BHRPartnership
Better care, better lives, together

APPENDIX B

ACS development event Summary output

Barking and Dagenham, Havering and Redbridge

10am - 12am on 31st July 2017
Maritime House, Barking

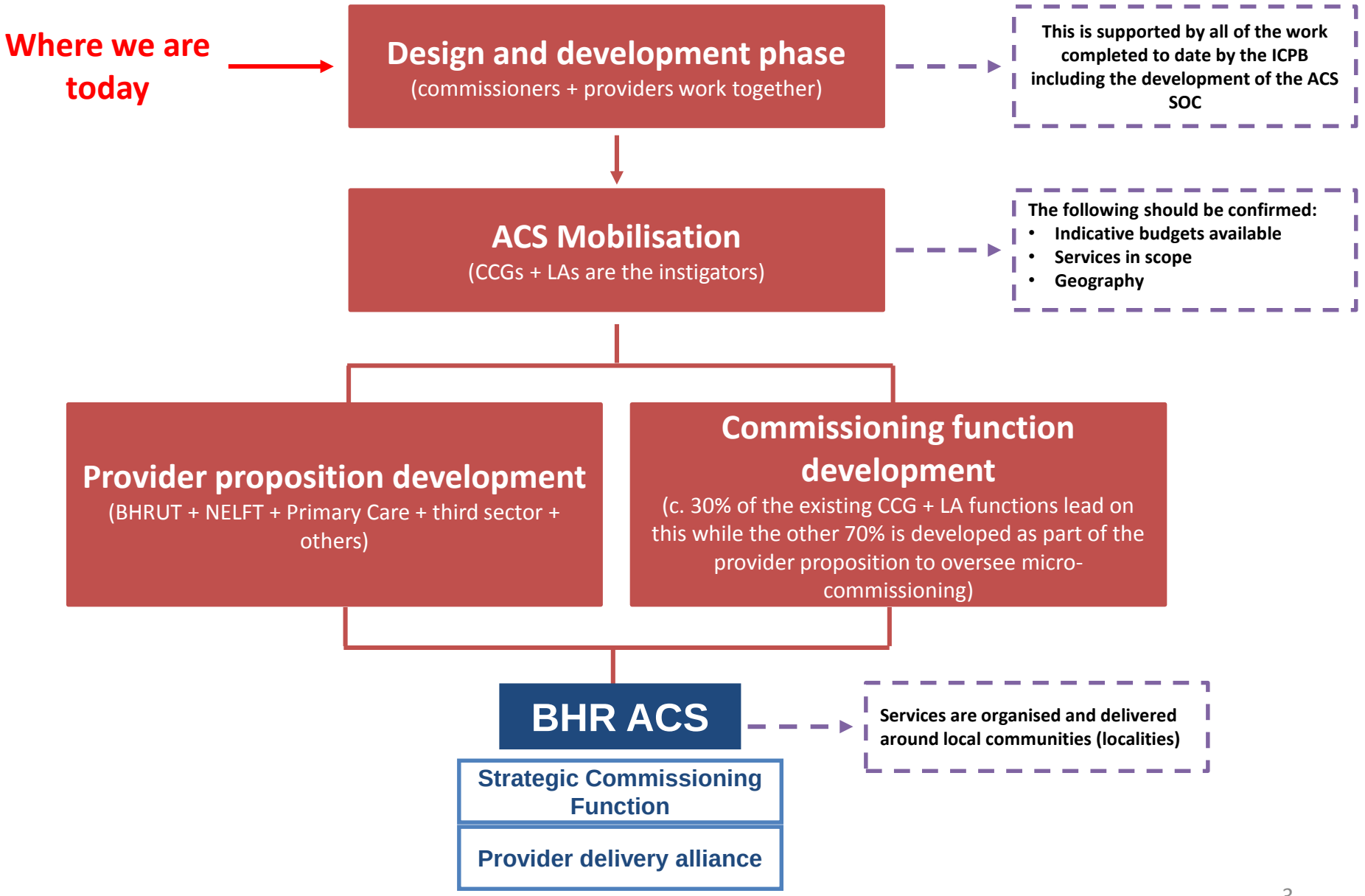





Attendees

- Andrew Blake-Herbert, LBH
- Anne Bristow, LBBD
- Christopher Bown, BHRUT
- Cllr Wendy Brice, Thompson - LBH
- Conor Burke, BHR CCGs
- Dr Adedeji on behalf of Dr Arun Sharma, B&D Federation Chair
- Dr Anil Mehta, Redbridge CCG
- Dr Dan Weaver, Havering Federation chair
- Dr Nikal Rao, Havering Network chair
- Dr Shabnam Quraishi
- Dr Siva Ramakrishnan, Redbridge Federation Chair
- Emily Plane, BHR CCGs
- Eric Sorensen, deputy chair - BHRUT
- Jacqui Van Rossum, NELFT
- James Langford, PwC
- Jane Gateley, BHR CCGs
- Joe Fielder, NELFT
- John Brouder, NELFT
- Kash Pandya
- Keith Cheesman, LBH
- Mark Tyson, LBBD
- Maureen Worby **(Chair),** LBBD
- Richard Coleman, BHR CCGs
- Sarah See, BHR CCGs
- Steve Collins, BHRUT
- Vicky Hobart, LBR Director of Public Health
- Vincent Perry (for Dr Caroline Allum), NELFT
- Mike Farrar, PwC
- Rowan Taylor, BHR CCGs
- Cllr Mark Santos

The ACS development journey



ACS development event - summary

The objective of this session was to make a decision about how to proceed with the BHR ACS and – if possible – to identify concrete next steps

- During the discussion around each of the presentations it became clear that partners in BHR would need four things to proceed with the ACS:
  - An investment fund (having a clear plan would help the system to make the case for access to transformation funding)
  - Alignment of the contract incentives for clinicians in the system
  - Longer term commissioned contracts to incentivise provider investment in services
