Better care together
Leicester, Leicestershire & Rutland health and social care

Moving Towards an Accountable Care System in LLR

A proposal from the System Leadership Team on next steps

DRAFT **Version 3** **(25 August 2017)**

Moving Towards Accountable Care in LLR - a proposal from the System Leadership Team on next steps

Working Together as One

> "*The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected episodes of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."*
> *"Our aim is to use the next several years to make the biggest national move to integrated care of any major western country. This will take the form of Sustainability and Transformation Partnerships covering every area of England, and for some geographies the creation of integrated (or accountable) health systems."*
>
> *Five year forward View*

1. INTRODUCTION

This proposal has been developed following the joint meeting of NHS board members (UHL, LPT and CCGs) together with local authority partners on 18 July 2017 at Leicester Racecourse. The proposal paper has been developed on behalf of the LLR SLT by a small working group of Dr Peter Miller (LPT CE), Sarah Prema (LC CCG) and Toby Sanders (STP Lead). An early draft of the paper was considered by SLT at its meeting on 17 August 2017 and this updated version, which incorporates discussion and feedback at that meeting, has been prepared for consideration by the boards (or equivalent) of individual partner organisations during September 2017.

In terms of context, major challenges around health inequalities, patient safety, financial and workforce sustainability, have led all statutory health and care partners in Leicester, Leicestershire and Rutland (LLR) to work together on a programme of service redesign for the past three years. The overarching aim is to create an integrated health and care system for our population, which is clinically and financially sustainable for the long term.

This work has been brought together within a shared system strategy 'Better Care Together', which sets out the future for health and care services in LLR through a population health approach and the creation of integrated care models.

Significant strides have been made to improve quality and safety in most services, and building capacity within our programme of integration, however the financial position across the system remains extremely challenging. Within this changing context, the original Better Care Together Strategy, whilst still shaping our collective vision, now needs to be enhanced and supplemented by a delivery mechanism that can help us align system ambitions and support our work to integrated models of care.

Furthermore, the national context now requires us to develop and deliver a Sustainability and Transformation Partnership with our partners across LLR, which will cover the next 3-5 years.

As part of the work to consider how we could accelerate and expand the impact of our collaboration, partners have been exploring the development of an Accountable Care System. This is seen as a potentially helpful and necessary vehicle to cement our partnership working and provide a framework to mobilise our effort; and remove the barriers to integration necessary to achieve our aspirations.

At a recent regional Sustainability and Transformation Partnership event on 3 August 2017 there were clear messages given by NHS England and NHS Improvement about the direction of travel towards the establishment of Accountable Care Systems, as detailed below.

“This is about moving progressively towards more system and less from organisational perspective”.

“Increasing expectation that STPs will develop into ACS delivery models”.

“Creating ACS is about STPs locally re-writing the NHS operating model”.

“No organisation can survive on its own – we need collaborative arrangements with commissioners and providers having mature conversations”.

“Working outside the STP is not sustainable”.

“NHS organisations will see more and more business come through the STPs”.

“Investment will only come to high performing STPs”.

“STPs need to repackage their resources to do something different”.

“Smarter CCGs will be pooling resources across their STP area to combine their management resource”.

“The system is too complicated for commissioners to micro-manage providers through service specifications”.

This paper sets out to build the foundation for, and define, our next phase of development, as an Accountable Care System. It is intended to provide a clear signal of intent for our direction of travel and the work programme to support this. It also sets out the high level implications for leadership, decision making and governance.

2. HOW COULD OPERATING AS AN ACCOUNTABLE CARE SYSTEM HELP DELIVER IMPROVED CARE FOR PATIENTS ACROSS LLR?

As described above our local system has taken considerable strides over the past two years to meet the challenges set out in our Better Care Together Programme and subsequently in the Draft LLR Sustainability and Transformation Plan. Despite the good work on integration, improving pathways and clinical service redesign we still as a system face significant challenges and barriers to true integration of care and the development of seamless pathways for patients. Many of these are as a result of the way that the system is structured and tackling these barriers will enable clinicians and organisations to work more effectively together.

Some of the issues faced are described in the table below together with how an Accountable Care System may support the change required.

