people 65+ & 4000 85+
- 13% of single person households are in 60+ age group
- In Wolverhampton 4.2% of the population are unemployed 25.9% of children under 16 years of age in Wolverhampton Borough were classified as living in poverty.
- Historically Wolverhampton has experienced lower than average earnings and qualifications.

The future sustainability of the system depends on us creating efficiencies, empowering people and communities to take responsibility for their own health and inspiring teams to grab opportunities for closer working and make the changes required to improve things for their patients and service users.

10. Positioning & Branding

The programme itself is led through the two overarching bodies (outlined earlier) which is made up of senior representation from multiple organisations that make up the ICA.

The programme to develop the ICA can only be successful if it brings together the teams working around the person. We must create a brand that helps to give these teams some identity.

As the ICA has no legacy of its own we must strengthen its position externally and internally to ensure that it stands out in what is a very complex sector and develops a positive reputation of its own.

The positive is that stakeholders, patients, the public and the media have an affinity with the services that exist in Wolverhampton and with the people who deliver these services. The positioning of the ICA will build on this in order to raise awareness of the work it does, how it ultimately will benefit the patient and enhance perceptions.

Positioning

What we do?

Scope: What area of activity are we in?

Working with you to develop person centred care in Wolverhampton.

Status: What status do we want to achieve?

Health planning decisions led by Clinicians and informed by the people of Wolverhampton;

Personalised health to the individual, with care decisions co-produced between them and their lead clinician

Why we do it?

Ambition: What is our heart-felt ambition?

Healthier lives for the people of Wolverhampton

Ethos: What are the principles behind our actions?

Passionate about your health

Compassionate about your care

Supportive of local services for local people

How we do it?

Style: How do we go about our business?

Working differently / giving things a new perspective;

Empowering front-line staff to take a shared responsibility together for the same population of patients to achieve shared (and better) outcomes;

Partnerships focussed on outcomes for people not on organisations;

Simple and straight forward/ plain talking

Response: What impression do we want to create?

I'm heard,

My views are represented to,

I'm healthier,

I'm in control

I'm cared for

Focus: Our basis for making decisions

The best results for people in Wolverhampton

Branding

Our brand identity is much more extensive than just a logo. Our identity is formed by what we do, how we exist in the minds of our stakeholders and the things that users of health and care services value.

The NHS mark has over a 90% spontaneous recognition rate amongst the public and has high levels of trust and credibility.

The challenge is to find a brand identity solution which addresses the challenges of communicating a change which requires partnership and mutuality from each partner organisation and one that is endorsed by the strength of the NHS brand.

The branding of the Wolverhampton ICA needs to ensure it is clear who the partner organisations are that are accountable and responsible for delivering the programme, whilst at the same time helping staff from the different organisations feel like they are working together as a single, unified team.

Therefore, we recommend that stakeholder and staff communications lead with the NHS lozenge top right and the City of Wolverhampton logo top left. The logo for Healthwatch can

sit bottom left and Compton Care can sit bottom right. By using the generic NHS lozenge, the communications materials are then applicable to any of the NHS organisations.

We will create a visual style for these communications to help stakeholders and staff feel that the partner organisations are working ‘as one’. This would be a ‘neutral’ visual style i.e. neither the NHS nor the council’s individual identities dominate. The visual style will include a graphic device and a strapline. The graphic device and strapline will be developed with the frontline staff representatives. The graphic device will not be positioned where organisation logos are usually expected i.e. at the top of the page. Placement is suggested as bottom left.

We need to ensure that acknowledgement and credit for the partnership relationship is evident in all communications. Broadly, this is the placement of a programme device with NHS lozenge and Local Authority Logo. We may also need to use an explanatory statement about the CCG, Providers, WCVS in a prominent place on high-end materials. The statement to be included should provide the reader with a greater level of understanding of who is involved in the partnership and their role in developing new care models.

11. Our Approach

We are committed to an empowering and collaborative approach.

An Empowering Approach

Empowerment is not just about the people and communities, it is also about organisational structures and processes being empowering.

When developing the integrated care alliance in Wolverhampton we will take an empowering approach to engagement.