  - Regulatory flexibility during the transition to give providers the space they need to develop (it was noted that this was likely to relate more to NHS I regulation as opposed to CQC standards)

- It was recognised that the role and scope of social care was wider than perhaps other partners traditionally associated – need to ensure this is understood across the BHR landscape

- It was recognised that the three boroughs / CCGs / Primary Care had clearly defined geographical boundaries whereas both NHS Trusts had significant interests outside of the BHR region

ACS development – what is already in place

ACS Strategic Outline Case

- This is the local case for change and includes a lot of detail about the current population / health challenges / other challenges which the ACS will need to address

Localities

- Localities in each borough have been identified. GPs have now organised and brought together their networks around each locality. Some NELFT services are already organised on this basis (in Redbridge)

The willingness to move towards a new model of care

- All three presentations showed a clear appetite for working together as a system to move towards the development of a new model of care

The vision for Accountable Care

- All three presentations contained a consistent vision about what the new model of care would look like with services being delivered on a locality basis. Work to integrate services around a locality has already begun but needs to be rapidly extended and accelerated. A formal written vision which corresponds to these ambitions is set out in the ACS SOC

Some aspects of the vision need more work

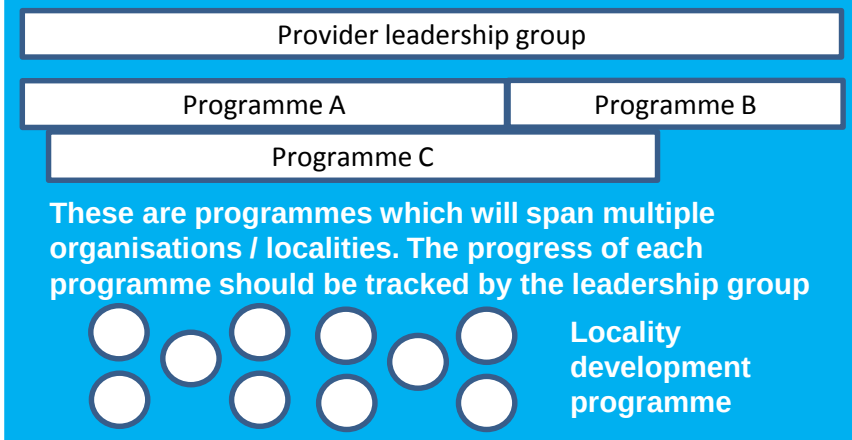
- More granular understanding of implications of current amitions
- Certain “mindset issues” need addressing e.g. role of competition
- Approach to risk transfer needs further development