Now	**What could an ACS support?**
Our system is fragmented, a series of individual services, which leads to multiple hand offs for patients between services and variability which impacts on patient care and outcomes	The ACS will be based on pathways of care with organisations working together to enable patients to move seamlessly into different levels of care at different times of their lives improving quality of care and outcomes for patients
Increasing demand in all sectors is impacting on our ability as a system to maintain financial balance and deliver quality care	Integrated pathways of care will facilitate care to be provided in the right care setting; facilitate more resources into preventative and early detection
The financial platform is not sustainable with all providers and the CCGs under increasing financial pressure Different payment and contract mechanisms across the system inhibit the flow of money around the system and thus stifle the development of integrated pathways and innovation	CCGs and providers will work together to develop a new financial framework including a system wide control total and the ability to flow money around the system in a controlled way to support improvements in patient care and the delivery of the Better Care Together Plan New contractual forms will incentivise the system to deliver optimal care pathways and improve outcomes for patients with the focus on operating cost and value for money not income/activity/price

Competing regulatory requirements impacts on organisations ability to respond to a system agenda Organisational accountability often takes precedence over system needs and can lead to perverse decision making and delays in implementation	The Next Steps on the Five Year Forward View states that ACS will get far greater control and freedom over the total operations of the health system in their area thus enabling us to do the best for the system NHS England and Improvement have indicated a willingness to move to single oversight arrangements for areas working as an ACS
There is often duplication and triplication across the system which leads to inefficiency Decision making process are complex and time consuming leading to delays in implementation	ACS will facilitate the development of integrated care streamline pathways to deliver cost effective care; back office functions will develop into a common platform providing services across the system Commissioners will work more collaboratively together making more joint decisions on system issues leading to coordinated decision making and speedier implementation

The view of SLT is that the development of an accountable care approach across LLR is essential to deliver the BCT clinical model and population health focus. The current system is locked into a regime of annual contracting cycles, organisational rather than system regulation, and payment models which do not create incentives for the outcomes our residents deserve. Too many of our clinicians do not have access to shared records and our staff have different objectives and priorities. These barriers will need to be overcome if we are to have the best chance of achieving our desired outcomes.

We have to be realistic – our challenges will not be solved by just simply creating an Accountable Care System. The total resource available to us in the system, both workforce and financial, will be the same and change will take time. There are also risks that too much focus on delivery vehicle and organisational arrangements could distract from the task of improving services and quality of care. It is equally true that ACS models in this country remain a fairly new and untested concept which, despite the international evidence, suggests that realising the potential benefits will take time to translate into a UK context. Notwithstanding this, ultimately the NHS partners across LLR have to ask ourselves whether on balance the development of an ACS will lead to more functionally effective arrangements that will support the use of our combined resource in a different way and have potential to improve the quality, safety and outcomes of patient care for local people.

3. WHAT IS AN ACCOUNTABLE CARE SYSTEM?

The Next Steps on the Five Year Forward View states that Accountable Care Systems will be an evolved version of a Sustainability and Transformation Partnerships that is working as a locally integrated health system. They will provide joined up, better care and over a number of years may evolve into an Accountable Care Organisation.

Accountable Care System: An Accountable Care System takes accountability for the delivery of care and outcomes for a defined population and geography within an agreed budget. In doing so it designs and delivers services to best meet the needs of its population and improve health and wellbeing outcomes. ACSs may take many different forms ranging from fully integrated systems to looser alliances and networks.

SLT envisages that an Accountable Care System in LLR would see partners working together and over time ceding some individual sovereignty for the current responsibilities they have within LLR into a joint endeavor. Ultimately, this could include all of these aspects:

- Working to a common purpose, vision and values
- A single system plan, objectives, initiatives and metrics
- A single place based budget, distributed across providers on an allocative and aligned incentive basis
- Single leadership teams (at place-based, network and LLR wide level)
- A common platform covering: ICT; business intelligence, improvement tools, methodologies and approaches
- Common governance and regulatory oversight.

