# PROGRESS UPDATE ON THE DEVELOPMENT OF AN ACCOUNTABLE CARE PARTNERSHIP IN HILLINGDON – AN INTRODUCTION TO HILLINGDON HEALTH AND CARE PARTNERS

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| **Relevant Board Member(s)** | Shane Degaris, Chief Executive, The Hillingdon Hospitals NHS Foundation Trust<br>Maria O'Brien, Divisional Director of Operations, CNWL<br>Dr Ian Goodman – Chair, Hillingdon CCG |
| **Organisations** | Hillingdon Health and Care Partners:<br>• Central and North West London NHS Foundation Trust (CNWL),<br>• Hillingdon Hospitals NHS Foundation Trust<br>• H4All CIC<br>• The four Hillingdon GP networks – due to become single Hillingdon GP federation in April 2017.<br>Hillingdon CCG |
| **Report author** | Jo Manley - Hillingdon ACP Programme Director |
| **Papers with report** | None |

## 1. HEADLINE INFORMATION

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| **Summary** | This report provides the Board with an update on the design and delivery of an Accountable Care Partnership (ACP) for Hillingdon.<br><br>HCCG plans to commission integrated services for people age 65 years from an Accountable Care Partnership (ACP) offering integration of services and partnership working at significant scale.<br><br>Hillingdon Health and Care Partners (HHCP) consists of a partnership of:<br>• Central and North West London NHS Foundation Trust<br>• Hillingdon Hospitals NHS Foundation Trust<br>• H4All Community Interest Company<br>• The four current Hillingdon GP networks |
| **Contribution to plans and strategies** | North West London footprint Sustainability and Transformation Plan<br>Hillingdon's Sustainability and Transformation Plan<br>Hillingdon CCG's Commissioning Intentions 2017/18 |
| **Financial Cost** | None arising directly from this report. The financial model is described in the report |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**That the Health and Wellbeing Board:**

a) **notes the update on the work that is going on in Hillingdon develop an Accountable Care Partnership (ACP), initially for older people**
b) **notes the progress to date, the proposed actions going forward and the current challenges within the ACP work plan.**
c) **has to opportunity to discuss and input ideas into the further development opportunities that may exist for this model within the Borough.**

## 3. INFORMATION

### What's the case for the proposed change to an ACP in Hillingdon?

According to the most credible growth assumptions for the next five years, Hillingdon will see approximately **21% more activity creating a system-wide funding gap of around £100m**. Our do nothing position is therefore untenable.

Approximately **one in six people with a long term condition over the age of 65 years is admitted to hospital each year**. Activities that improve anticipatory care, reduce the need for crisis management and support joined up care for vulnerable groups are key to affecting rising non elective activity and in providing a better standard of care closer to home, with **providers working together to improve care.**

Contracts and organisational forms as they exist currently hinder rather than help the integration of services and the development of innovative approaches to service redesign. Perverse incentives exist that reward providers for doing more activity rather than doing **the right activity and achieving the outcomes that matter** to patients and citizens.

Changes in care models will therefore be combined with a **new commissioning approach** where provider organisations are required to collaborate to manage the common resources available to them, based on a set of design principles. This will require changes to the current **contractual forms, development of outcomes based commissioning, reallocation of risks within the health care system and sustainable financial payment system** based on a capitation payment model.

**What's our vision for care of older people in Hillingdon?**

We've listened to older people and their carers and some of things they have told us that would make their care better include:

- those involved in their care talking to each other, sharing information and knowing what each other is doing.
- to only have to tell their story once.
- to feel their care is being co-ordinated.
- to have less visits from or to different teams/ departments/services.
- to receive the best possible care and to stay in their own home.
- to know who they can call if the need any help or advice and try to avoid needing to call out emergency services or be rushed to the hospital unless it's absolutely needed.
- If they do have to go into hospital then when they are discharged to have the information about their care shared with their GP and for services to be ready to support them on their return home.