ACS development – next steps

Providers

- The providers agreed to explore forming a sub-group to look at the options for formal collaboration in response to the commissioners intent to begin to offer shadow place based budgets
- As part of this, providers will need to agree the future ways of working / structure / governance around the provider collaboration

Suggested structure:



These are programmes which will span multiple organisations / localities. The progress of each programme should be tracked by the leadership group

Locality development programme

- Providers recognise that they will have to work together at multiple levels (as a single leadership group and at a locality level) to deliver the change programmes required to build out an ACS
- Other specific requirements included:
  - A joint programme of work between primary and social care to better understand each other's roles and contributions
  - Specific activities to bring all local GPs up to speed
  - Baseline of current spending at service level

Commissioners

- A sub-group of the JCB will now look at the budgets available for the ACS with a view to putting an initial shadow budget in place by April 2018

As part of this work to develop the ACS shadow budget, commissioners will need to consider:

- **What's in – services and associated contracts**
- **What geography – areas / localities covered and phasing**
- **What risk – how will risk be shared with the providers**
- **Outcomes and contracting – what type of model do commissioners want to move towards?**

- Continued development of plans to set up a BHR strategic commissioning function with pooled budgets (as per 17/18 to do list in commissioning slides – Appendix B)

Across both providers and commissioners, there was agreement to establish a system wide programme leadership function that bridges commissioner/provider governance arrangements and to ensure the delivery of the ACS is aligned

Appendix 1: Primary care slides

The role of General Practice in the BHR Accountable Care System

Dr Dan Weaver and Dr Shabnam Quraishi

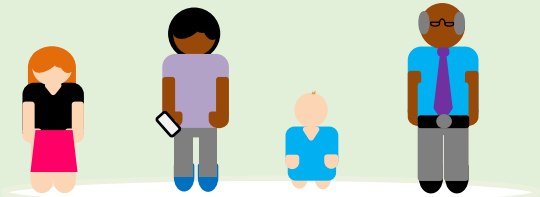
July 2017

The local GP Network/Federation Partnership is mature enough to take a lead role in Population Health Management

BHR has Established Networks & Federations; Symbiotic single voice

Together delivering:

- ✓ Cradle to Grave
- ✓ Pan-specialty
- ✓ Gate-keeping and signposting
- ✓ 90% of contacts



Meeting our challenges to impact on outcomes

→ Less secondary/Social Care Burden/Disability

Challenges	Achievements
Variability / Quality	**Quality Improvement** ▪ Reduce Variability ▪ Consistent Approach & Message ▪ Nursing Home scheme ▪ AF/Diabetes
Workforce and Workload	**Workforce Solutions** ▪ Clinical Pharmacists ▪ New 2 Nursing ▪ International recruitment ▪ Access Hubs / UCC ▪ Workflow
Premises and Regulatory Standards	**CQC Practice readiness support**
Training	**CEPN / PTI** **Up-skilling existing workforce**

The Networks / Federations have a clear vision

Consistent Message

Network / ACS wide:

- Advice & Signposting
- Addressing Expectations
- Joined up - IT/DATA SHARING

Variability

Network Led 'Searches' & Templates; EG:

- Atrial fibrillation – Stroke prevention
- Diabetes – vascular disease prevention
- Reduce complications/outcomes → **Less Secondary/Social Care burden**

Right Person – Right Place – Right Time

- More Self Care
- Less variability in Primary Care
- → Less Secondary/Social Care burden