Community Empowerment Dimensions



By ‘**confident**’, we mean, working in a way which increases peoples skills, knowledge and confidence – and instills a belief that they can make a difference.



By ‘**inclusive**’, we mean working in a way which recognises that discrimination exists, promotes equality of opportunity and good relations between groups and challenges inequality and exclusion.



By ‘**organised**’, we mean working in a way which brings people together around common issues and concerns in organisations and groups that are open, democratic and accountable.



By ‘**cooperative**’, we mean working a way which builds positive relationships across groups, identifies common messages, develops and maintains links to national bodies and promotes partnership working.



By ‘**influential**’, we mean working in a way which encourages and equips communities to take part and influence decisions, services and activities.

A Collaborative Approach

The development of the communications and engagement takes place in a wider context. Collaboration is essential across the partner organisations and can help us to maximise use of resources.

The Governance Group will take overall strategic responsibility for collaborative working between the different partner agencies, for reducing barriers and duplication.

12. Model/ engagement and communication principles

We will be true to the following principles in all our conversations.



Recognising our commitment to an empowering approach, we can make the following statements:

- Giving the right information, at the right time in the right way
- By listening to what you tell us and taking the time to hear what you are saying
- By making it easy for you to get in touch with us
- By making it easier for people to work better together
- By working with partners to give you the skills, knowledge and confidence you need to participate
- By being transparent in our decision making processes
- By recognising and valuing your contributions
- By learning to appreciate and make better use of what we already have in our communities
- By feeding back to you – even if it is a difficult conversation

13. Audience

To be successful in developing new models of care we must involve, inform & inspire a wide range of audiences (stakeholders) including,

- People who use services- Patients, Public & Carers
- Wolverhampton Health and Social Care Employees
- General Practitioners and their staff
- Community & Voluntary Sector Partners
- Members of Parliament
- NHS England and NHS Improvement
- Local Councillors
- Neighbouring Health Economies
- Providers (Statutory, independent & voluntary sector)
- Media & Trade Press
- Healthwatch Wolverhampton
- Health & Wellbeing Board
- Others (the list is not exhaustive)

Each audience will require its own communication channel and approach but to ensure consistency we must create protocols for consistent, timely and effective conversations with each of these groups.

The mapping and segmentation for the stakeholder analysis will help us to consider the:

Messages to communicate and the objectives of the messages

The **strategy** by which we wish to reach the target audience

Tactics for reaching them, to be selective in the approach

The **timescale** in which to work, and to hit trigger points

Resources that we have to reach the target audiences (either individually, or collectively if we choose to work in partnership with other organisations)

A map of these stakeholders can be found in [appendix 3](#) this prioritises and ranks the target audiences, and management of them falls into four areas: inform, consult, involve and partners.

Group 1 – high power, high interest - Partner. The relationship we have with these stakeholders and our ability to meet their communication needs is essential to the successful recognition of the ICA. The stakeholders in this grouping require individually tailored information and their involvement in the process is to be encouraged.

Group 2 – high power, low interest - Involve. Whilst not requiring in-depth information about developing the integrated care alliance at this stage, it will be useful to provide this group with specific information when requested and general information on a regular basis. Decisions will need to be made by the steering group as to how to manage these relationships and by who, as these groups could very soon gain interest and will have a high level of influence.

Group 3 – low power, high interest - Consult. It is important that we keep this grouping involved and aware of the project developments. Many of these stakeholders are routinely involved in a number of groups.

Group 4 – low power, low interest - Inform. Whilst not essential to the success of the programme, this group will be valuable in enabling access to a wide range of the public and

other stakeholders and good relationships with them will make the programme run smoother. Mass media will be the usual form of communication.