The ACS arrangements would bring together a hybrid of commissioning and provider responsibilities on a more functionally integrated basis. With a focus on population health, there needs to be a strong public health focus as well as support to enable communities to take responsibility for their own health and wellbeing.

Accountable Care Organisations: An Accountable Care Organisation is a group of providers, under one contract with a commissioner which has accountability for all care and outcomes for a population for an agreed period of time.

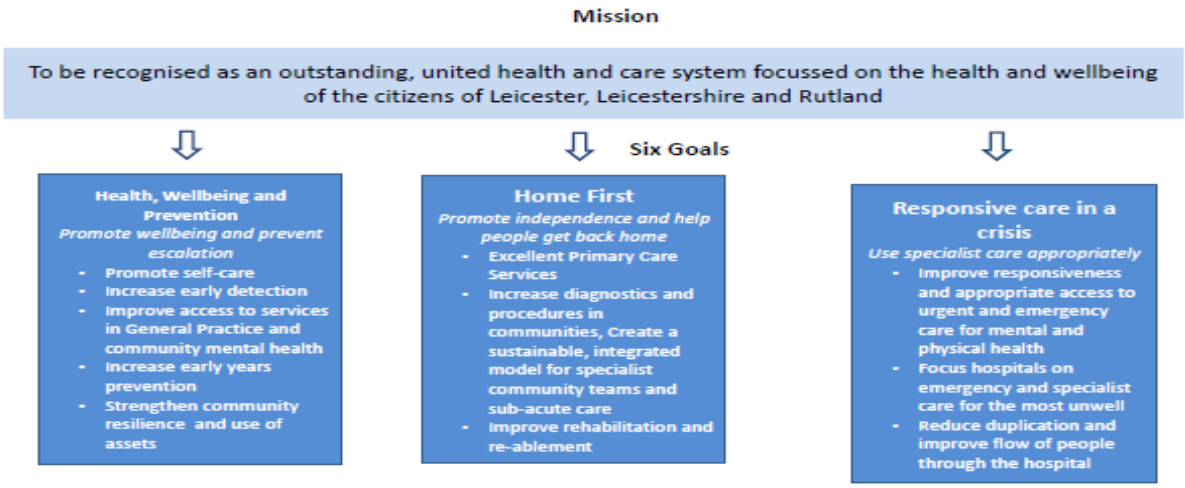
At this stage there are no plans to develop an Accountable Care Organisation in LLR which is supported by the Next Steps on the Five Forward View which state that ACSs may evolve into accountable care organisations over number of years.

4. OUR AMBITION: WHAT ARE WE TRYING TO ACHIEVE AND WHY?

Our current delivery arrangements across LLR are not enabling us to make the progress we need in terms of service quality, safety and value for money for people who live in LLR in a number of ways. The care they receive both in the community and in hospital is of variable quality – some is excellent but some is not of the standard we would want for us or our family. There are also marked inequalities in health outcomes. The current way we are working costs too much in terms of organisational overhead, leads to significant duplication and other inefficiencies, and provides a disjointed experience – especially when people move from one care setting to another.

The partners have collectively agreed that a new approach is needed through our Better Care Together Plan. The starting place for this endeavor is creating a common vision and purpose that we all share. This vision describes our final destination and the purpose outlines our overarching objectives. Both are underpinned by a common set of values and guiding principles that will shape the way we work together.

Work on shaping our vision, principles and outcomes has been led by the Clinical Leadership Group and shared with the LLR system at the recent Clinical Leadership event. Further work is required to refine these but the latest version is detailed below.



5. WHAT MIGHT ESTABLISHING THE FIRST PHASE OF AN ACS IN LLR LOOK LIKE?

Looking comparatively at existing ACS arrangements internationally, and the national accelerator sites in the UK, suggests that we would need to evolve our operating model in LLR at three linked levels:

I. **System** – this would be about working across organisations as "one team", focused on the same common goals and with aligned financial incentives and joint decision making. This is not about organisational mergers but would be about creating the right environment and conditions that would enable and empower our clinical and operational staff to work together in a more integrated way focused on doing the right thing for LLR patient and the NHS pound in LLR.

