Integrated Care Coalition

Better care, better lives, together

Barking and Dagenham, Havering and Redbridge

An Accountable Care Partnership Building on Integration and successful collaborative working

Barking and Dagenham CCG | Havering CCG | Redbridge CCG | Barking, Havering and Redbridge University Hospitals NHS Trust | NELFT | London Borough of Barking and Dagenham | London Borough of Havering | London Borough of Redbridge | Together First | Havering Health | Healthbridge Direct

Vision

“To accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and contribute towards sustainable provision of health and social care services”

Challenges

Area		Challenges
Health and wellbeing challenges	Population	▪ Life expectancy is variable across the patch and very low in some places ▪ Fast growing population projected to increase in by over 110,000 in the next 10 years (a 15% increase by 2025) and within this there are significant forecasts in both 0-19 and over 75 year olds – above the London average ▪ Behavioural risk factors: Smoking (23.1% vs 17.3% London), alcohol abuse (B&D 7% harmful, 17% high risk, 14% binge drinkers) and inactivity ▪ Proportion of overweight and obese children is significantly higher that the London average and not declining ▪ Emerging needs linked to population change, e.g. housing challenges/pressure on primary, acute and social care, changing disease profiles and expectations of health services
Care and quality challenges	Disease prevalence	▪ Health outcomes are mixed and reflect wide socioeconomic gradients across the patch ▪ Significant variation in take up and delivery of screening, health checks and immunisations across the system ▪ High prevalence of hypertension and diabetes, with a significant proportion undiagnosed ▪ Wide variation in care outcomes for people with long term conditions, particularly for Diabetes and COPD ▪ High rates of late diagnosis of cancer and the second worst one-year survival rate in London (63.9% in B&D vs 69% national average) and variability across the system ▪ Delayed diagnosis of cardiac problems and variability across the system ▪ 50% of dementia cases are undiagnosed, with limited support for people and their families post diagnosis ▪ Prevalence of multiple conditions is significant in the over 75s ▪ High admission rates: higher than average unplanned hospitalisation for chronic ambulatory care sensitive conditions (898 per 100,000 pop vs national average 784 per 100,000)
	System issues	▪ Fragmented health and care commissioning system that needs to work to address and support a 'distressed economy' ▪ BHRUT (and Barts Health) currently in special measures ▪ Large number of GPs approaching retirement age ▪ Local/national shortage of key clinical and professional staff ▪ Inability to retain and recruit staff across the system and address workforce development requirements ▪ Inability to generate robust data and intelligence on interventions and outcomes across whole pathways of care ▪ Embed prevention immunisations (childhood vaccines 93.2% vs 95% England; PPV 62.5% vs 70% England) ▪ Embed early intervention, e.g. health checks (3-4.5% offered vs 7% London) ▪ Unhelpful structures and governance arrangements in general practice, which inhibit whole-system working ▪ Access to and quality of Primary care (active programme of work including Prime Minister's Challenge fund for out of hours access) ▪ Quality of residential and domiciliary care in a market under financial pressure; not helped by fragmented commissioning ▪ Market diversification, in response to personalisation, leading to a multitude of unregulated care providers and fewer contractual levers
Funding and efficiency challenges	Funding Gap	▪ BHR system total estimated funding gap of £429.9m and our current plans will not fully address this. (LA figures are for adult social care and public health but scope could expand to children's services) ▪ Marked distance from capitation at organisation level ▪ Public Health Grant reductions proposed; further pressure on public health and social care expected in CSR15 ▪ Pressures emerging in parts of the social care market (residential and domiciliary care), exacerbated by National Living Wage and compromising ability to meet Care Act duty to promote sustainability
	Efficiency	▪ BHRUT has: High non-elective admissions rate (41% emergency admissions as a percent of total admissions vs 35% England, 33% London) High occupancy levels (94.7% vs England average 86.9%) Planned care performance and efficiency challenges ▪ All three BHR CCGs have higher than average inpatient spend for over 75s (e.g. B&D gastro 6.5 per 100,000 pop higher than comparable CCGs; respiratory 5.5 per 100,000 higher; gastro intestinal 5.5 per 100,000 higher) ▪ Commissioning for Value: Integrated care pathways, February 2015, Redbridge CCG, Havering CCG, Barking and Dagenham CCG, Public Health England, NHS England and Right Care