14. Narrative and key messages

Our narrative will be built upon a statement of intent which is being developed by partners. Some of the key messages are:

- Our model of care builds on a joined up network of GP practice led, community-based multi-disciplinary teams which enable staff from health, social care and the voluntary sector to work better together.
- We will work differently to make the changes required, to think about solutions and make them happen, regardless of the traditional organisational barriers that exist. We will focus on the person at the centre and their care needs.
- We will develop standardised clinically led, best practice pathways of care so that all services which need to be delivered in hospital and our Community are commissioned in a way which incentivises optimum outcomes for the patient, maximises efficiency and enables effective communication back with the GP.
- We will support people to remain at home wherever possible.
- We will enable the integrated delivery of 7-day community health and social care services through an accessible and fit for purpose estate.
- We will improve the care for the elderly through the re-design of services for people living with frailty and the integrated MDT model
- We will ensure patients; staff and other stakeholders are informed of, and able to contribute to, the new model, taking every opportunity to shape care that is person centred.
- We will be a person-centred – doing things ‘with you’ not ‘to you’, acting as advocates for patients, helping patients care for themselves.
- We value partnerships – we are committed to working together to achieve the best health outcomes for the people of Wolverhampton
- We are listening – we will actively seek out and value the views of Professionals, members, patients and the public, acting on their feedback to shape and improve services.

15. Channels

Given the span of organisations which come under the development of new ways of working and the development of a new model of care, it is important that we make best use of existing communication channels whilst building a new ICA brand and identity which has no organisational host.

See [appendix 4](#) for details on the channels available for each key audience.

16. Resources

The resources required to deliver this strategy will be met in part through the existing communications and engagement infrastructure in that we are utilising existing channels. However, a decision needs to be made by all partners of the steering group as to what financial resource support is given to ensure effective delivery of the communications and engagement strategy.

17. Risks

The programme will manage its own risk register with the Communications and Engagement work stream escalating appropriate risks to the Governance oversight group.

Risks in relation to this work stream and those that are directly linked to the delivery of this strategy are summarised below. Mitigation to these comes through the delivery of the strategy and its action plan.

- e) Inability to align partner organisations to the direction of travel
- f) Inability to articulate case for change to stakeholders resulting in opposition to plans
- g) Lack of public and patient voice in developing the model leading to judicial review and other challenges
- h) Reputational damage to partner organisations as a result of failure to deliver as an integrated care alliance.

The last point is particularly relevant given the direct political context within which the programme is operating. As far as reputation is concerned, Wolverhampton has quietly been getting on with developing innovative ways of working and organisations' have been individually recognised for this, therefore we need to ensure we continue in this vein.

A press and media protocol will be established to ensure that all media enquiries are handled in the same way, regardless of their point of entry into the organisation and at what level. It is essential that the protocol is followed to ensure that the partnership as a whole protected; responses thoroughly researched and approved, avoiding ad-hoc answers being given to the media.

18. Roles and responsibilities

The delivery of this strategy will fall to the Communications and Engagement Workstream, reporting to the Governance Group on progress.

Membership of the work stream is detailed below,

- The Royal Wolverhampton NHS Trust – Sally Evans, Head of Communications
- NHS Wolverhampton CCG – Helen Cook, Communications Manager
- Healthwatch Wolverhampton – Tracy Cresswell
- City of Wolverhampton – Paul Brown, Communications Manager
- The Black Country Partnership NHS Foundation Trust – Michelle Carr, Communications and Engagement Manager
- Compton Care – Rep to be identified

Sally Evans will represent the group at the Governance Group. Helen Cook will represent at the Clinical Pathways Group. All members have a responsibility to act as the communication channel back to respective organisations.

19. Implementation

An action plan outlining the specifics of how the engagement and communications strategy will be delivered is included in **appendix 5**.

Progress against these actions will be delivered through the communications and engagement work stream and overseen by the steering group.

20. Measurement and evaluation

Expected measures and indicators for the communications and engagement are included in more detail in the action plan..

However there are important outcomes that the programme is monitoring which work on this strategy areas will inform and support.

The ICA programme is ‘whole system’; this has important implications for evaluation

- This is not a discrete ‘intervention’ with a clear beginning, end or boundary: it’s a programme of system change
- Comprises multiple, interrelated actions within different parts of an open system
 - System characteristics: interdependence, feedback loops, emergence, etc.
- Likely to evolve over time and also to look different in different local places according to different local needs
 - Some activity is already well-established; some is in the planning
- Evaluation therefore needs to account for this variety and complexity:
 - Changes in systems and culture
 - Evolution over time
 - Non-linear model of causation
- Plus, evaluation should be both formative (support programme evolution and implementation) and summative (document effects, help others learn)

Methodology

As this is a whole system approach to new ways of working there is not a single indicator that can best track improvements in patient experience. It is also an emerging model, with areas of implementation at various phases of development. All of these factors mean that the evaluation methodology needs to both draw on existing metrics and create new ways of understanding the impact on individuals as a result of these new ways of working.