II. **Network** – this would be about establishing a set of clinical/service networks that cover the whole of LLR and bring commissioners and providers together to jointly agree service models, care pathways and service investment. This would build on some of the more developed/mature examples of current clinical workstreams like urgent care, but the significant difference is each network would take responsibility for looking across a portfolio of linked services and the resource investment associated with these. The focus would be on improving quality, safety and outcomes across settings of care and driving down operating cost.

III. **Locality** – this would be about building on the current integrated locality team working and GP federation/at scale arrangements but making a major step towards fully integrated local MCP/ACO new care models. This would bring community health and social care services together wrapped around hubs of GP practices serving geographically defined local populations. The focus would be on proactively managing local population health, care planning and co-ordination. This would require teams from across different organisations to work together under shared clinical and managerial leadership – effectively forming a locality clinical 'division'. It would also require a move to local place based budgets, new contracting arrangements and an element of devolved decision making.

To work successfully as an ACS across LLR will require each of these three elements to be in place. Their relationship would not be a hierarchical one – each is necessary but would play a specific role within the system that taken together offers the prospect of constructing a far more effective set of delivery arrangements than our current organisation centric model. The following paragraphs expand on the potential elements and implications of moving in this direction across the three levels:

SYSTEM - LLR Health Partners "working as one team"

- Creating the environment focused on integration and collaboration, not competition and organisational autonomy and interest.
- Evolve the System Leadership Team, (SLT) into a ACS Leadership Team.
- Reformed as single 'system executive team' for LLR, with clinical and executive director roles for key portfolios. This could either build on the existing model of chief officer leads for each workstream, or move to more of a clinical director type model for system workstreams with chief officers retaining overall oversight.
- Based around portfolio roles not organisational positions and working to collectively manage a system financial control total.
- Formally recognise difference between 'parties' to the LLR ACS agreement (CCGs, UHL and LPT) and those who would be 'partners' to it (LAs, EMAS, DHU). This would clarify the relationship between local government and the NHS/STP as focused on operational and service working not structural, governance or financial integration.
- Strengthen role of Chairs and Non-Executive Directors/lay-member in more formal oversight and assurance group. This could involve moving the current informal chairs meeting into a more formal quarterly oversight group with CCG lay member rather than clinical input to maintain a level of independence.
- Supported managerially by a re-booted set of programme management functions. These could either build on the current separate PMO arrangement or look to embed support functions within mainstream CCG capacity and/or Commissioning Support Unit services.
- The three LLR CCGs moving towards closer collaboration and greater joint working. The focus will be on increasingly working as one commissioning team across LLR serving the three statutory bodies. To support this the three CCGs will formalise their joint decision making arrangements by setting up a joint-committee that will enable a wider range of common decisions to be taken once, in the same place.
- Move functions across NHS organisations (commissioner and provider) to more of a 'shared' mindset (e.g. finance, communications, safety) focused on working together as virtual teams seeking to deliver the same goals from their respective parts of the system. This would be not be about outsourcing but collaboration and shared service.

- Work with NHSE/I to streamline oversight and assurance arrangements into a single accountability framework across commissioners and providers. This would need to be progressed and formalized through the development of a memorandum of understanding setting out how the LLR ACS arrangements would operate and be overseen. Copies of example MOUs from other areas are attached in Appendix 1.

NETWORK: vertically integrating care pathways across LLR

- Take existing BCT workstreams a step on to work as managed care networks, vertically integrating specialist and generalist care across pathways, each led by a 'clinical director' and executive level sponsor.
- Each network 'blurring' commissioner and provider roles with responsibility both for service planning, redesign and operational delivery across different care settings.
- Each network taking a place based approach to the total healthcare funding available to support delivery and the operational cost and spend.
- And accountable for delivery of local outcomes, national standards and impact on activity and use of resources.
- Consolidate current BCT workstreams into a smaller number of strategic priority areas with more direct link to national NHS delivery priorities e.g.:
    - Urgent and Emergency Care
    - General Practice
    - Mental Health and Learning Disabilities (including Dementia and CAMHS?)
    - Planned Care and Cancer
    - Integrated Teams (including Long Term Conditions; Prevention; End of Life Care; Falls)
    - Home First (including Step Up; Step Down; Reablement; Rehabilitation; Recovery; Care Homes; Single Point of Access; Community Hospitals; Carers)
    - Children and maternity
- And bring together the various enabling and foundation workstreams under a single focus on creating a common platform e.g.:
    - Financial framework (LLR wide system control total distributed on an allocative and aligned incentive basis)
    - OD and clinical leadership – commit to single LLR Way
    - Business intelligence and population health segmentation
    - IM&T
    - Estates
    - Workforce
- CCG (and elements of NHSE/clinical networks) management and clinical resource working together as a virtual LLR-wide team aligned to delivery of STP system priorities.

