Healthy London Partnership

Strategic Partnership Board

10 August 2017

Title:	Integration paper
Author (name and title):	Multiple: London Health and Care Devolution team, HLP and London Councils
Date paper completed:	4 August 2017
Purpose of paper:	• Provide a progress update on the health and care systems support offer and the wider integration landscape in London; • Support a discussion about the developing London narrative on health and care systems; • Support a discussion on principles for ACSs; • Share learning on emerging options for ACS development and seek views on these options from partners; and • Support a discussion on how partners could best address regulatory barriers by working collectively with NHS England, NHS Improvement and CQC.
Executive summary:	We presented a paper at the May SPB which described the ongoing integration effects in London and emerging support priorities. This paper provides an update on that work and will be used to support partner discussion within key early areas of priority. The update will also bring in details of other aligning initiatives.
Action required by Board Members:	For discussion: Discussion questions are included within the paper.

Healthy London Partnership

Supporting integration and the development of health and care systems in London

London Health and Care Strategic Partnership Board

10th August 2017

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

Structure of update

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2	**BCF**	**Paper 5.2** Pg. 41-43 Discussion questions: pg. 43
3	**Care Closer to Home**	*[TBC]*

Healthy London Partnership

Paper 5.1: Health and care systems

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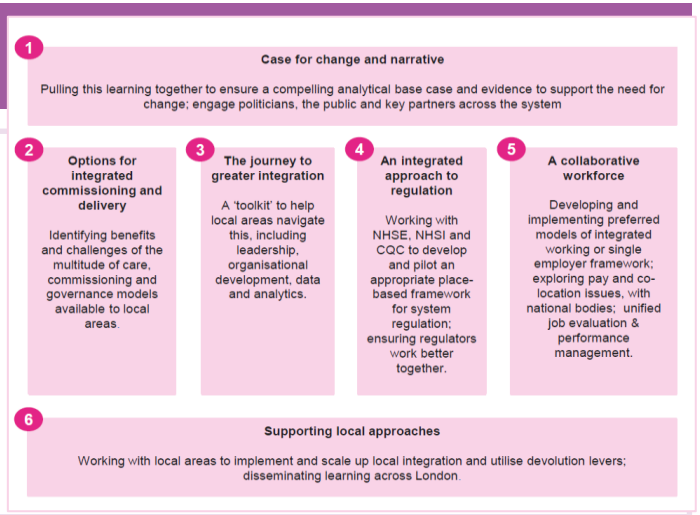
Progress Update

Update

At the last Strategic Partnership Board meeting (24 May 2017):

- We presented a paper which described the ongoing integration effects in London and emerging support priorities. Members then discussed the developing programme of work and six workstreams.
- Members were broadly supportive of the overall direction of travel, noting the need to provide a flexible and permissive resource, rather than a prescriptive pan-London approach.
- It was agreed that an Integration Working Group would be established, with full representation across partners.



Since the last meeting

- Local and multi-borough areas have fed back on the emerging support offer (p5. These areas have asked for particular areas to be prioritised, leading to some key areas of focus for the summer (p6).
- An Integration Working Group has been established and met for the first time on 28th July (p7).
- We have begun to build up a picture of the work underway in London, and support needs within different areas (p8).

Today we plan to focus on:

- The developing London narrative on health and care systems, including how ACSs fit into the wider integration agenda;
- Developing principles for ACSs;
- Emerging options for ACS development; and
- An integrated approach to regulation.

We are engaging on the content of this offer with partners across London's health and care system

London partners (CCGs, NHSE, London Councils, GLA, NHSI, PHE)	Strategic Partner-ship Board	STP leads	Trust CEs and CCG COs	High-level review at London Health Board	HWB Chairs network	ADASS	CELC Health Sub Group
23rd May	24th May	May, June, July	2nd June	14th June	15th June	23rd June	10th August

Iteration with local areas and STPs

To include:
- All STP & devolution pilot leads
- Any systems identified by STP leads as potential early adopters
- Local government, CCG and provider perspectives

Integration working group provides a forum to augment engagement with individual organisations and systems

This engagement has led to some key areas of early focus

Case for change and narrative

- **Describing London's approach to health and care partnerships (including clarifying the relationship between ACSs and STPs)***
- Setting out and testing the wider system narrative, including evidence of outcomes where possible
- Describing the long term vision, informed by discussions with system leaders

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Options for integrated commissioning and delivery

- Setting out the options for integrated commissioning, governance and delivery, building on case studies from across the country
- Identifying outcomes where these are available
- Exploring the implementation challenges
- **Understanding the implications of these different models and examples to inform the 'must dos' and principles for an effective ACS***

The journey to greater integration

- Describing the path to integration
- **Identifying the 'must dos' and principles for an effective ACS***
- Focused work on:
  - Organisational development
  - System leadership
  - Commissioning implications

Supporting local approaches

- **Establishing integration working group***
- Exploring the New Care Models learning platform ('Kahootz') and identifying whether it could be used to support spreading and sharing learning within London.
- **Identifying emerging health and care systems in London, based on discussions with local areas and STPs***
- **Clarifying the support requirements of local areas to inform the support offer***
- Clarifying resource availability for focused local support

*** Areas of focus today**

The Integration Working Group met for the first time on 28th July

The Working Group was attended by representatives from each STP and many emerging health and care systems alongside NHS Improvement (London), London Councils, London CCGs, Public Health England and the Healthy London Partnership. Attendees included local government, provider and CCG representatives.

Theme	Key points of discussion
Developing a picture of London	• Representatives from local and sub-regional areas described examples of the integrated working and developing health and care systems within their footprints (see p9). • Representatives from PHE, NHS Improvement, London CCGs and the Care Closer to Home (CC2H) programme gave an overview of some of the programmes already ongoing to support aspects of integrated working (e.g. data analytics, population health, CC2H programme). • It was agreed that there needed to be more sharing of learning and connecting of support offers on a pan-London basis. A number of local representatives asked to be connected into various pieces of work, for example on population health and prevention. • We are collating resources and learning that were identified on the day and will circulate shortly.
ACSs	• The group described significant confusion in terminology and requested clear descriptions of different types of integration efforts. • Members discussed the rationale behind the developing London principles for ACSs – both the potential benefits and some concerns. Partners saw value in a set of principles that were co-developed for London by London. It was felt that principles would need to describe a minimum for ACS arrangements and that these should not limit ambition. • The first draft of the ACS principles was discussed. A strong shared view was that the drafting felt too NHS focused and the language too managerial, but most of the tangible features of accountable care identified felt broadly in the right place.
Regulation	• Representatives briefly discussed the process of working with regulators to move to a more system-based model. Local representatives were asked for help prepare case studies, to evidence the current barriers. Case studies can then form the basis of an autumn workshop.

STPs have given some details around their ongoing work and early indications of potential support needs

The summaries below are not intended to be substantive explanations of all the work being carried out within the five STP footprints, but reflect the updates provided during the first Health and Care Systems Working Group meeting.

NWL

Developing borough-based plans and then considering how broader systems could operate within the STP footprint. Key areas of consideration and challenges include: collective decision-making, money, regulation, relationships, aligning transformation and business as usual, and risk sharing.