We are talking to the public about our plans and they are shaping what successful integrated care means for them.

We will draw on insight that we already have to form some baseline data, for example the GP survey has indicators for Access.

Expected measures and indicators for the programme

Measure(s)	Key Measures of Success	Possible Indicator(s)/evidence
Increased empowerment / ability to self-manage (patients)	Patients describe changes in their knowledge / ability to manage their condition(s) following introduction of MDT	Self reporting tools such as used by #HelloOurAimIs campaign

Improved social / care outcomes (patients)	Change in % of patients reporting that their desired outcomes were achieved	Self reporting tools such as used by #HelloOurAimIs campaign
Improved Access to Services	<p>People know where to go to get advice</p> <p>People can get an appointment to see a GP when they need to</p>	<p>GP access survey</p> <p>Patient experience reports drawing on F&F data etc.</p>
<p>Care and support are person-centred:</p> <p>personalised, coordinated, empowering</p>	<p>People feel supported to attain their own health & well-being goals: what matters to them</p> <p>People's experiences of:</p> <ul style="list-style-type: none"> • involvement in decisions, • control & independence, • wellbeing, • confidence to manage, • feeling supported <p>People's reported access to personalised care and support planning</p> <p>People's experience of care coordination – including discharge & transitions</p> <p>Access to records and personal budgets</p> <p>Care professionals' knowledge, confidence & skills in person centred approaches</p>	<p>Care plans</p> <p>Living review of people in MDT</p> <p>Self reporting tools such as used by #HelloOurAimIs campaign</p> <p>OD and shared learning process with front-line staff to empower them to engage together and with the ICA</p>
Services are created in partnership with citizens and communities	<p>Different groups of people reporting their experiences of being listened to, involved, supported, worked with in partnership</p> <p>Improvement in the number of less heard people/groups listened to and relevant actions taken</p> <p>Experts by experience/patient and lay leaders report that they are making real difference</p>	<p>Audit trail of engagement with relevant citizens, community groups, service users etc to review/redesign services, inc reported experience of engagement</p> <p>Lay involvement at all key levels inc</p>