Seamless handover and information sharing

- Avoid Duplication/Pathway Delay
- Less Secondary/Social Care burden

Pan ACS pathways

Locally developed & agreed **pan ACS Pathways** – Enabling **Quality** Primary Care:

- Management Steps
- Investigations
- When to REFER
- Templates under development by Networks
  - EG Cardiology Video Conferencing;
  - **AF**, PSA, Osteoporosis, Menstrual Bleeding disorder
- Primary Care Training and Accessible Guidance from BHRUT/NELFT

Access and efficiency

- With investigation results → 1 Stop
- Conversion to surgery ratio for surgical out patients

Handover back to primary care

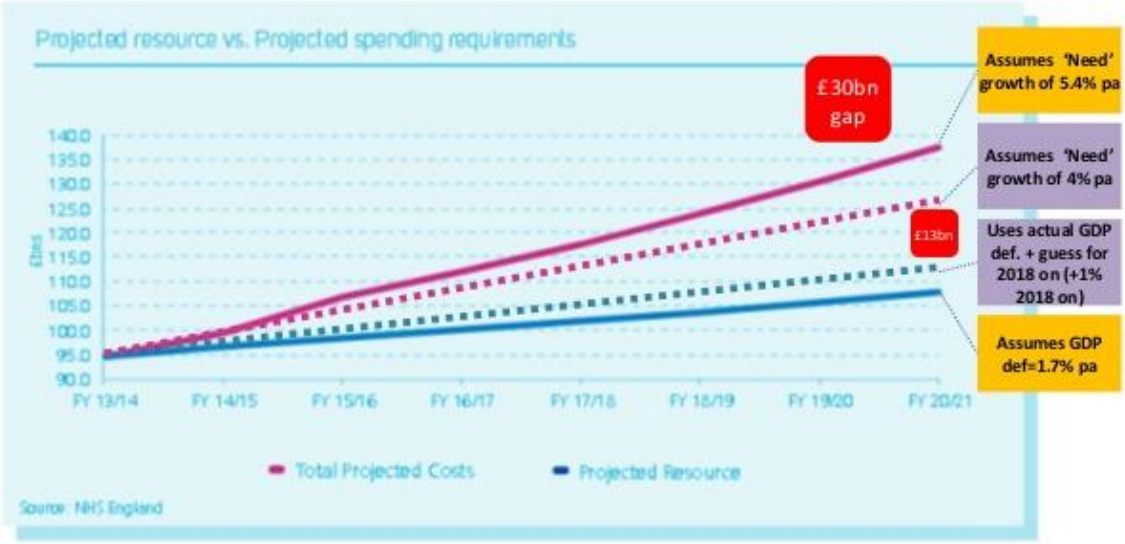
Reciprocal, appropriate **handover back to primary care** on discharge from out patient or inpatient care:

- Minimising re-referral/re-admission
- **→ Less Secondary/Social Care burden**

SPEND EVERY £ BETTER

General Practice needs to take a leading role in our Accountable Care System

NHS England: *Call to Action*: £30bn gap by 2020/1 (could be smaller…. But still a gap)



"The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best." *Call to Action*

- 30% productivity demand
- Inclusive ACS
- Meeting the needs and challenges of all stakeholders
- Acknowledge stakeholders strengths & fixed costs
- Fair funding for work done
- Population Health Management is what General Practice does best
- General Practice leadership → vision which grass root GPs can buy in to:
- Population Health management depends on primary care performance & engagement:
- Fundamental foundation blocks of adding value in an ACS
- Solution = ↑ spending @ front of Care Pathway → ↓ secondary/Social care burden

What we need; next steps

Agreement and engagement to start work on developing the transformation - building a new model of care based around our geographical networks / localities

Agreement to explore how we upscale Primary Care resources as a proportion of the local care budget

- *deliver better care at the beginning of the patient pathway*
- *Apply initiatives across all networks*
- *→ Less Secondary/Social Care burden*

Management support including resource sharing with other community providers as appropriate