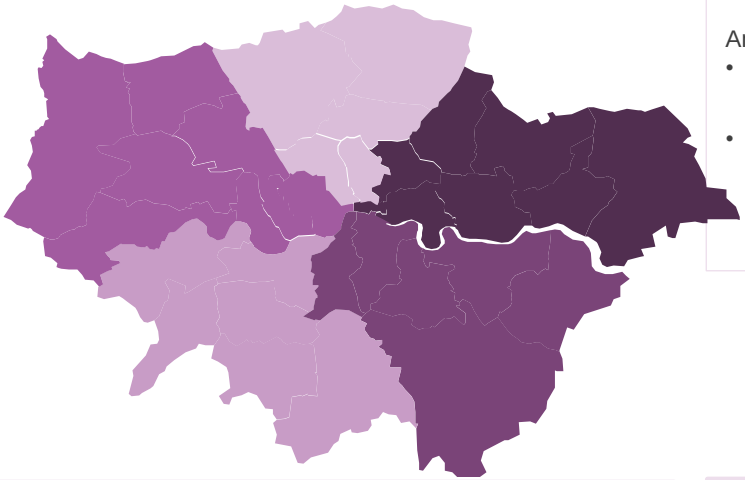
Anticipated support needs:

- Would welcome any joint narratives around investment in out of hospital services.
- Particularly interested in regulation, keen to be a pilot.
- Pan-London workforce support where appropriate. Apprenticeship levy mentioned in particular.
- Additional interest in: evaluation, evidence and rolling out what works, risk-sharing and procurement.
- Sharing of learning and facilitation of networking.

NCL

NCL CCGs have recently appointed a single AO at STP level. Haringey and Islington have an Accountable Care Partnership agreement in place, with nearly all partners signed up and a developing governance architecture.

Support needs: TBC



NEL

NEL is loosely starting to work in three multi-borough geographies (BHR; Hackney & the City; and Newham, Tower Hamlets and Waltham Forest) focussing on out of hospital care. BHR completed a strategic outline case to become an ACS last year. City & Hackney's plans are also well-developed.

Anticipated support needs:

- Connections to national programmes (ACS).
- Exploring contracting, governance and accountability implications.
- Assessing which spatial level is most appropriate for different functions.

SWL

SWL have organised themselves based on four 'places', and have done a lot of collaborative work on the service model (locality teams etc.). Partners are curious as to what the ACS model can offer.

Anticipated support needs:

- Developing a compelling narrative – and ensuring the developing SWL and London narratives are complementary.
- OD – support staff in undertaking transformational change; leveraging the improvement architecture in London.
- System leadership.
- Hands-on support/capacity.
- Access to previous learning to cut down the timescales for development and implementation.

SEL

SEL partners are collectively planning to 'stocktake' on their integrated arrangements, and also noted a need for clarity on the key features and benefits of an ACS arrangement. Arrangements will be borough based for community care purposes.

Anticipated support needs:

- OD
- Hands-on support/capacity
- Access to previous learning

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An emerging London narrative on health and care systems

There is a wide spectrum of ongoing work which aims to better integrate health and care

Key

- Integration/integrated working
- Health and care systems
- Accountable care systems

Diversity of population groups: *Extent to which the whole population is targeted*	Small segment (e.g. frail and elderly or those with multiple co-morbidities)	Significant proportion of the population (e.g. adults)	Whole population within a geographical area
Diversity of needs: *Extent to which total health and care needs are addressed*	Discrete needs (e.g. diabetes pathway)	Significant proportion (e.g. all physical health needs or all mental health needs)	As close as possible to total health and care needs
Diversity of partners: *Extent to which partners that provide or commission different services are involved in the initiative*	Few partners, all with the same roles (for example, two GP practices)	Multiple partners with different roles (e.g. NHS provider forum within a borough)	All partners with levers to impact the needs in scope
Geographic/spatial level: *Geographical areas covered*	Locality (e.g. 20-50k primary care model)	Single to multi-borough	Pan-London

Separately, there will also be variance in formality of arrangements (e.g. organisational/governance structures). Different levels of formality could occur within any one of the above boxes and formality does not necessarily correlate with the factors outlined above.

A great deal of terminology has emerged from the national focus on integration and some consistency could assist local discussions

Integration: Integration could be any kind of joining up of services or health and care staff at any spatial level. Bringing a pharmacist into a GP practice, creating shared patient records, and bringing together the provision of acute and community services are all examples of integration on different scales. If integration is the 'what', then 'integrated working' is a 'how'. 'Horizontal integration' is between providers operating at the same level or part of the pathway, for instance, a network of GPs within a borough. 'Vertical integration' is between providers working at different levels or parts of the pathway, for example integrating hospitals with community services.

***Health and care systems*:** 'Health and care systems' is also used as a wide 'catch all' term, but we suggest that this term is different from integration in two ways:

- Health and care systems is a 'how': the system is a means by which integration is achieved and refers to the coming together of different organisations with responsibilities for health and care.
- Health and care systems suggests a certain scale of integrated working, and we would anticipate that systems would include a number of partners with different roles. Health and care systems could happen on a very small geographical level and focus on particular pathways or groups.

***New Care Models (NCMs)*:** NCMs are, as the term states, models of care which focus on how health and care needs can best be met by a partnership of organisations. The key features of the NCMs are not focussed on the underlying arrangements.

Vanguards: Vanguards are the areas piloting/testing the NCMs. They are an example of health and care systems, but have no prescribed requirements for the underlying arrangements.

Accountable Care Systems (ACSs): An ACS is a health and care system which:

- Involves the coming together of all health and care partners with responsibility for the health and care needs of a population, and
- Involves those partners taking collective responsibility for the **total health and care needs** of their population.

NHS England has set some criteria for the national ACS programme, which focuses on what underlying arrangements are required to enable this shared accountability. The criteria do not prescribe a care model. In London we are working to develop principles for these ACSs that work for the London context.

Accountable Care Organisations (ACOs): ACOs are a further formalised iteration of an ACS, where one provider/multiple providers in a formal legal structure come together to take the accountability for total population needs. Commissioners are involved in the development of ACSs and over time take on more of an assurance role.

Sustainability and Transformation Partnerships (STPs): STPs are groups organisations responsible for health and care in a place who came together to develop a five year plan. They are an example of health and care systems. In some areas of the country, these partnerships may further formalise into an ACS. In London it looks likely that ACSs may form on smaller geographies.

Better Care Fund (BCF): the BCF requires CCGs and local authorities to enter into pooled budgets arrangements and agree an integrated spending plan.

These approaches can be assembled in different ways

For example:

- **BHR's Accountable Care System**: A multi-borough, whole population based arrangement with a broad partnership across health and care.
- **Camden's Frail and Elderly Multidisciplinary Team**: A team led by a GP, with input from geriatricians, hospital and community-based nurses and allied health professionals, social workers and mental health workers. The team co-ordinates care for the most vulnerable elderly people.
- **The West London St Charles Integrated Care Centre**: A dedicated space that brings together health, social care, mental health, voluntary organisations and other services under one roof for 'older adults'. Services include: social care, pharmacy, a community dementia nurse, basic foot care service from Age UK, lifestyle activities at the Open Age centre located next door, and access to community cardiology and respiratory services.
- **The NWL integrated care pilot for diabetes:** The pilot aimed to integrate care across primary, acute, community, mental health and social care for people with diabetes through care planning; multidisciplinary case reviews; information sharing; and project management support.
- **Tower Hamlet's Multispecialty Community Provider** vanguard: A partnership including commissioners and providers of acute, community, mental health, social care and primary health services, and developing close working links with wider partners including the local community, voluntary sector and hospices. Initial areas of focus included adults with multiple long term condition, children & young people.
- **Southwark and Lambeth Integrated Care**: A partnership between the three local NHS Foundation Hospital Trusts (GSTT, SLAM and King's), local GPs, the CCGs, local authorities, the voluntary and community sector and citizens across the two boroughs. The programme has been supported by the Guy's and St. Thomas' Charity.