In Hillingdon, we have been have looking at how we can work together in partnership to provide a more positive experience for residents/service users whilst delivering shared outcomes and a shared budget.

We want older people to experience joined up care, bringing together hospital services, community care and GP services that they may be using to form a partnership to provide a more proactive, preventative and supportive care plan.

**What is an Accountable Care Partnership (ACP)?**

In order to achieve the types of changes we'd like to see delivered for older people we are looking to introduce an accountable care partnership (ACP)as the vehicle through which deliver more integrated care.

An ACP is a partnership of organisations which:

- Is commissioned to jointly deliver an agreed set of outcomes
- Is accountable for end to end care of the population so that the resident receives a seamless offering across organisational boundaries
- Built around a registered population e.g. older people, children
- Functions at a scale sufficient to hold clinical and financial accountability for a population
- Makes decisions on resource allocation and performance within the partnership, sharing financial risks and benefits
- Embeds service users/residents in decision making and governance

Hillingdon CCG commissioning intentions for 2016/17 said:

*"We believe that high quality, integrated services can **best be delivered by accountable care partnerships** which have developed **appropriate models of care** for their population; which are commissioned to deliver **clear outcomes** for the different segments of the population; which **share accountability** for achieving those outcomes and which **share financial risks and benefits** through a capitated budget"*

A capitated health budget is one where the total allocated amount available for the population cohort's health care is held in a single budget.

The local STP plan outlines our intention to develop care models and supporting system enablers to encourage greater integration in the delivery of health care between the current separate providers, moving to a single outcomes based contract for people aged 65 and over, funded through a capitated payment.

**What is the ACP contracting model?**

In Hillingdon we are initially looking to deliver our ACP through an alliance contract model. This is a form of contractual joint venture. It does not create a new legal entity. It generally involves bi-lateral "pillar contracts" based on the NHS Standard Contract, with a separate multi-lateral alliance contract, the scope of which is flexible.

When entering into alliance contracting arrangements, the separate sovereign organisations remain, and appropriate delegations need to be made to those interacting between organisations at the governance forum created by the alliance contract.

The design of the governance arrangements under an alliance contract is flexible, however there are limits upon the decision making authority of the governance forum, which is dependent upon those participating in the governance forum, and the extent of their authority from their own sovereign organisations.

**Who are the current ACP partners in Hillingdon?**

In Hillingdon four provider organisations have come together to form a Hillingdon based ACP, commissioned by Hillingdon CCG to deliver better quality integrated services for older people in Hillingdon.

These partners are:

- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central and North West London NHS Foundation Trust (CNWL),
- H4All CIC, a federation of voluntary sector partners – Hillingdon Age UK , Harlington Hospice, DASH, MIND Hillingdon and Hillingdon Carers
- Hillingdon four GP networks, due to become Hillingdon GP federation from April 2017

Together as an ACP we are now named Hillingdon Health and Care Partners:

