Health Scrutiny Panel Report - 15 November 2018	
1	**Integrated Care System Update** **Background** 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 future. The 14 Integrated Care Systems (ICS) already operating in this way will prepare a single system operating plan and take responsibility for a system control in 2018/19. In terms of the policy context there is now work being undertaken by NHS Commissioners, NHS Providers, NHSE and NHSI on further blurring of the purchaser provider split. The Trust is an active participant in the discussions. In addition to this and Integrated Care Provider (ICP), formerly known as ACO's, contract paper has been released by NHSE in August 2018 for wider consultation. The Trust has formally responded to this document which had a consultation deadline of the end of October 2019.
2	**The Current State of Play** The Trust and CCG are spending considerable time developing local system relationships and plans with Wolverhampton CCG and there are now two forums that will design the new healthcare system, • Wolverhampton Integrated Care Alliance (ICA) Clinical Development group • Wolverhampton Integrated Care Alliance (ICA) Governance Group
2.1	**The evolving ICA Strategy has several organising principles** • An agreed, collaborative shift in patient care to ensuring that those patients who can be cared for in a non-hospital setting where appropriate • 'Bend' the demand curve for acute activity ensuring more pro-active primary and community focus with the accompanying financial resources to support this • Institute positive, aligned and collaborative working relationships with and between all Providers (Primary, Acute, Community, MH and LA) in the Wolverhampton health economy • Ensure the alignment of all GP Practices into collaborative groupings, (recognising that there is a mixed model in Wolverhampton of PCH, Medical Chambers and VI)

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- Ensure that Multi-Disciplinary teams are grouped around clusters of GP practices to ensure the delivery of pro-active community care
- Discard the perversely incentivised Acute PbR contract
- Agree a collaborative new contract solution with the Acute/Community provider and a virtual contract/compact between stakeholders with improved allocative efficiency to respond to changing health challenges, while ensuring that the Acute provider remains financially viable
- Ensure that the LA are part of the solution
- Craft the right solution as emerging thinking and regulatory directions of travel emerge (rather than adopting an 'a priori' hard dogmatic approach)
- Appropriate public consultation and engagement

3.0 **Recent Key Developments**

3.1 **Clinical Co Design of Pathways**

All clinical pathway groups report to the ICA Clinical Development Board co-chaired by Dr Salma Reehana (CCG Chairperson) and Dr Jonathan Odum (RWT Medical Director). The intent behind this is for co-creation based on patient needs as opposed to organisational drivers.

The initial set of clinical pathways for patient cohorts has been determined and Task and Finish groups have commenced work these include

Pathway	RWT Clinical Lead	CCG Clinical Lead
Frailty	Dr Elizabeth King	Dr Gill Pickavance
Urgent Care	Dr Jonathan Odum	Dr Helen Hibbs
End of Life	Professor Ann Marie Cannaby	Dr Manny Samra
Children and Young People	Dr Annabel Copeman	TBC
Mental Health	Currently being scoped by WCCG commissioner Sarah Fellows	

3.2 The Trust has also secured £125,000 of analytical and consultancy support for the ICA developmental work streams from the Midlands and Lancashire CSU Strategy Unit. The Wolverhampton System and the Strategy Unit have entered into a 3-year partnership to underpin innovation programmes in Wolverhampton with the expertise of the Strategy Unit (and its selected specialist partners as applicable) to the benefit of both parties (CCG and RWT) and also the wider NHS.

The work programme of the partnership is to be agreed through an on-going dialogue between the partnership members. An update meeting will take place each quarter to set the partnership priorities, review the work programme and confirm the financial resources available to the partnership each year. The three most developed integrated care work streams of End of Life, Frailty and Children and Young People are included in Year 1 activity and independent descriptive analysis and benchmarking of size of the opportunity are being developed by the CSU strategy unit.

3.3 **Informatics**

It is the intention to institute a citywide IG/Informatics Sub Group with the key aim of ensuring any blocks to progress are identified and addressed for IG or Informatics/data support to the work streams. The CCG have drafted ToRs and principles for this group which are with key executives in RWT for consultation prior to producing a response. The group will be co-chaired by the Trust's Clinical Director for IT Professor Dev Singh and Mike Hastings the CCG Director of Operations.

3.4 **Finance & Contracting**

A new model is being finalised developed to move from the current PbR method of contracting to a mixed model of contracting and is locally described as the Aligned Incentive Contract (AIC). This is made up of a number of broadly components:

Component 1 Fixed Cost (block) NE activity		Component 2 Risk Gain Share Elective activity
Component 3 Cost & Volume		Component 4 Medicines

The following principles support the development of proposed approach:

- Financial risk will be shared across the parties recognising the financial challenges present across the health economies.
- A commitment to develop a clinically sustainable model with a focus on moving care closer to home supported by the transfer of funding to community/primary care services where agreed, although it is recognised that any funding re-alignment will not apply in year unless jointly agreed .
- A commitment to develop a long term financially affordable model that seeks to maximise the value for money of the costs of healthcare delivery to the system as a whole.
- To harness clinical engagement at the heart of the programme to ensure that future service provision is clinically driven and supported.
- To be open and transparent in all we do and recognise the impact of our decisions on each other.

Contract Management

The agreement of the AIC represents a move away from a cost and volume, tariff-based contract. Consequently, it represents a change to the established routine of financial and contract management systems and processes. This departure offers new and exciting opportunities; however, it is not devoid of risk.

The AIC has been designed on the basis of existing and forecast patterns of service delivery and patient flows, any emergent issues which develop in-year can be flagged by either partner and a joint review will be conducted to determine the nature, scale and impact of the issue together with an agreed resolution on the response.

In order that risk can be managed effectively, PbR (NHS Tariff based system) will continue to run in shadow form to support the AIC model and there will be a quarterly reconciliation between PbR and AIC. This will include a monthly oversight meeting to monitor the performance of the AIC in order to identify any significant deviations from plan and the timely development of control mechanisms. Both parties are committed to securing broad agreement by the end of September 2019 for enactment from 01 April 2020.

3.5 **Risks**

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

- NHS service redesign in the pathway areas described in this report have had limited success in the English NHS with Non-Elective activity continuing to grow inexorably on a national basis. Whilst Wolverhampton has bucked some of this trend thanks to good commissioning and provision, much more focus on care outside of the hospital in the community and primary care is needed.

- Evidence based approaches that have worked in Canterbury (NZ), Alzira in Spain and parts of the US have relied heavily on clinical informatics, strong evidence base and a fundamental departure from standard approaches in managing patients with long term conditions.

- It is accepted that chronically sick patients are overall not receiving adequate long-term proactive care. Conventional primary care is designed to handle acute conditions, so emphasizes brief clinical encounters to diagnose signs and symptoms, to arrange for triage, ensuring patient flow, and offering only brief patient education followed by patient-initiated follow-up care. The current model of primary care needs to be strengthened to cope with long-term, incurable conditions and city of Wolverhampton must and expedite the transformation of primary care, community and acute hospital medicine to work as a cohesive unit across Wolverhampton.

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