Organisations may use different arrangements to enable their vision

An illustration of how different initiatives could fit in the context of an overall model of health and care:

Vision
The 'why'

The vision and priorities will need to be grounded in a clear shared understanding of the population, including wants and needs.

Care model
The 'what'

- Outlines the way that health and care services are delivered and how the partner organisations aim to meet health and care needs of those within scope.
- The model may be or include features of a **New Care Model** (NCM). The NCMs look at how the health and care sector interfaces with citizens, not only in terms of how services are delivered, but also in terms of community engagement, self-care etc. The Integrated Primary and Acute Care System (PACS) and Multi-speciality Community Provider (MCP) models are whole-population service models, based on the GP registered list, thereby making primary care fundamental to either model.
- The model may not be or include an NCM, but may include some or numerous measures of integration. Service providers may have formed some form(s) of health and care system to better integrate their services.

Underlying arrangements
The 'how'

- Underlying arrangements enable the care model to meet the vision.
- CCG and local authorities will have entered into **BCF** arrangements, and may have entered into wide integrated commissioning arrangements.
- The **contracting and commissioning arrangements** may be directly linked to an NCM (for example, arrangements may make use of the MCP contract).
- Partners will be part of a **Sustainability and Transformation Partnership** and will have signed up to a plan for that footprint.
- Partners may also be part of an **Accountable Care System**, through which they take collective responsibility for the **total health and care needs** of their population. In London in looks likely that ACSs will be formed on a smaller spatial level than STPs. The national ACS criteria focus on the 'behind the scenes' arrangements which enable partners to work together. NHS England have not attempted to prescribe a service model or impose detailed contracting/commissioning arrangements. In London we are working on the principles of an ACS in the same context.
- Partners within an area may also be working integrated ways, other than the examples mentioned above.

We have aimed to clarify the relationship between ACSs and STPs

- **The 5YFV delivery plan has just re-emphasised the importance of integrating care locally**. The Sustainability and Transformation Partnerships are developing strengthened governance and implementation support. The Delivery Plan also describes potential 'Accountable Care Systems' – STP footprints around the country where NHS commissioners and providers are working in partnership with local authorities to go further, taking collective responsibility for resources and population health. In return, these ACSs will gain more control and freedom over the local operation of the health system.
- **The direction of travel set out in the delivery plan resonates with our journey in London**. It adds more detail to how national partners will support London to deliver a system where residents will increasingly see services delivered in a joined-up way, helping to deliver greater access to primary care services and in patients' homes, as well as providing more options for accessing urgent care.
- In London, **our work on health and care devolution seeks to support local areas through new approaches to accountability, regulation, governance and finance**. Alongside our focused efforts on estates and prevention, we anticipate securing national commitments in many of these areas **to enable our integration efforts in London to go further and faster**, consistent with the national direction of travel. Securing this commitment will bring a range of incentives to drive forward our ambitions.
- **London has many unique characteristics that inform our approach to health and care system integration**:
  - London's five STPs are larger than the national average (1.7 million average population per London STP vs. 1.2 million nationally). Even within a single STP, we have considerably diverse communities, health challenges and quality of health and care services.
  - Different approaches are already emerging within STP footprints to support health and care to come together. It is clear from our Vanguards, devolution pilots and other innovative partnerships that one size doesn't fit all and a more permissive approach - that can be responsive to the needs of the local citizens and system – is more likely to be successful.
  - It is clear from the integration activities driven within localities, boroughs and multi-borough partnerships that transformation must be locally led, based on strong relationships and aligned priorities between London's many strong health and care leaders. The support of clinicians and politicians are particular 'success factors' to drive significant system improvements.
- It is therefore essential that tailored approaches and solutions are developed to respond to these needs.
- **In London, health and care providers and commissioners have been working more closely together at all spatial levels** – localities, boroughs, multi-borough arrangements, STPs and London-wide.
- The STP footprints are key planning areas for the devolution of estates and they will be essential for planning at scale across a health economy. But **STPs are not reintroductions of five local health authorities**.
- Many of the draft STP plans describe working in partnership in smaller footprints than an STP. If local or multi-borough areas choose to adopt an ACS-type arrangement, this would be a powerful unit for more local health and care delivery, consistent with the direction of travel signalled in many STP plans. In London, ACS areas are likely to be smaller than STP footprints. But **there is no predetermined number of ACSs and it will be up to local areas to determine the appropriate size and footprint of ACSs within an STP**.

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The commitment to support ACS-type arrangements reaffirms the importance of more local delivery alongside STP & London-level actions

Potential ACS

STP

- Supporting the health economy to develop and manage financial risk
- Supporting local areas to set up ACSs
- Assessing interdependencies, opportunities and challenges across ACS boundaries
- Commissioning across the geographic footprint where this is the most appropriate level e.g. some specialised commissioning
- Focused work on enablers (data, workforce, information sharing, estates)

Local or multi-borough

- Identifying local priorities based on local population needs and current services
- Identifying intended outcomes
- Developing local partnerships
- Decisions regarding whether to proceed with greater integration and which model(s) are preferred
- Delivery of locally stated aims

STP areas and ACSs would work to shared principles including:

- tailoring services to the needs of local populations
- strengthening connections between health and care
- aggregating when this supports clinical services, manages risk and enables services to be more sustainable

How this compares to the national approach

	National	London
Relative size of STPs and ACSs	8 'shadow' ACSs are co-terminus with an STP footprint or smaller than a STP with plans to scale.	For the most part, ACS areas will be smaller than STP footprints. The STP footprint remains important as an essential vehicle for planning at scale across a health economy
Role of local government	'NHS commissioners and providers in partnership with local authorities'	Local authorities as a key – and equal – partner in integrated health and care systems
Focus on performance	Supported to delivering faster efficiency and service improvements than elsewhere in the country on cancer, primary care, mental health, urgent & emergency care	Support for 5 operational priorities will continue to be delivered across the STP in the first instance, taking the 'improvement collaborative' approach.
Approach to establishing an ACS	Based on • The appetite/interest of STP areas. • Track record of delivery given focus on performance	There is no predetermined number of ACSs. These must be built bottom up. Considerations are likely to include: • locally-determined appetite, priorities and relationships • Capacity • Patient flows (balanced with the focus on primary and community care) • Population size It will be up to local areas to determine the appropriate size and footprint of ACSs within an STP.