Hillingdon Health and Care Partners

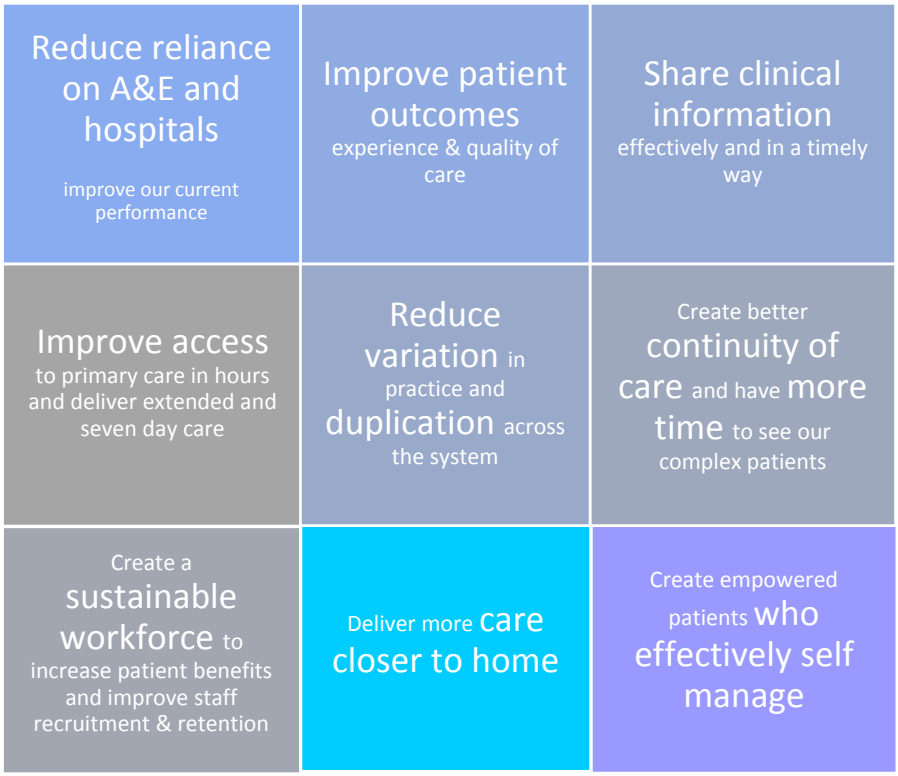
Although the Council is not formally part of the ACP, Adult Social Care and the Hillingdon Health and Care Partners have been working closely together where this will deliver better outcomes for Hillingdon's residents, e.g. delivery of the 2016/17 Better Care Fund Plan.

**What does our partnership in Hillingdon aim to achieve?**

Our aim is to establish a truly integrated health and social care system which:

- Addresses individual needs in a holistic way
- Offers more care in the community and in people’s homes rather than in acute hospitals
- Invests in prediction, prevention, early intervention and out of hospital services
- Joins up services across organisations and across care settings
- Adopts evidence based pathways
- Concentrates acute services to enable delivery of care in the most appropriate setting
- Offers better overall value for money