Sharing of data

Appendix 2: Commissioning slides

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Towards Joint Commissioning

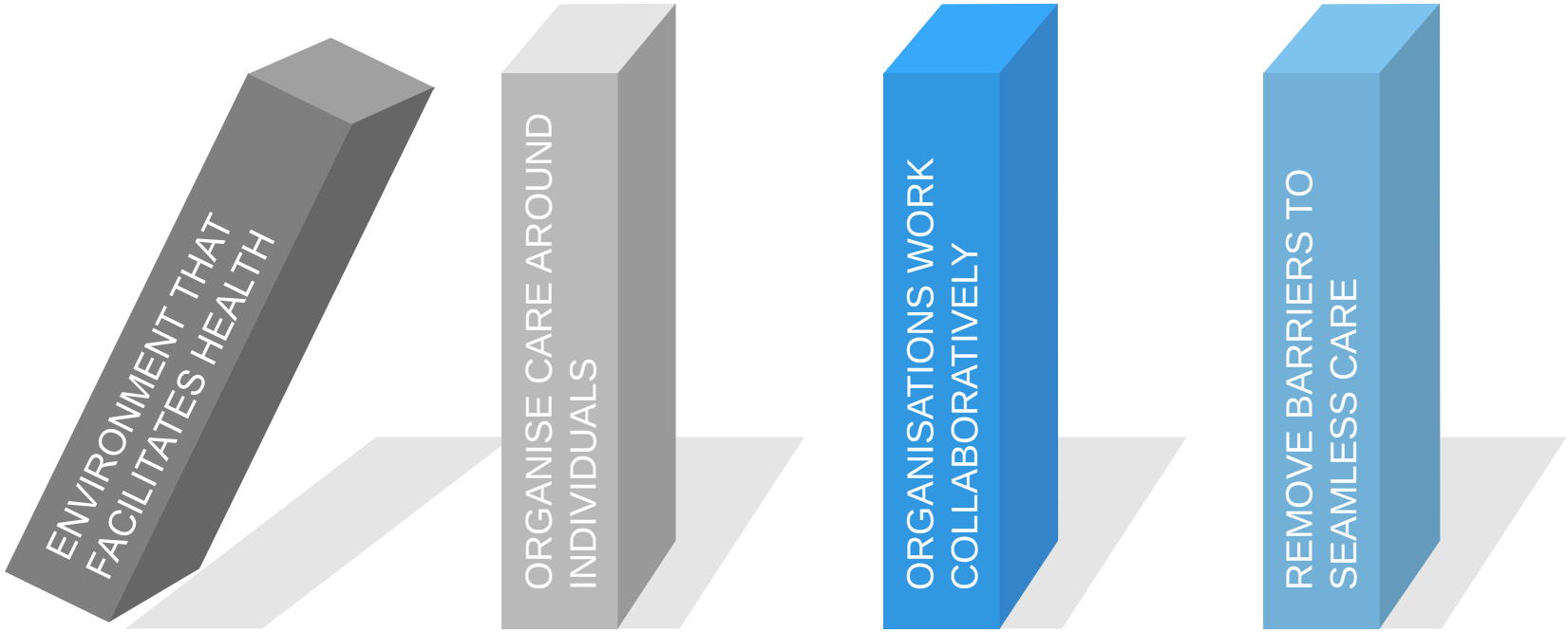
31 July 2017






Our ambition, restated…

Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services



enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing

involving and empowering, integrating across agencies, single point of access, and providing locally where possible. It will meet best practice quality standards and provide value for money

sharing data where appropriate, and maximise effective use of scarce/specialist resources (e.g. economies of scale).

bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.