Discussion questions

- *Do these slides reflect your understanding of the terminology? Is it helpful to try and provide this clarity?*
- *Is this narrative consistent with your views of ACSs and STPs?*

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Developing principles for ACSs

ACOs and ACSs are built from the same fundamental principles

Accountable Care Organisations

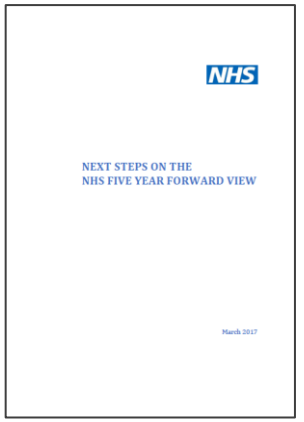
A group of providers agrees to take responsibility for all care for a given population, for a defined period of time, under a contractual arrangement with a commissioner.

- In the US, accountable providers come together in a formal organisational structure (for example, a physician hospital organisation or independent practice association).
- Under the 5YFV Delivery Plan, an ACO is defined as being a model "*where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in that areas*."

Accountable Care Systems

The 5YFV Delivery Plan explains that ACSs are:

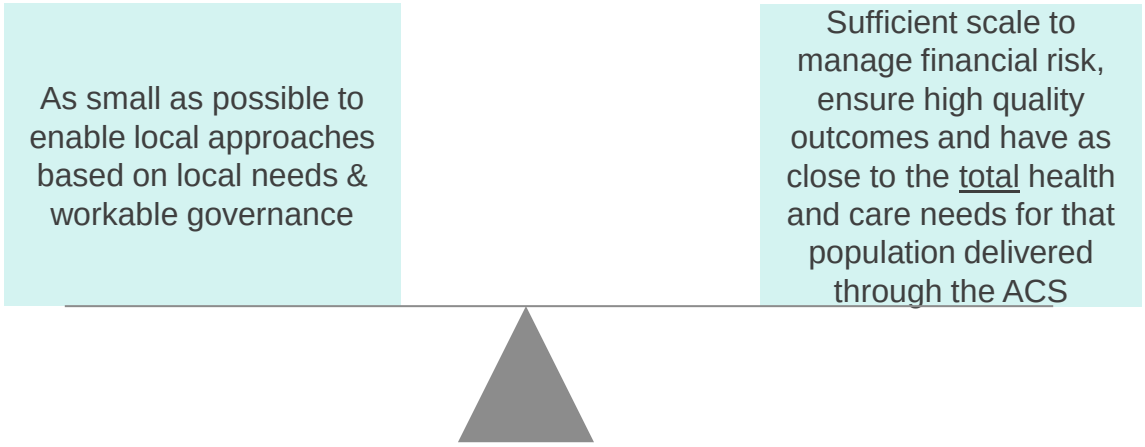
"***Systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility*** *for resources and population health…In time some ACSs may lead to the establishment of an accountable care organisation…A few areas (particularly some of the MCP and PACS vanguards) in England are on the road to establishing an ACO, but this takes several years.* ***The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk****, means they will not be the focus of activity in most areas over the next few years."*



The key practical difference is the **formality of arrangements and organisational form.**

Although not all ACOs involve a single provider, the model involves organisations coming together in a formal structure. Part of the US eligibility criteria is that an ACO is required to "*develop a formal legal structure that allows the organisations to receive and distribute payments for shared savings*". In an ACS, it is envisaged that organisations will initially sign up to an MoU to formalise mutual aims and agreed ways of working. MOUs are not legally binding but they carry a degree of seriousness and mutual respect.

There has been considerable appetite for clarity on how we are defining an ACS in London and any 'essential ingredients'



- This means consideration of viable population sizes, patient flows, workable governance and clarity of which health and care services are in and out of scope (e.g. highly specialised services).
- The starting point would be the total health and care needs of a defined population, with issues such as population size and patient flows then influencing how that population is defined (size, number of boroughs etc.).
- These issues must be clearly defined and agreed upfront to ensure that different systems in London develop with some coherence and with absolute transparency around any 'must-dos'.

The *Next Steps* delivery plan included some national requirements for the eight pilot ACS systems

National NHS England ACS requirements

- Develop collective governance and decision-making
- Agree an accountable performance contract with NHS England and NHS Improvement that will include delivering faster efficiency and service improvements than elsewhere in the country (priorities include cancer, primary care, mental health, urgent & emergency care)
- Together manage funding for the ACS's defined population through a system control total
- Demonstrate how providers will 'horizontally integrate' whether virtually or through merger or joint management
- Simultaneously 'vertically integrate' with GP practice formed into locality-based networks or 'hubs' of 30-50,000 populations.
- Deploy rigorous and validated population health management capabilities
- Establish mechanisms to ensure patient choice

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In London, partners have asked for key principles for ACSs to ensure clarity and congruence across the system

The process of developing principles for accountable care in London

- Within London, the appetite and ambition to develop accountable care arrangements varies within and between different local and sub-regional areas.
- A number of areas in London will be unfamiliar with the ACS concept. It is anticipated that the principles will assist local conversations, by providing clarity around the parameters of an ACS and what partners would need to enable them to move to this type of arrangement, should this be desired by local partners.
- The principles are intended to inform the minimum necessary for an ACS to be formed. They neither require areas to move forward with ACS arrangements, nor limit ambition. The principles must be flexible to suit whatever structural model is in place.
- The principles aim to ensure transparency and fairness for areas in London that wish to explore ACS arrangements.
- The principles must be co-developed and co-owned by the London system. Consistent with the principle of subsidiarity, they must enable local developments.
- The principles will be evidenced so far as possible, and tested with areas across London to ensure they work in the interests of local population needs and in a variety of circumstances.
- The principles will help to achieve congruence across the system to ensure that all arrangements are workable within the wider London system.
- The principles only apply to ACSs, and are not criteria for health and care systems more broadly.
- The principles will stay in draft until they have been tested. There are a number of questions relating to each suggested principle, which require working through.
- The principles must be clearly linked to the tangible benefits that accountable care aims to achieve for citizens (in this case, for Londoners).