**The HHCP goals are to:**



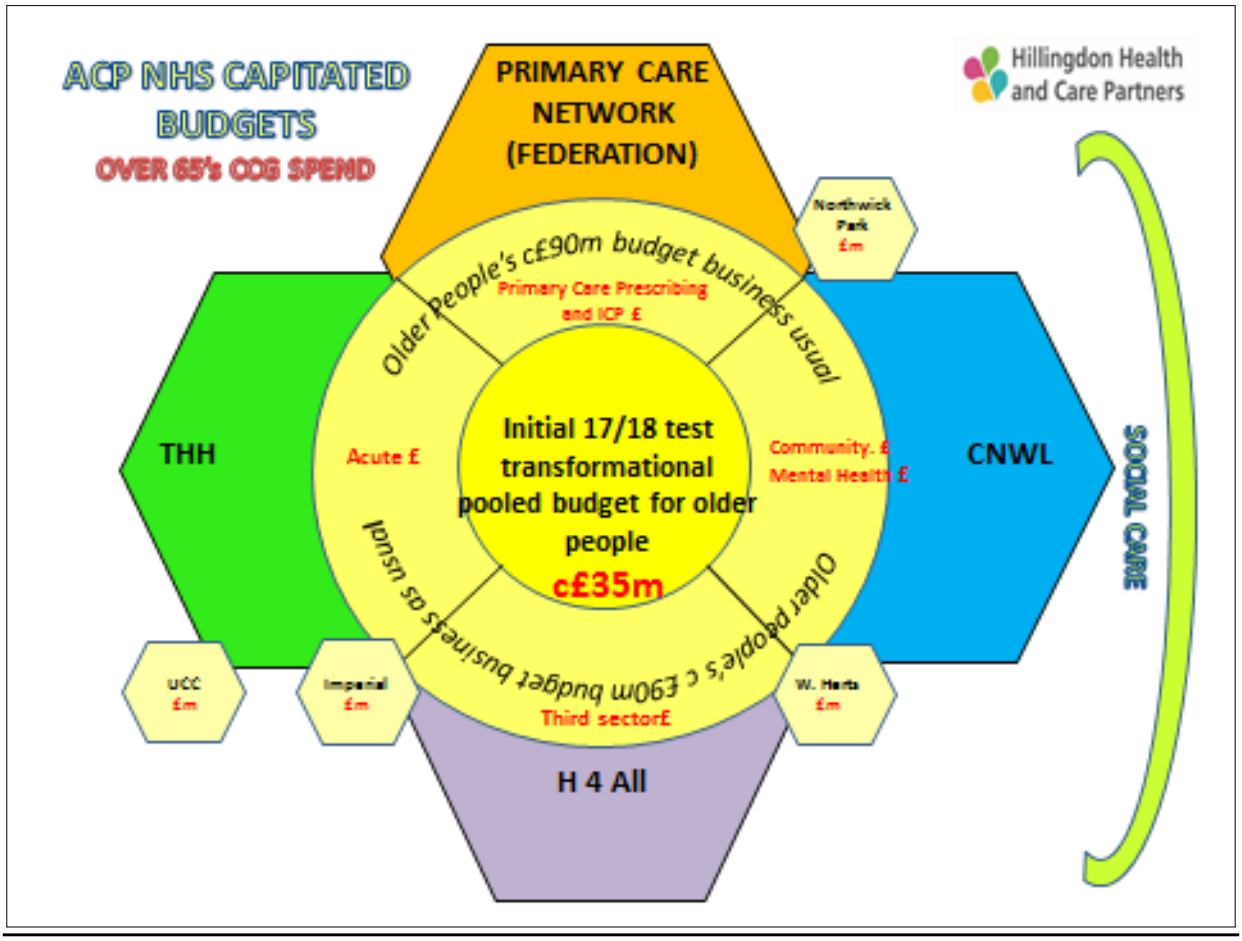

**What population group will the ACP initially cover?**

We have agreed that the first step of the alliance in Hillingdon is to focus on older people, over the age of 65.

The initial work on the capitated budget for this population group GP registered in Hillingdon is suggesting a value of circa £90m spend (15/16), though there is still work to be done on exact costs and scope of the envelope.

For 17/18 the providers have agreed to initially pool into the ACP, a range of service budgets which are specifically targeted at the over 65's that totals approximately £35m. However it is expected that we will monitor the impact on the full capitated budget for this client group (£90m) in order to test the concepts in advance of 18/19 when it is expected that we will be contracting for a full capitated budget for all people over 65.

**This picture aims to provide a simple illustration of the ACP model and budget we intend to pool (2017/18) in the dark yellow area, with the lighter yellow indicating the total financial value over 65's spend which will be monitored, with the intention of moving to a fully capitated budget in 2018/19 :**




**What will this mean for how care will change for older people in Hillingdon?**

Services in the initial alliance 'pool' include: care of the elderly wards and clinical teams at the hospital, community nursing and rehab services, rapid response, discharge teams, health and well-being services, primary care integrated care planning, end of life and palliative care.

These services are really key to the delivery of care for older people but we recognise that there is real scope for them to be delivered in more joined up and effective ways so that patients only have to tell their story once, that they are enabled to move out of hospital more quickly and be better supported at home.

A Clinical Design Group (CDG) is overseeing the development of a more joined-up approach to the way that the ACP partners work. Through a range of task and finish works streams work is underway to change care models which will reduce duplications, identify gaps and put the patient at the centre of their proactive care plan. We are working to ensure we have service users and carers involvement in this planning work and are going out to listen to people in Hillingdon whenever the opportunities present.

The core element at the centre of the Hillingdon model of care is the Care Connection Team (CCT). We aim to have 15 of these locality teams throughout the Borough. Each one will work with a very small group of GP practises (2-5 depending on list sizes) to identify those people at

greatest risk, to proactively plan their care to reduce risk of emergency admission and to enable people to remain in their own home as long as possible. The team will costs of the GPs, a senior Guided Care Matron and a Care Co-coordinator, liaising and involving a much wider range of health, social care and voluntary sector providers as needed.