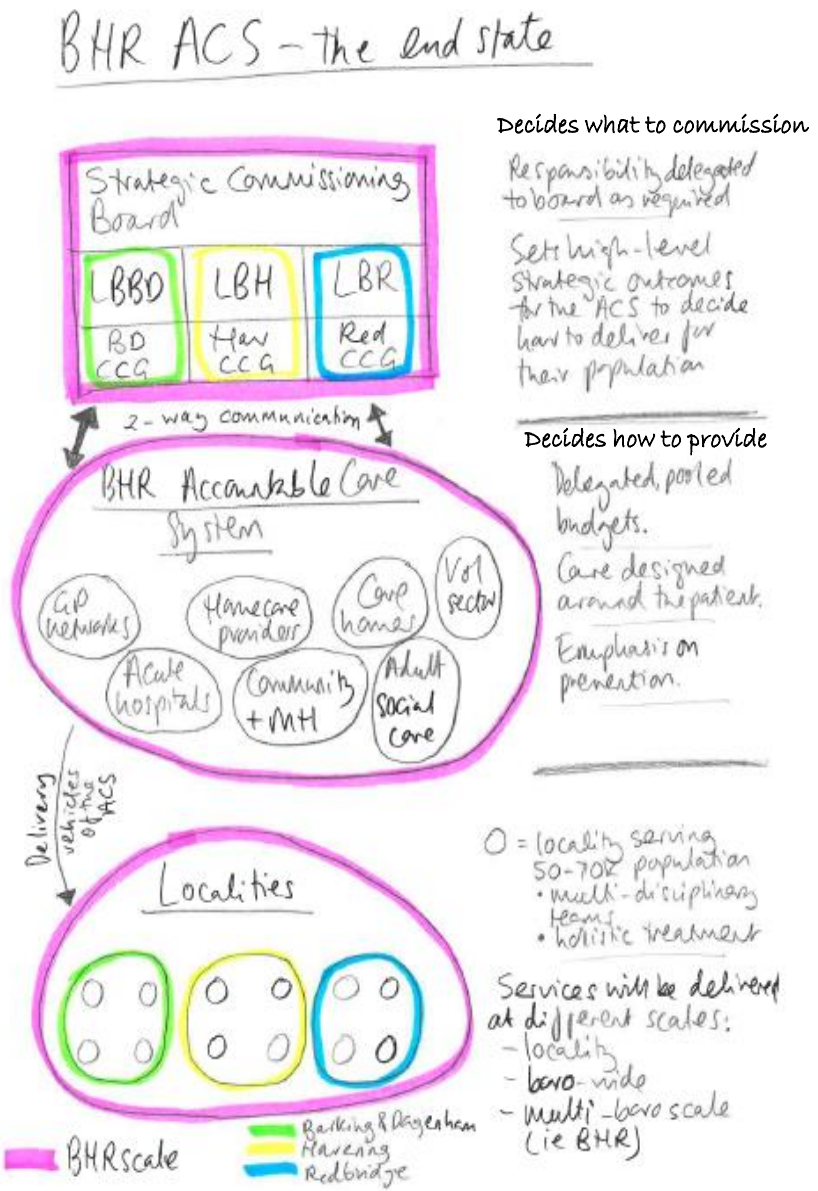
Structures – the 'end state'

The opposite diagram illustrates the current proposition for what the BHR ACS 'end state' will look like.

Strategic commissioning and providing are shown as separate, with a strong two-way connection between them, but we expect providers to potentially have a greater role in commissioning within an ACS/capitated budget system.

Localities are units of integrated provision but could also carry out a more local commissioning function as well (eg local community asset-based approaches).

ICPB members are asked to build upon this at their workshop on 31 July so that all partners have a shared understanding and single clear vision of the end state that we are all working towards.



The three major drivers for joint commissioning

1: ACCOUNTABILITY

Cementing moves over the recent 18 months to bring both democratic and clinical leadership to health and social care planning.

3: SYSTEM LEADERSHIP

To make an Accountable Care System work effectively, commissioners must act in harmony and provide, as far as possible, a single voice to ACS partners. Most of all, conflicts of direction must be avoided if the ACS is to deliver for residents.

2: FINANCE

It is not expected that savings in joint commissioning alone are significant: care markets in particular are already under significant pressure.