Any change would need to be for the benefit of Londoners

Aim	As a result Londoners will see that…	Does this highlight any principles for ACSs?
Models are grounded in the needs of Londoners	• Health and care service provision (e.g. access) is changing in response to their wants and needs. • It is recognised that partners will be operating in tight financial circumstances - Londoners will understand the prioritisation of services and how this best responds to their needs.	• Partners need to have a shared understanding of their population and its needs. • Partners need to have a shared vision which is grounded in the wants and needs of their population. • Cross-organisational public engagement will enable a more holistic view of population needs, and provide clarity for Londoners, avoiding confusion and mixed messages. • Clear, shared outcomes enable Londoners to understand the rationale behind change. • Financial collaboration enables organisations to better adapt to changes in need and deploy resources based on shared priorities.
Londoners are supported to stay healthy	• Healthy choices are actively encouraged and promoted through everyday interactions (e.g. through employers and on the high street), making healthy choices easier choices. • They are supported to reduce the risks of poor health, helping them feel more confident about their health and wellbeing. • The impact of external factors such as housing, employment and other pressures) are recognised, taken into consideration and addressed.	• ACSs will need to take a preventative approach, focusing on keeping Londoners healthy. Prevention will need to be a key part of 'business as usual' for all partner organisations. • Preventive approaches must be multi-agency, including partners with resource and power to address the wider determinants of health (education, housing, voluntary sector etc.).
The different health and care needs of Londoners are taken into account	• There is timely and accessible support for all their health and care needs (including mental health and wider determinants of health). • There are people accountable for all their needs, and no-one 'slips through the gap' between organisational responsibilities.	• All partners need to take ownership of the total population health and care needs. Incentives need to encourage collective ownership. • ACSs need to involve all partners with the levers to meet the population's health and care needs (including Londoners themselves). All these partners need to work collaboratively.
Needs are met in a joined up way	• Their care is joined up – they do not have to repeat themselves or make the connections between their different needs on their own. Mental and physical health treatment is joined up – and health and care services are joined up. • Mental health and wider determinants of health are always considered by health and care professionals who interact with Londoners, increasing the likelihood that any issues are addressed at an early stage. There are clear referral pathways.	• So far as possible, ACSs will need to be able to look after the total health and care needs of their populations. This means that all the people who look after those needs will need to be signed up to the vision and ways of working. • ACSs require partnership working across organisational boundaries. • Partnership working across organisational boundaries at scale will require a form of collaborative governance.
Londoners are able to receive their care closer to home	• They are only in hospital when they absolutely need to be. • Where they do not need to be an in hospital, their health and care needs can be met as close to home as possible.	• Service provider(s) need to be enabled and incentivised to keep people well in non-hospital settings. • Cross-organisational working will be required to enable expertise and services to be provided in setting closer to Londoners' homes.
The model protects choice and the rights of Londoners	• They maintain the right to choose where they receive their care and treatment.	• Models need to maintain patient choice and deliver the NHS mandate and other statutory obligations.

We have distilled this analysis into the following principles

Draft key principles

1. ACSs will put Londoners first, with collaborative working enabling partners to **better understand and meet the total health and care needs of their population.**
2. **ACSs will focus on keeping Londoners healthy, with prevention being a fundamental part of the shared vision** and becoming an ever greater part of the everyday business of all partner organisations.
3. **All parties with a role in improving the health and care of the population will be involved** in the ACS, and will be **committed to partnership working across organisational boundaries** at every level.
4. Partners will take **collective responsibility for the needs of their population, and for demonstrating shared outcomes which show tangible improvements for their local communities.**
5. **Care is of the highest quality possible, in settings which are as close to home as possible**, and incentives enable this aim to be realised.
6. ACSs will ensure that partners are collectively meeting needs and adapting to changes through an **agreed financial arrangement**.
7. ACS arrangements **maintain all the fundamental rights of Londoners, including patient choice**.

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Essential ingredients could emerge from these principles

Key principle	Emerging ingredients: Design questions

1 ACSs will put Londoners first, with collaborative working enabling partners to better understand and meet the total health and care needs of their population.
 	
**This will necessarily exclude e.g. highly specialised services, but the aspiration is for the ACS to meet as close to the total health and care needs of that population as is possible.*
	• What core mechanisms need to be in place to **enable partners to jointly understand their populations** and to develop models of health and care that respond to these needs, irrespective of organisational form? This could include shared data, but also joined up mechanisms of community involvement etc.
	
	• The NHSE candidate ACSs have populations which range between approx. 324k and 1.5 million. To what extent is there an **evidence-based optimum range of population sizes** for an ACS in London?
	  ◦ The ACS would need to be large enough to enable management of risk and enable the majority of health and care needs to be met within that ACS.
	  ◦ But a system which is too large could be practically unworkable in governance terms and is less likely to meet the needs of the local population.
	
	• What **percentage of patient flows would need to be internal to the system, to enable partners to meet the total health and care needs?** How does this relate to the current flows within the system and relate to the choices that service users are currently making?
	
	• It is likely that this figure may exclude flows from certain services (for example, highly specialised commissioning). Which services would need to be excluded, with the majority still remaining within the ACS?
	
	• How would this impact on provider flows in different parts of London?

2 ACSs will focus on keeping Londoners healthy, with prevention being a fundamental part of the shared vision and becoming an ever greater part of the everyday business of all partner organisations.	• **ACSs are likely to need to consider how they will secure the input of wider public services**. A number of the vanguards have brought the wider public sector (e.g. schools/ police) into their prevention initiatives and social prescribing has emerged as a key feature of the New Care Models. • Wider determinants of health (e.g. housing, planning, employment) will similarly need to be a key feature of any emerging ACSs and this means that the spatial level of the borough will need to be prominent within any ACS, as this is where most of this activity takes place.
3 All parties with a role in improving the health and care of the population will be involved in the ACS, and will be committed to partnership working across organisational boundaries at every level.	It seems likely that ACSs will require : • Some form of **joint governance** to bring together health and care partners within the system. • **Strong working relationships and a commitment to partnership working across all sectors (including primary care, social care and the voluntary sector)**. • **Strong leadership** to develop collaborative culture**.** • A **baseline shared vision, grounded to the wants and needs of local communities,** to ensure the system understands its mutual aims. • Appetite for **cross-organisational working at all spatial levels to enable the ability to manage and co-ordinate the care of individuals**, requiring robust staff and clinical engagement.

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Essential ingredients could emerge from these principles

	Key principle	Emerging ingredients: comments and questions
4	Partners will take collective responsibility for the needs of their population, and for demonstrating shared outcomes which show tangible improvements for their local communities.	• ACSs would need the **full scope of health and care organisations engaged and a clear means by which all organisations are represented.** Learning from the vanguards suggests that it is difficult to bring primary care into arrangements where there is not a clear mechanism by which GPs have already come together (e.g. federations). Most primary care is administered on the locality level with populations of 30-50k, so the locality will be an important unit of delivery. Is there **a minimum degree of primary care integration required** for ACS arrangements to be workable? Similarly, is there a **minimum degree of social care or voluntary sector integration** required? • Are there any **evidence-based upper limits to the number of discrete partner organisations**? An ACS will need sufficient partners to manage risk, however too many organisations could make proper engagement, decision-making, relationships and risk-sharing unworkable.
5	Care is of the highest quality possible, in settings which are as close to home as possible, and incentives enable this aim to be realised.	It is likely that ACSs will require : • A **clear case for change**, which is grounded in the wants and needs of the population and resonates with health and care staff and politicians and a shared vision as to what accountable care means in the particular footprint. • **Formal agreement from all partners involved**. All partners need to understand the implications of moving to an accountable care model. Whilst arrangements can be phased, there needs to be clarity regarding the overall direction of travel. • **Developing outcomes-based payment mechanisms – with outcomes that all partners can agree and shared accountability across the system for achieving these outcomes**. • A reinforcing regulatory environment – recognising the ACS as the unit of analysis for many services. Discussions with regulators will be needed to co-design this systems-based regulatory approach. • **Strong clinical and political leadership.**
6	ACSs will ensure that partners are collectively meeting needs and adapting to changes through an agreed financial arrangement.	• It is likely that partners will need to **agree that there is capital/resource within the system** to move forward with the necessary transformation work and invest in key enablers (workforce, technology, data analytics etc.). • Partners would need clear accountability and governance to manage a financial control total.
7	ACS arrangements maintain all the fundamental rights of Londoners, including patient choice.	• We suggest that models should be **grounded in the evidence as to where patients are choosing to receive care** (see 2). • In addition to the mandate, we are trying to understand if there are there are any other non-negotiable deliverables.