21. Appendices

1. SWOT analysis
2. PESTEL analysis
3. Stakeholder map
4. Channels for key audiences
5. Detailed action plan

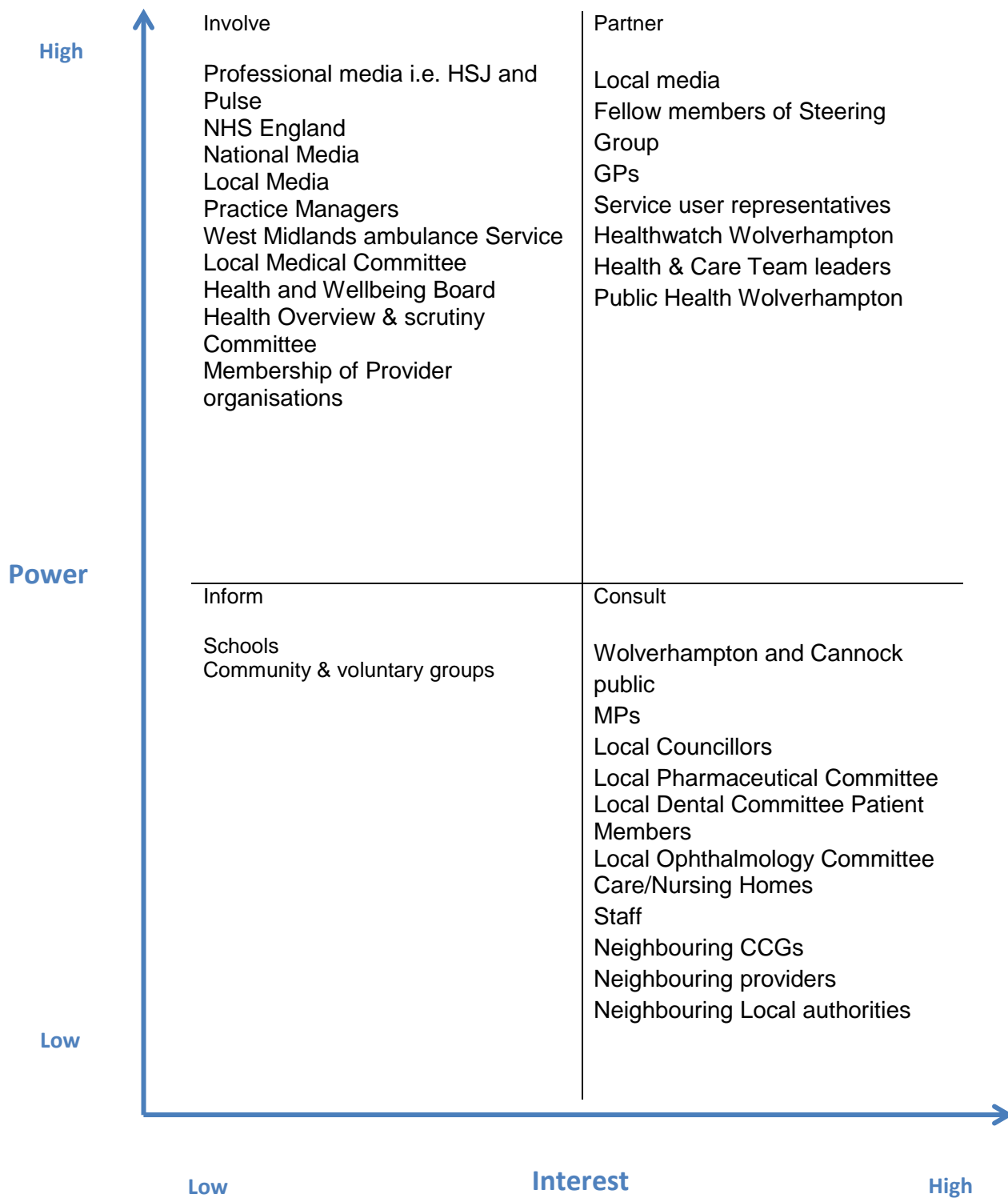
Appendix 1- SWOT analysis



Appendix 2- PESTEL analysis

Political	<ul style="list-style-type: none"> Nationally stable All parties are supportive of the Long Term Plan Potential for change in local government administration 	Technological	<ul style="list-style-type: none"> Many different IT systems Medopad
Economic	<ul style="list-style-type: none"> Reduction in real time budgets for health and social care 	Environmental	<ul style="list-style-type: none"> Ageing estate Pressure nationally to be carbon neutral etc...
Sociological	<ul style="list-style-type: none"> People's expectations are increasing People are becoming more independent People living longer, with more complex health issues Lifestyle health indicators – High prevalence obesity, smoking, teenage pregnancies 	Legal	<ul style="list-style-type: none"> Health and social care act The Long Term Plan Data protection act (data sharing agreements) Clinical Commissioning Groups have a legal obligation to involve patients