Joint Commissioning of an ACS model must drive out the inherent financial perverse incentives of separate organisational interests

Complexities of Accountable Care

1. System management

Resolving competing contracting drivers, internal tensions, and demands on the system from different stakeholders.

2. Procurement and contracts

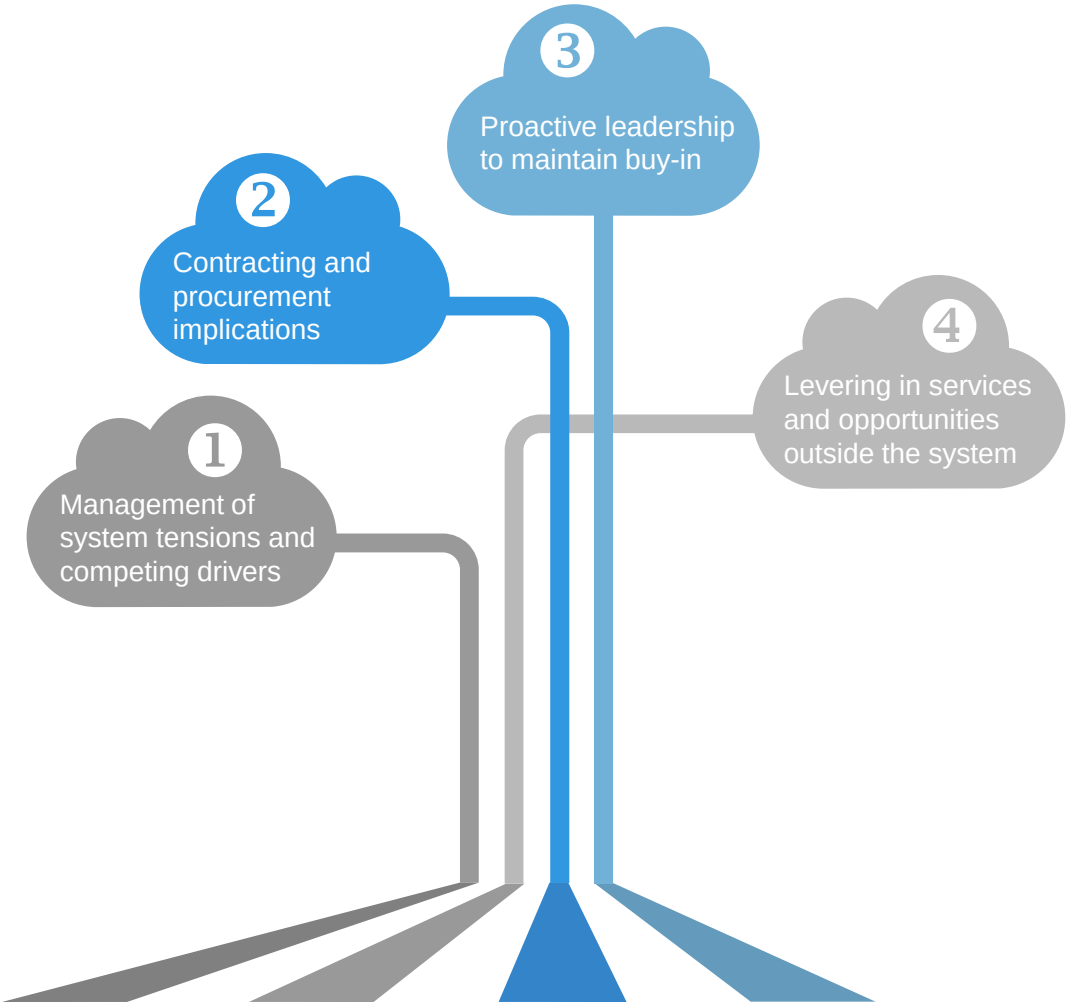
Determining and delivering the most appropriate path to structural form