Discussion questions

- *Reflections on the emerging principles of accountable care in London*
- *Are these the right questions and issues to be exploring?*

1d

Emerging options

From discussions with local areas, there are three emerging models of ACS in London

The national ACS Memorandum of Understanding is likely to confirm that the national programme views the ACS arrangements as being co-terminus with an STP footprint. Within London, the size, complexity and patient flows within STPs suggest that smaller spatial levels may be more appropriate. London areas have instead been considering variations to the national ACS model that recognise our specialist services, STP sizes and complex patient flows:

Large single boroughs with co-terminus health and care boundaries and clear patient flows (smaller size has risk management implications). Minimum size would be dictated by population needs, patient flows etc.

Multi-borough areas (most), with 2-3 boroughs and providers across the geography, resulting in MCP-type arrangements within each borough and an Acute Care Collaboration-type model between 'networked' providers. Risk could then be managed across the multi-borough geography. Examples of areas interested in this model include Barking & Dagenham, Havering and Redbridge.

The ***complex provider model*** applies to large Trusts who have significant inflows from a far bigger spatial area (which often spreads outside London), and will therefore be required to interact with multiple ACS arrangements. For example, GSTT is also part of an acute care collaboration with Dartford & Gravesham.

Discussion question: Would the proposed ACS models– at a first glance – meet your local or multi-borough needs? How can these best be tested or further explored?

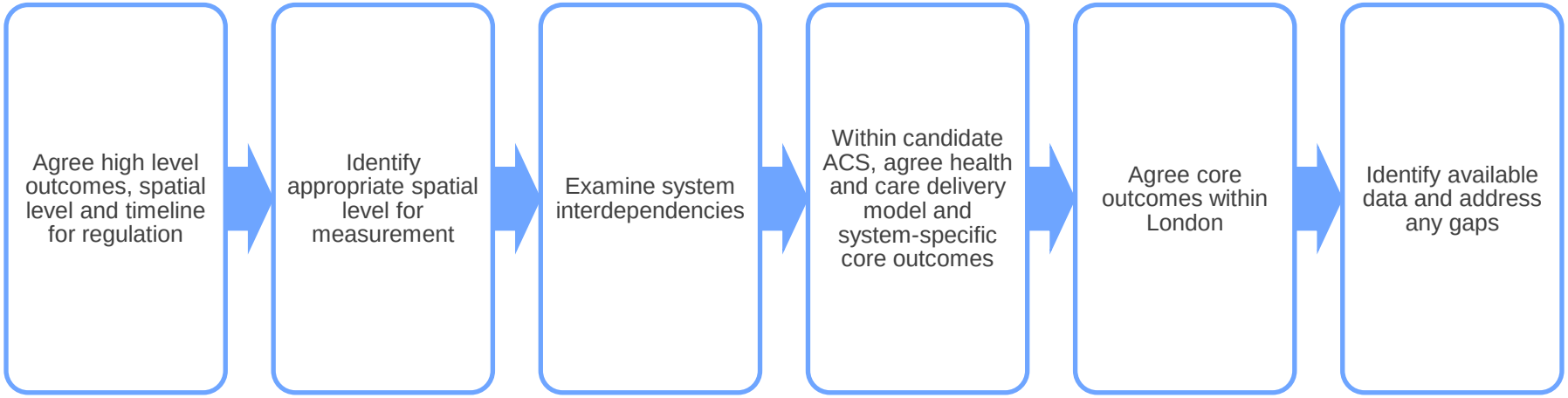
Whether partners are working towards an ACS model or a different form of integrated arrangements, there is learning from the New Care Models and other areas of the country that can help inform discussions around options for commissioning and delivery . See Appendix A for an illustration of some of the learning we have drawn from models around the country.

1e

An integrated approach to regulation

Many areas are particularly interested in a more integrated approach to regulation

Draft process for determining system-based regulation:



We plan to hold a regulation workshop in the Autumn to bring together emerging health and care systems with CQC, NHSE and NHSI to work through a series of regulatory issues emerging from local case studies.

Discussion questions:

- *Is this a desirable approach?*
- *Are there active case studies that could be developed locally to support this?*

Appendix A

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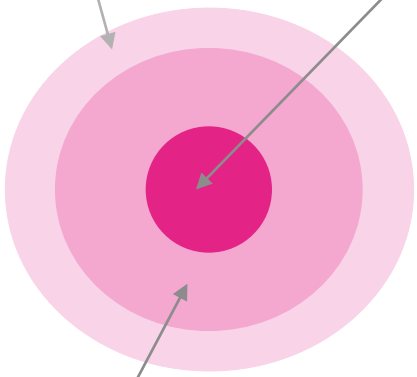
Areas have plans to put different models together in different ways

Portsmouth

Portsmouth CCG are looking at an MCP model with a local Trust and GP providers.

Portsmouth CCG's population is around 217,500.

STP population: ~2mil

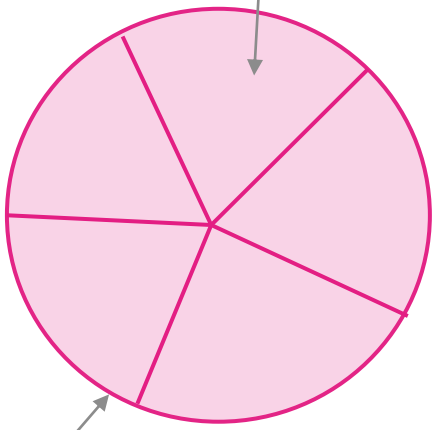


Portsmouth and South East Hampshire are coming together in an ACS style model.

The population of the 3 CCGs is ~ 550-600k

South Yorkshire and Bassetlaw

Each of the 5 CCG footprints (populations ~ 300k) are forming local accountable care arrangements ("Accountable Care Partnerships").



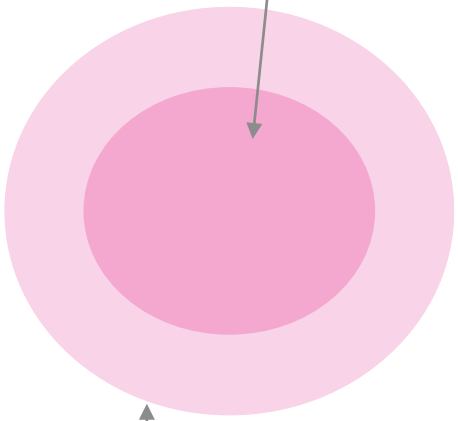
STP and ACS on the same footprint

Population: ~1.5 mil

Blackpool and Fylde Coast

ACS and MCP starting at the same spatial level.