Delivery & impact timeline - ACO

	Year 1 – 2016/17 Consistency	Year 2 – 2017/18 Evolution	Year 3 – 2018/19 Transformation
Objective	▪ complete business case for ACO – determine scope, structure and accountability ▪ develop implementation plan ▪ establish co-design principles and commence work ▪ understand and address ACO risks	▪ phase one of implementation (driving out first phase of resource shift) ▪ re-engineering budget structure ▪ evaluate progress and impact	▪ develop full ACO Governing Body with full budget accountability ▪ consolidated governance structure: ACO established with combined commissioning and provision ▪ aligned incentives for tariff and combined budgets ▪ evaluate progress and impact
Co-design	▪ engagement with front line staff ▪ engagement with local population ▪ engagement with Healthwatch and VCOs ▪ Identify front line staff to lead re-design	▪ address outcomes of the engagement ▪ develop detailed design with staff and the BHR population	▪ robust systems of co-design embedded
Workforce	▪ staff and professional engagement ▪ workforce plan linked to the CEPN ▪ identification of staffing and skills gaps to be addressed and engagement of Royal Colleges	▪ consultation on change ▪ fundamental review of skills and roles across health and social care ▪ commencement of training and development	▪ transition to new organisation form ▪ recruit and train staff in new roles ▪ infrastructure to support new roles
Leadership and governance	▪ shadow ACO Governing Body reporting to respective organisations decision making bodies	▪ shadow ACO Governing Body reporting to respective organisations decision making bodies	▪ ACO Governing Body; a decision maker in its own right
Academia	▪ establish academic partners, brokered by Care City and UCL Partners ▪ develop approach to ongoing evaluation	▪ embed '4P' approach (Pre-emptive, Predictive, Personalised and Partipatory) in ACO	▪ ensure ACO transformation underpinned by latest evidence and ongoing commitment to population health
Public system reform and regulation	▪ review current regulatory body reporting and statutory accountabilities to propose changes and plan future governance	▪ shadow changes to regulatory body reporting ▪ need to take account of Personalisation – public commissioning services for themselves and how will this fit	▪ amend and reduce regulatory body reporting

6 Business case development timeline

	Completed by
SET UP ▪ ICC leadership agreed and joint SROs confirmed as Cheryl Coppell and Conor Burke ▪ Confirm resources for business case and set out project structure ▪ Full engagement and involvement of all partner organisations at front line level, including the LMC and regulators, to shape the ACO through early enabling workshops ▪ Determine ACO membership and leadership model ▪ Define the challenges and risks for the ACO and how these will be addressed ▪ Development of communications strategy with all partners	31/12/15
ENGAGEMENT ▪ Public engagement ▪ Staff engagement	Ongoing
GOVERNANCE: ▪ Establish Project ACO Board arrangements ▪ Develop model to include clarification of ACO governance and accountability arrangements ▪ Sign off of model by all partners to ensure system ownership at ICC	31/03/16
BUSINESS CASE DEVELOPMENT, SUBMISSION AND DECISION MAKING: ▪ Develop options for ACO model including scope/coverage, operational model and impact evaluation on existing commissioning plans and strategies ▪ Quantify outcomes – linked to scope ▪ Confirm budgets for inclusion (linked to scope) – including centrally held budgets, e.g. specialised commissioning ▪ Identify the other gaps alongside the health and social care system funding gap, e.g. worklessness, welfare, etc. and how an ACO would benefit these ▪ Complete business case options appraisal to determine preferred option and if not ACO what changes can be made ▪ Finalise and sign off business case ▪ Submit business case for review by NHSE	30/06/16
LEADERSHIP AND OVERVIEW ▪ ICC to receive statement of progress at the end of each quarter ▪ Updates submitted to NHSE at the end of each quarter	Quarterly

7 Support Required: System asks

BHR partners will require the following support to implement this ACO bid

Provide investment and access to expertise

- financial support to enable the co-creation of a detailed business case for the creation of the ACO over the next three months, in partnership with primary care practitioners and staff across BHR
- **phase one: first six months £750,000 required for engagement and surveys to establish a PMO and develop business case. These funds will be match funded through local resource (staff and resource equivalent to £100k per organisation from 3 LAs, 3 CCGs, BHRUT, NELFT, and UCLP)**
- expert advice including: Legal/HR advice, expert financial support (Treasury), Communications support, Engagement support, population health analytics support (PHE)
- peer review and challenge
- access to the Transformation Fund and financial support for double running to establish new system (determined by business case)

Revolutionise regulation

- create a separate and single regulation system for the ACO to reinforce required behaviours across the system and focusing on population outcomes
- ensure individual regulation reflects additional ACO obligations proportionately in the performance assessment
- permissions to operate differently/ outside of guidance in development stages
- ACO enabled to take control of the setting of priorities and planning timelines

Develop new workforce models

- professional and contractual issues
- training and development link to national agenda

Reform to financial flows

- relevant centrally held commissioning budgets, including Specialised Commissioning, that have large population impact, being returned to the ACO, e.g. primary care, public health etc.
- budgets brought to capitation level within an agreed timeframe
- flexibility around tariffs and payment mechanisms – beyond current flexibilities
- ACO to take accountability for all relevant property enabling a system wide view of estates to support the development of the ACO and release relevant resources for transformation

Decision Timescale

- Part of the overall devolution package for London
- Current shape of bids:
  - Sub regional care integration (BHR)
  - Sub regional estates pilot
  - Local care integration
  - Local prevention pilot
- November/December final decision