Appendix 3- Stakeholder map



Appendix 4- Channels for key audiences

Stakeholder Group	Risks / opportunities	Current and future comms and engagement plans
Service users, carers, families	<p><i>Risks of poor engagement</i></p> <ul style="list-style-type: none"> • Complaints / concerns • Media activity • Disengage from services <p><i>Opportunities</i></p> <ul style="list-style-type: none"> • Feedback and contribution • Be ambassadors for the programme • Help shape our services 	<p><i>Current channels</i></p> <ul style="list-style-type: none"> • Publications • National and local surveys • Trust Information - Patient screens / Patient leaflets • Patient experience • Community events / national awareness days • Websites • Twitter feeds • Facebook Pages • Media/press coverage • Publications • Mobile Apps • Tea and chat • Screens in GP practices
Children and Young People	<p><i>Risks of poor engagement</i></p> <ul style="list-style-type: none"> • Complaints / concerns • Disengage from services <p><i>Opportunities</i></p> <ul style="list-style-type: none"> • Feedback and contribution • Be ambassadors for the Trust • Help shape our service 	<p><i>Current channels - As above plus</i></p> <ul style="list-style-type: none"> • Healthwatch
Staff	<p><i>Risks of poor engagement</i></p> <ul style="list-style-type: none"> • Demotivation • Feeling undervalued • Critical of the programme objectives to others • Focus on the wrong things • Poor productivity • Absenteeism <p><i>Opportunities</i></p> <ul style="list-style-type: none"> • Ambassadors for the new ways of working • Develop new ways of working / innovators • Promote the work of the ICA to others • Promote Wolverhampton as a great place to work 	<p>Current channels</p> <ul style="list-style-type: none"> • Staff survey / Staff FFT • Board meetings • AGM • Website • Media coverage • Publications • Twitter • Mobile Apps • Team meetings and briefings • Intranet site <p>Specific to CWC</p> <ul style="list-style-type: none"> • ADD <p>Specific to WCCG</p> <ul style="list-style-type: none"> • ADD <p>Specific to BCPFT</p> <ul style="list-style-type: none"> • ADD <p>Specific to RWT</p> <ul style="list-style-type: none"> • Trust Brief

		<ul style="list-style-type: none"> Trust Talk Senior managers briefing (SMB) Trust management committee <p>Specific to Compton Care</p> <ul style="list-style-type: none"> ADD
GPs	<p><i>Risks of poor engagement</i></p> <ul style="list-style-type: none"> GPs take leave the system because they feel the programme will not support them with increasing workforce challenges Members feel like they don't have the opportunities to get involved <p><i>Opportunities</i></p> <ul style="list-style-type: none"> Attracting more GPs to work in Wolverhampton More co-ordinated and streamlined patient journey 	<p><i>Current channels</i></p> <ul style="list-style-type: none"> ADD
Press and media	<p><i>Risks of poor engagement</i></p> <ul style="list-style-type: none"> Negative media coverage Limited understanding of the integrated care alliance agenda Information sourced from inaccurate sources Story grows into wider issues <p><i>Opportunities</i></p> <ul style="list-style-type: none"> Tell our story Gather support for new model Highlighting case studies Recognition Raising our profile wider 	<p><i>Current channels</i></p> <ul style="list-style-type: none"> Media presence at public meetings Pro-active press releases Features/interviews/case studies Photocalls and event invites Reactive press statements Publications Twitter facebook
Local Council, MPs and councillors	<p><i>Risks of poor engagement</i></p> <ul style="list-style-type: none"> PMQ's (Prime Minister's questions) Often asked to comment by the media Can often cause delay to processes <p><i>Opportunities</i></p> <ul style="list-style-type: none"> Ability to publicly support the programme Political influence Frequent contact with constituents and the media 	<p><i>Current channels</i></p> <ul style="list-style-type: none"> Overview and scrutiny committee MP briefings with CEOs / Chairs Invitation to events Website Press / Media coverage

Appendix 5 – Detailed Action Plan

Strategic Stages	Objectives	Our pledge	Measures	Key deliverables/ outputs	Timescale	Progress
<p>1. Developing a collective understanding of the context, scope and boundaries of our new model of care; and of the motivations, assets, needs and constraints of our leaders, teams, local people and communities</p>	<ul style="list-style-type: none"> • Identify and analyse our current and future stakeholders • Understand what is important to local people, communities and teams • Manage and maintain stakeholder expectations • Have a shared understanding of how things will be different in the future 		<ul style="list-style-type: none"> • Level of challenge to plans • Level of challenge to decision making processes 	<ul style="list-style-type: none"> • Establish a database of key stakeholders that is clearly categorised and managed • Meet/engage with key stakeholder groups to understand what they want/need to know • Engage first on the key programme areas of access, continuity, coordination and communication before shaping a full engagement plan to include statutory consultation • Benchmark public opinion on key work areas along with trust and confidence in services • All partners to sign a common statement of intent 		