3. Leadership and buy-in

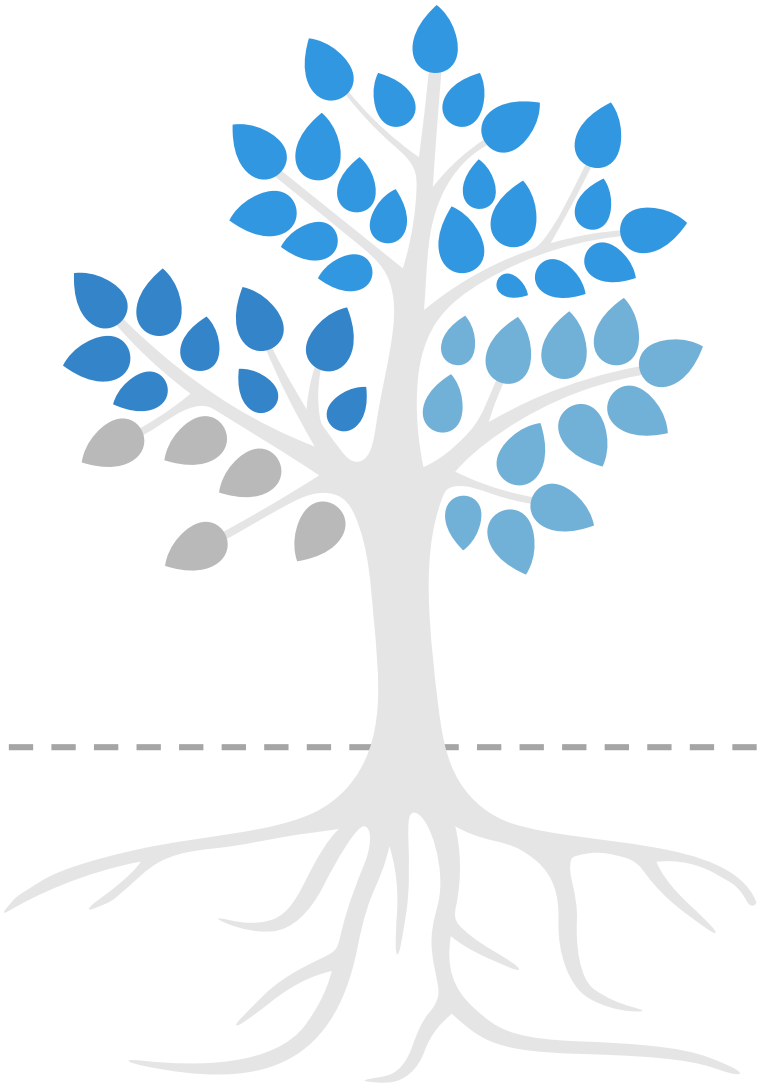
Ensuring senior leaders have mechanisms for debating issues that arise, addressing wider stakeholder concerns, and ensuring that the ACS meets wide-ranging need.

4. Levering in opportunities

Ensuring that the wider determinants of health are addressed through strategic relationships with services and policy areas outside of the ACS (e.g. housing, welfare)



Current and planned joint commissioning



Prevention
Re-commissioning of community services to support a new intermediate care tier
Better Care Fund
Learning disabilities (incl. TCP)
Mental health
Equipment

Current/future opportunities

Positive developments

Sexual health services
Joint Assessment & Discharge Service
Riverside Mental Health
Equipment

A transitional development…

First Steps

Shared initial products for BHR: JSNA, Market Position Statement, specific strategies.

Initial scope of support structure.

Joint Commissioning Board.take real, practical first steps on joining up, e.g. Intermediate Care

Legal scoping for ACS procurement issues. First draft ACS outcomes set.

Focused joint work; building trust

Decisions on specific risk share commissioning programmes, delegated authorities and budgets.

Decisions on an integrated support structure, by secondment or shared staff teams.

ACS Outcomes, contracting mechanisms and finance flows in draft form.

Integrated operations across the system

Full delegated control over whole outcomes-based budgets for health and social care.

Integrated commissioning operations, governed by agreements with contributing partners.

Supports fully functioning Accountable Care System now operating to Outcomes Framework.