Population: 324k



STP population: 1.7 mil

The vanguards have tended to come together through wide strategic alliances

Vanguard partners

	CCGs	Local authorities	Primary care providers	Hospital service providers	Community service providers	Mental health service providers	Social care service providers	Voluntary/ Independent sector
Integrated Primary and Acute Care System (PACS)	All vanguards name CCGs as partners.	All vanguards name local authorities as partners.	Six of the nine vanguards name GPs as partners.	All the vanguards name multiple trusts providing (collectively) hospital, community and mental health services. One vanguard names another organisation (Circle, in Nottinghamshire).			All vanguards name local authorities and two include trusts which provide social care services.	Four of the nine vanguards name voluntary sector partners.
Multispecialty Community Provider (MCP)	All vanguards name CCGs as partners.	Twelve of 14 vanguards name local authority partners.	All but one of the vanguards name GPs as partners, often through federations.	The MCP model may include some services based in hospitals (e.g. outpatient clinics). Eleven of the 14 vanguards name acute trusts as partners**. Some vanguards also name ambulance trusts.	All vanguards name at least one community service provider as a partner.	All but one of the vanguards name specialised mental health providers as partners.	Most vanguards name local authorities but only one names another social care provider as a partner.	Nine of the 14 vanguards named voluntary sector partners.
Enhanced Health in Care Homes (EHCH)	All vanguards name CCGs as partners.	All vanguards name local authorities as partners.	Two of the six vanguards explicitly name GPs as partners.	All but one of the vanguards name NHS trusts/FTs as partners. The trusts generally provide a mix of acute, community and mental health services. A number of the vanguards name wider community service providers in additions to the trusts.			All vanguards name local authorities as partners.	All but one vanguard name voluntary or independent partners (usually multiple).

Arrangements have not been finalised for the new Accountable Care Systems (ACS), as announced in the *Five Year Forward View: Next Steps* delivery plan. However, the expectation is that **all NHS commissioners and providers, and local authority partners** will be committed to working together in an ACS.

*For the purposes of this analysis we have considered PACS, MCPs and the care home vanguards.
**Acute trusts refers to trusts that have not specialised in either mental health or community services. In some, but not all, cases the acute trust will also provide some community or mental health services.

Emerging formal arrangements often have a narrower scope

In almost all cases the strategic alliance will be much wider than the list of organisations who enter into formal partnerships/new organisational forms. On the basis of the data we have found, **most of the vanguards moving towards more formal arrangements are proposing to begin with a sub-set of services (often excluding core primary care and some (if not all) social care services).**

Vanguard	Formal arrangement	Included services	Excluded services
PACS			
Mid-Nottinghamshire	Alliance contract	Adult mental health and learning disabilities, enhanced primary care, acute and community services for adults, independent and third sector, social care (some to be included on a phased basis).	Children's services, core primary care, prescribing, continuing healthcare.
Salford	Prime provider contract	Adult social care, community, hospital and mental health.	• Primary care is not currently included, but is part of the wider integrated system. • Children's social care is not included
Northumberland	Prime provider contract held by the FT	Acute hospital, community health, mental health, social care.	Core primary care not included at present.
South Somerset	TBC	Acute hospital, community health, mental health, primary care	Core primary care, social care (may be included later).
MCP			
Sandwell and West Birmingham (Tentative/to be decided)	TBC	Most core acute, community and mental health services, core primary care (if GPs are one of the prime providers)	Social care (not initially, may be included later)
West Wakefield (Tentative/to be decided)	Alliance contract in 2017-18, moving to MCP contract in 2018	Non-core primary care, community health, some primary and secondary mental health services, some adult social and public health prevention services	Core primary care, children's social care and some adult social care.
Dudley	Procuring for a single provider to sign up to an MCP contract.	Community-based physical health, some out-patient (high-volume, low-tech), primary GP care, local improvement schemes, urgent and primary care out of hours, emergency admissions due to falls, ACS conditions, or from care homes, mental health, learning disability services, NHS Continuing Healthcare needs intermediate care, end of life, voluntary and community sector, some public health, adult social care (to be phased in over contract period), CCG activities.	• Social care (initially, to be phased in), some public health, acute emergency services. • Service scope includes the full range of services the CCG would ideally want to commission under the contract. A number may be phased in over the life of the contract. • Option for primary care to be included but dependant on willingness of GPs to surrender APMS/GMS contracts.

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The King's Fund has described new contracting models as the 'scaffolding' for more integrated models of care

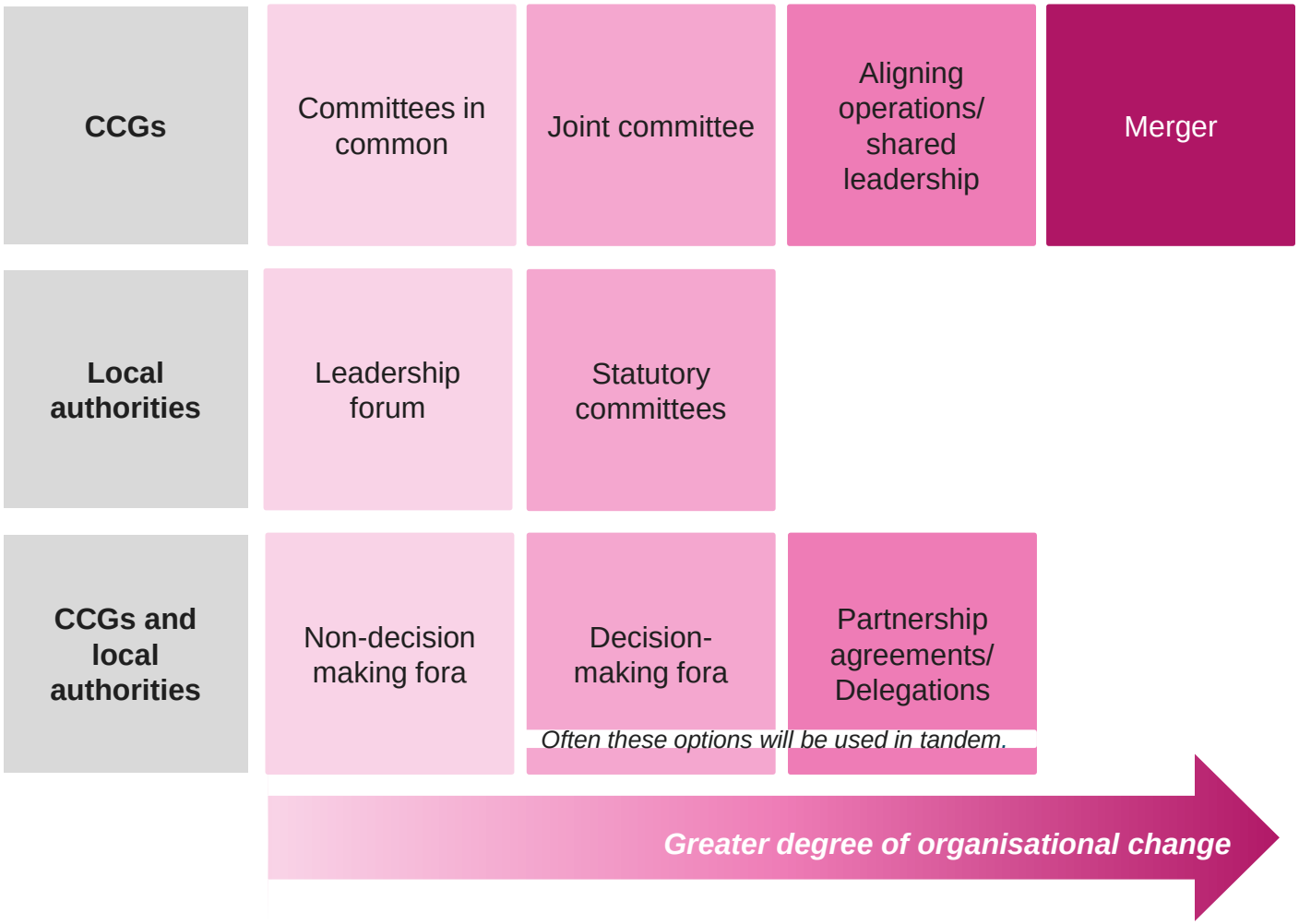
Our review suggests that there are some 'contracting'* models which will be of key importance in building health and care systems.