2. Supporting our leaders and teams to develop skills, knowledge & confidence to:						
<p>a) communicate effectively using common key messages and information</p>	<ul style="list-style-type: none"> • Raise the profile of the ICA and inform key audiences • Manage reputation • Share successes to inspire teams • Ensuring that information regarding ICA is readily available if needed • Ensure all staff understand their role in the ICA 	<p><i>Giving the right information at the right time</i></p> <p><i>Make it easy for you to get in touch with us</i></p> <p><i>Feedback to you even if it's difficult</i></p>	<ul style="list-style-type: none"> • Media coverage • Awareness of programme • 360 stakeholder survey • Staff opinion survey • 	<ul style="list-style-type: none"> • Develop visual brand • Create partnership board newsletter to cascade to stakeholders • Develop media handling protocol • Participate in national and local awareness events • Develop new partner website for new models • Collaboration platform to aid sharing in place 		
<p>b) listen to what people say and understand how to share what is heard</p>	<ul style="list-style-type: none"> • Patient voice is integral to plans of an ICA • Staff inspired to lead and encouraged to shape the future care model 	<p><i>Listen to what you tell us and take time to hear what you're saying</i></p> <p><i>Recognise and value your contributions</i></p>		<ul style="list-style-type: none"> • Listening events with staff and other key audiences • Listening into action events • Staff champions • Ensure public voice represented at Board 		
<p>c) carry out consultation appropriately and inclusively, and involve people and communities in influencing decision</p>	<ul style="list-style-type: none"> • Listen and share successes • Create appropriate engagement opportunities with real opportunity to 	<p><i>Be transparent in our decision making</i></p> <p><i>Recognise and value your</i></p>	<ul style="list-style-type: none"> • Audit trail of engagement with relevant citizens, community groups, service users etc 	<ul style="list-style-type: none"> • Ensure that work stream plans are informed by ongoing involvement • Seek advice on 		

<p>making though clear, transparent processes</p>	<p>influence for people, communities and staff</p>	<p><i>contributions</i></p>	<p>to review/redesign services, inc reported experience of engagement</p> <ul style="list-style-type: none"> Lay involvement at all key levels inc programme leadership, planning & steering groups, redesign/task & finish groups 	<p>legal duty to consult and feed into relevant statutory organisations</p> <ul style="list-style-type: none"> Ensure audit trail of engagement activity and research that has informed model development Establish a patient and public reference group for the ICA 		
<p>d) facilitate co-production of health and care</p>	<ul style="list-style-type: none"> Make real changes for person centred care Steps are taken to move towards more and more services being co designed and co-produced 	<p><i>Recognise and value your contributions</i></p> <p><i>Appreciate and make better use of what we already have in our communities</i></p>	<p>Care plans</p> <p>Living review of people in MDT</p> <p>Patients describe changes in their knowledge / ability to manage their condition(s) following introduction of MDT</p> <p>Self reporting tools such as used by #HelloOurAimIs campaign</p>	<ul style="list-style-type: none"> Raise awareness of publics views on how they want their care to be Encourage staff to come forward with ideas for changes to improve person centred care 		
<p>3. Monitor and evaluate the effectiveness and impact of our communications and involvement of people and communities in the</p>	<ul style="list-style-type: none"> Create an evaluation tool Ensure that patient voice and lived experiences form a key part of the 		<p>Staff survey</p>	<ul style="list-style-type: none"> Ensure that the logic model used to evaluate the programme includes lived experiences and 		

<p>five year journey.</p>	<p>overall programme evaluation</p> <ul style="list-style-type: none"> • Ensure that staff experiences are reflected in the new model 			<p>patient experience metrics</p> <ul style="list-style-type: none"> • Create an evaluation indicators for this strategy to monitor key performance such as media tags for coverage • Keep a log of all activities 		
<p>4. Draw out and share learning from evaluation and apply it to ongoing communication and involvement activities.</p>	<ul style="list-style-type: none"> • Organisations commitment to the communication principles and engagement pledges • working together to use the knowledge and insight they have to inform the programme direction 			<ul style="list-style-type: none"> • Regular workstream meetings to capture learning across the partnership and feed up to board • Close working with partners in Healthwatch to capture wider public views on changes 		