- NHS provider managerial and clinical lead recourse aligned to work within and lead care network model.

LOCALITY: local horizontally integrated multi-disciplinary community provision

- Building on the Integrated Teams work, creating a stronger local delivery model for our 11 localities (which in the step up phase could work together in 3 groups/clusters).
- Effectively operating as place based leadership teams and service directorates for each patch across a number of service areas delivered on an out of acute hospital basis.
- Builds on GP federations, primary care home and neighborhood hub and spoke models already being supported in each CCG area working with their Member Practices.
- Taking devolved responsibility for delivery of a set of services within a delegate budget (shadow initially) to their local population to agreed health outcome metrics.
- Could for example include primary care at scale delivery, urgent care, community nursing services, social care, community mental health and specialist acute outreach team input.
- Some CCG functions aligned and embedded and delegated to support locality delivery with their Member Practices (e.g. medicines management, primary care and locality development).
- Would also impact on provider contracting arrangements, with each locality managing service and resource decisions against a strategic outcomes framework (i.e. not detailed commissioner service specifications).
- In time could progress to new Multispecialty Community Provider (MCP) / ACO contractual forms.
- Recognising the different starting positions of each of the three CCG areas, the early phase of development may require CCG specific oversight boards which may also have a longer life as ‘clusters’ of localities working together (e.g. the four federations working together across West Leicestershire). This would enable a strong localism reflecting population and service provision differences within a common LLR wide framework.

6. POTENTIAL NEXT STEPS

Developing the ACS will be an iterative process with phased development over the next few years. The first phase would concentrate on the governance, financial terms of trade, setting out what we want to achieve as a system, developing a Memorandum of Understanding and resources and would consist of the following elements:

Phase One September 2017 to March 2018

Action	Timescale
Organisational support for the direction of travel	September 2017
Development of a Memorandum of Understanding to set out how the system will work together in a ACS	October to November 2017
Approval of MOU by individual organizations	December/January 2018
Finalise system vision, mission, principles, values and outcomes	September to November 2017
Reform System Leadership Team into the ACS Leadership Team	September to November 2017
Consider how to formalise Chair, non-executive and lay member involvement in ACS governance oversight	September to November 2017
Formalise the Chief Finance Officers Meeting as a part of the formal governance structure	September to November 2017
CCGs to move to a formal joint committee arrangement to improve decision making process	September to November 2017
CCGs to consider areas of collaboration to reduce duplication and improve implementation	Ongoing
Agree and implement new arrangements for PMO functions	September to October 2017
Develop and agree approach to contracting for 2018/19 and system control total	September to December 2017

It should be clearly stated that Phase 1 does not by default commit partners to any next stage in development. There would be clearly identified milestones and gateways set out in a work programme for the ACS at which Boards and Partners would need to give due consideration about movement to the next stage. This would include specific agreement about any formal ceding of sovereignty and formal delegation of responsibilities. A MoU which is operational for Phase 1 would then need to be refined and agreed by Partners to reflect any future changes.

All organisations Boards are asked to consider this document in September 2017 with particular emphasis on the following questions:

1. Are you supportive of moving towards the creation of an ACS model across LLR?
2. Do you think this should be done in a phased approach?
3. What issues would need to be worked through in establishing the new model across the three different levels?
4. Are there other issues that impact on integrated/collaborative working that this proposal does not appear to address?
5. Does the Next Steps capture the key actions required to establish the ACS?

Appendix One:

Example of MOUs

Bay Health Care Partners.pdf

South Yrokshire.pdf