Increasing levels of formality and change

Model	Interaction with PACS model	Interaction with MCP model	Interaction with variations on these service models
A Memorandum of Understanding (MoU) is a non-contractual option to bring partners together.	MoUs do not form a part of the New Care Model frameworks, but some vanguards have used them as a mechanism to bring partners together (e.g. Mid-Nottinghamshire).		• The MoU can be used as a mechanism to bring together any group of commissioners and providers. • The national Accountable Care System programme is using an MoU to bring together all providers and commissioners within the eight systems announced in the *Next Steps* delivery plan.
Alliance contracting brings together organisations whilst retaining existing service contracts.	The 'virtual PACS' (option 1) uses alliance contracts (e.g. Mid-Nottinghamshire).	The 'virtual MCP' (option 1) uses alliance contracts.	The alliance contract can be used as a mechanism to bring together any group of commissioners and providers or any group of providers.
Under the **prime contractor or provider model,** a single organisation would take responsibility for all services within scope.	The 'partially integrated' and 'fully integrated' PACS models (options 2 and 3) use a prime provider style model (e.g. Salford).	The 'partially integrated' and 'fully integrated' MCP models (options 2 and 3) use a prime provider style model (e.g. Dudley).	This model could be used with a variation on the PACS/MCP model.
National MCP contract	No PACS contract published yet.	MCP contract published. Rather than a model, this is a new contract, **which uses prime provider style arrangements.**	Contracts are specific to the service models, although an MCP contract could potentially be used as part of a whole-system arrangement.

* We recognise that an MoU is not a contract, but we use the term for simplicity.

Different options exist for *commissioners* to come together, dependent on local appetites and desired outcomes



The above boxes do not indicate a desired progression. The selection of the model would be dependent on the aims, appetites and needs of local areas, recognising that organisational form must follow desired function.

Different options exist for *providers* to come together, dependent on local appetites and needs

Informal Collaboration

Leaders forum/ Advisory groups

Buddying/ information partnerships

Aligning decision-making

Internal delegations: Committees in common or individuals with delegated powers

Joint leadership/ appointment

Contractual arrangement

For example, a group of providers may contract to jointly provide a service across a number of sites.

Corporate joint venture

Through a corporate joint venture, providers would create a new legal entity (i.e. a company or LLP). Many GP practices have come together by forming a limited liability company.

Merger/ Acquisition

Certain organisations will have the option to merge or to acquire the whole/a part of another organisation. For example, two NHS Trusts may merge and the newly formed Trust may then absorb some social care services which were previously carried out by the local authority (including a transfer of staff).

Delegation of functions

Local authorities do not work under the same commissioner/provider split. Local authorities are able to 'delegate' functions to NHS providers under a s.75 agreement (as in Salford).

Least formal

At this point new legal rights and obligations are created.

At this point a legal entity is created or changed.

Most formal

- *In practice, there is scope for overlap between these different models and commissioners and providers are typically using a range of different contractual and structural arrangements to tie together their systems.*
- *For example, often an option from column 2 (aligning decision-making) will be used to provide governance for contractual arrangements.*

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Vanguards have begun to publish promising initial outcomes that could have relevance to health and care systems in London

	Multispecialty Community Provider (MCP)	Primary and Acute Care Systems (PACS)	Enhanced Health in Care Homes (EHCH)
Primary Metrics	Reductions in A&E attendances, elective and non-elective admissions, wait time, inappropriate GP visits, home visits, telephone consultations, admissions from care homes, referral time	Reductions in A&E attendances, elective and emergency admissions, non-elective bed days, admissions from care homes, secondary care elective referrals, inappropriate attendances	Reductions in A&E attendances, emergency admissions, bed days, ambulance calls
Financial Impact	Reported savings from reductions in primary metrics, full year savings projected in the millions	Full year savings projected in the millions	Reported savings from reductions in primary metrics, full year savings projected in the millions
Patient-Reported Outcomes	Increases in patients feeling involved in own care, providers of care working together as a team, and increased independence	Increases in aggregate health confidence and aggregate wellbeing scores, attendance to new community groups, and confidence to control own healthcare. Decreases in isolation and visits to GP	High levels of patients reporting the service as “very good” or “good,” feeling they had been treated with kindness, being involved in making decisions about their care, and the service helping them cope better at home and stay more independent
London Context Impact - *DRAFT*	Modelling against Wellbeing Erewash, London could decrease admissions from care homes from 29,131 to 25,053, leading to an overall reduction of 4,078 in 1 year	Modelling against Mid Nottinghamshire’s 22% decrease in 4-hr emergency target breaches, London could reduce breaches by 104,148, increasing the percentage who spend <4 hrs in A&E from 88.2% to 90.8%	Modelling against Sutton, London could reduce unplanned admissions from care homes by 2,622 (savings of £8.3M) and A&E attendances from care homes by 6,200 (savings of £1.64M)

MCPs have also reported **more personalised care** through an increase in the focus on care planning for people with long-term conditions and a more personalised approach to care according to staff surveys. **Staff Surveying** also reported implementation of more useful training initiatives, more joined up management of patients with LTCs, increased collaborative working, trust and openness within the system, and making more of a difference to patients.

PACS have also reported **IT improvements** through new data sharing models implemented to increase patient record sharing, as well as **more integrated care** through implementation of health and social care hubs to decrease admissions and attendances.

- Overall, in the last year, **MCPs** and **PACS** have shown lower levels of growth in emergency admissions per capita than non-new care models (PACS: 1.7%, MCPs: 2.7%, rest of England: 3.3%)

Healthy London Partnership

Paper 5.2: The Better Care Fund

Supported by and delivering for:

Public Health England

NHS

SUPPORTED BY MAYOR OF LONDON

The planning requirements for the Better Care Fund were published in July

- Following delay, the planning requirements for the Better Care Fund 2017/19 were published in July, following on from the policy framework published earlier in the year.

- Part of the delay in the publication of the planning requirements was caused by difficulties in finding agreement on how the additional £2 billion funding announced in the Spring Budget for adult social care should be used.

- The government has said that while it is up to local areas to ultimately decide how to use the additional funding it has also set out what it identifies as the three main purposes for this money namely:

  1. To help local areas meet adult social care needs
  2. Reduce pressures on the NHS by helping to ease the pressures on hospitals
  3. Helping to support the provider care market.

- The national debate has shown a degree of contested space, in particular around the variable emphasis on easing NHS pressures and the pressure this may put on local areas to come to agreement on a particular approach to use of the funding.

Discussion questions

- *Are there any points of principle to share/discuss in term of how London Partners will approach the forthcoming BCF planning and assurance round?*
- *Does the SPB wish to receive an update on the London position following September submissions?*