The Royal Wolverhampton NHS Trust

Integration Director's Report
7 October 2019

Agenda Item No: 8.1

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS
NHS Trust

Trust Board	
Meeting Date:	7 October 2019
Title:	Integration Director's Report
Executive Summary:	This report provides the Trust Board with an update on the Wolverhampton place based Integrated Care developments.
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	
Alert	
Author + Contact Details:	Sultan Mahmud Director of Integration Tel 01902 695963 s.mahmud@nhs.net
Links to Trust Strategic Objectives	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	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs.

	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.
Equality and Diversity Impact	None identified
Risks: BAF/ TRR	
Risk: Appetite	
Public or Private:	Private
Other formal bodies involved:	
References	Next steps on the NHS Five Year Forward View 2018/19 Planning Guidance NHS Long Term Plan (published 7th January 2019)
NHS Constitution:	In determining this matter, the Trust Management Committee should have regard to the Core principles contained in the Constitution of: • 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**
1.1	**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.
1.2	**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 to 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
1.3	**Clinical Development Group Update** Strategic Planning in the End Of Life (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 ICA work on EOL includes piloting EPACCs; FREMS proposal/Ethical Framework and a Breathlessness business case for clinics in the community. The ICA work on Frailty is progressing faster than other parts of the region specifically – Recognising End of Life and Escalating Deterioration (FREED), the STP are keen to roll it out STP wide as an exemplar of good practice. In addition

	adverts are going out for 6 Healthy Aging Co-ordinators which will employ 1 FTE in each PCN working to support links into community assets and additional support on discharge from hospital for identified patients from the Frailty Unit. There is a growing number of workforce issues, particularly regarding 'new' workforce coming into PCN's and the fact that there needs to be a strategic approach to ensure individual organisations are not de-stabilised by staff moving aroundthe system and the question of a lead employer, ongoing professional development, supervision and accountability of these staff. To address these issues a Workforce Summit was held on the afternoon of 18th September to address both local and regional issues/concerns. The RWT workforce Director is to lead this programme of work as the STP workforce lead. The Community EOL Proposal has been approved by the Clinical Pathways Group to proceed to full business case and work is ongoing to ensure input from the finance and commissioning sub group and full engagement of the EOL Sub Group
1.4	**<u>Governance Group Update</u>** A proposal to bring together and merge the 5 work streams of the Wolverhampton Better Care Fund Programme into the development of the Wolverhampton ICA to ensure just one manageable programme of work. This aims to avoid duplication and make best use of the resources available. Approval has been received from both the ICA Alliance and the BCF Programme Board and this is now moving to implementation phase. 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 work-streams that may impact on the local ICA development which will need to be considered.
1.5	**<u>The Contracting and Commissioning Sub Group</u>** The core purpose/ responsibilities of the ICA Contracting sub-group are as follows: • Develop a standardised approach to assessing the financial and contractual impact of proposed service changes • Support clinical work streams in developing costed pathways • Ensure resources are redirected to follow service delivery and patient outcomes • Develop and implement an overarching agreement to support the changes • Horizon scan the contracting landscape to identify best practice and national policy developments. • Share learning from other health and care economy/ community areas who have introduced similar agreements, to help inform the best option The group has recently established links with the national New Models of Care team and is also part of the Integrated Care Payment Forum, which is a peer

	network for integrated care sites that are designing, testing and implementing new payments models. The next phase of work includes defining some rules of engagement for business cases for the ICA and considering objectives, assumptions and desired outcomes for the next contracting round. A paper is to be tabled at the October Governance Group.
1.6	**<u>The Outcomes Framework Sub Group</u>** The ICA Outcomes sub-group has been tasked with developing an Outcomes Framework for the emerging Wolverhampton ICA. The framework will include both outcomes for the identified clinical pathways and for the ICA itself. Some work has already been undertaken from the clinical pathways groups (End of Life, Frailty, Mental Health , Children and Young People) who have tried to identify some key outcomes that they are trying to achieve. In addition to this a number of models from areas outside of Wolverhampton have been considered and Wolverhampton CCG has begun to identify a set of outcomes and measures based on the Canterbury model. This has been shared with partners as a “starter for ten” to promote discussion. The Midlands and Central Lancashire CSU Strategy Unit has been commissioned to lead two workshops and the outputs are currently being collated into a recommended outcomes framework using the NHSE Logic Model under 3 domains which were agreed at the first workshop as being Population Health; Experience of Care and System Infrastructure. Both workshops were well attended by a wide range of stakeholders from across the system partners. Outcomes will be presented to the October Governance Group. .
2.0	**<u>Bringing the Transformation of Community Nursing into the Integrated Care Alliance</u>**
2.1	**<u>Summary</u>** 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	**<u>The Situation in Wolverhampton</u>**

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.

2.3 **<u>Update on Transformation of Community Services Programme</u>**

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.

Division 3 senior management presented a further progress report to the ICA Governance Group Tuesday 17th September and positive discussions with stakeholders took place.

It included the project implementation plan and key milestones;. The schedule includes details of steps taken to meet with PCN Clinical Directors in order to co-produce the wrap around services. Division 3 is developing an 'offer pack' for each PCN that will be targeted at their patient population.

The update recognised that 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. A full paper on the model is being presented under separate cover to this TMC.

3 **<u>Data and Information Sharing across the Wolverhampton Place</u>**

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. Good 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 is now in place and accelerating progress.

Work has also commenced with voluntary GP Groupings across the city to receive and share data based on the ground breaking 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

Excellent progress is being made towards gaining integration of data across the health economy and in building clinical data systems to drive better patient care. The live integrated data system across the Wolverhampton place is amongst the most sophisticated and clinically dynamic in England.

It was agreed that a specific agenda item be tabled at the October Governance Group so that the co-chairs can present detailed progress to date and raise any ongoing issues that require further support or escalation.

3.1 **<u>The Structured Clinical Data Set (SCDU)</u>**

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 iscomplete 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.

3.2 **<u>Clinico-Informatics Group</u>**

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 clinico informatics group convened by Prof Dev Singh is central to evidence based service redesign internally and across the Wolverhampton place.

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

The meeting held in September focussed on delivery and roll out of the programmes noted above as well as progess and position with the ICA programme of work in support of the system data architecture. The next meeting of this group is set for 19th December 2019

4

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.

This month the team has been working to embed prevention into everyday care, by supporting the contracts team to introduce systematic identification and brief advice for smoking and alcohol with in-patients. The aim is to make it as easy as possible for clinicians to deliver evidence based interventions, by providing patient-held brief advice cards, Ask-Advise-Assist training, and prescribing resources for Nicotine Replacement. This work will contribute to a broader programme of work towards a Smoke Free Trust, which will be launched in October with a series of events and communications linked to the national Stoptober campaign.

In support of work to develop collaborative care across community services and general practice, the team have produced PCN (Primary Care Network) profiles that give an overview of each PCN's population demographics, levels of need in relation to Long Term Conditions and frailty, current levels of community services provision, and geographical spread. These will facilitate conversations about co-location, communication and opportunities to address unmet need by working collaboratively.

5

ICA Communications and Engagement Plan

The RWT Head of Communications is co-ordinating the inputs to the delivery plan and has aligned communications leads from all partner organisations to each ICA sub group who are now working on their specified areas of delivery.

6	**<u>Overall Integration Programme Risks</u>** 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	**<u>Conclusion</u>** The Trust Board is asked to note the contents of this paper.