Supporting this primary care model is the outreach of acute hospital services such as community geriatricians and specialist nurses. We are also working on the closer integration of arrange of smaller contracts to try and ensure that hospital and community services work better together to enable timely and effective discharge processes, as well as prevent the need for admission.

We then also have the newly re designed health and wellbeing services being delivered by our voluntary sector partnership H4All, working with individual and communities to improve self-directed care and reduce areas such as social isolation.

**So how does it work in real practice?**

We have been running two Care Connection Team pilots in the north of the Borough and this is a typical sample case study to show how it's working in practice**:**

Mr N is a 79yr old man who lives with his wife who is also his main carer. Mr N's GP had noticed an increase in his attendances to A&E and that he was making frequent calls made to the surgery requesting GP home visits. The Practice made a decision to refer Mr O to the Care Connection Team (CCT).

The CCT Guided Care Matron (GCM) went out that same day to conduct an initial assessment on Mr O. This determined that Mr N suffered from a number of health conditions which caused him anxiety and he needed some reassurance about his conditions. One of his concerns was the stoma bag he had, which he was having difficulty managing, and this was resulting in him going to A&E.

The GCM discussed and agreed a Care Plan with Mr N, which was then also discussed and agreed with his GP. This Integrated Care Plan was then out on Mr N's primary care clinical record.

Initially, the GCN conducted domiciliary visits with Mr N on a weekly basis to review his health concerns and alleviate any anxieties he had. In addition, Mr N was provided with a telephone number to contact the Care Coordinator should he experience difficulties with his anxieties in-between his planned appointments. The Care Coordinator would listen to his concerns, reassure him, and agree to ring him back later in the day until he became more confident.

Mr N's progress was discussed with the GP and Care Coordinator during the weekly 'huddle' meeting, which kept the GP regularly informed.

The CCT also referred Mr N to various other services including:

- Dietician- to help mitigate problems with the Stoma.
- Talking Therapy – to help with his low mood caused by worrying about his health problems.
- Social Services – to help provide more support, as his main carer (wife) was not managing well and needed a carer assessment.
- Weekly contact from the GP practice's over 75's GP service.

Mr N has had approximately 13 home visits by the GCN since being admitted onto the CCT caseload. Initially he was seen once a week, but with progress his visit frequency reduced and he is now being reviewed monthly by the GCN. It is anticipated that this will further be reduced to telephone contact with the Care Coordinator if the CCT deems this appropriate for Mr N's needs.

Since the involvement from the CCT Mr N has not had any A&E attendances or GP visit. He describes feeling much less anxious and more able to cope. The CCT has been able to reduce the number of admissions through support from using the GCN and Care Coordinator by phone calls and visits and referring him to relevant services.

**What's been achieved so far in 16/17?**

- **CCG support for transition costs to enable development of an HHCP development team**. Programme director & officer roles including information and finance roles and senior clinical leadership capacity

- **Introduction and delivery of the new clinical model**
    - evaluation of two pilot Care Connection Teams in the north of the Borough next step is developing the 15 care connection teams across the Borough.
    - new community geriatricians are in post.
    - H4All wellbeing scheme started and using Patient Activation Measure (PAM).

- Overarching governance of the development is through the **ACP Development Board** which has membership of the Chief Executives of the four provider partners and the CCG.

- Progress is being made on building the **capitated budget model** including risk and gain share arrangements through the joint finance and contracting group with the CCG.

- **Provider-led sub work streams with work plans** are in place for workforce, legal, IT, information and finance and communications.

- There is now a **signed off Heads of Terms** by all partners. Next step is the Alliance Contract.

- The four GP networks have agreed to develop **a single Hillingdon GP federation** and the Chief Officer has been appointed.

- The providers have been using the NWL Change Academy coaching programme to **develop trust, relationships & approaches to problem solving and change.** Strong provider relationships in place and a real commitment to working together for the senior team. Hillingdon were selected to be part of the **NHSE's Accelerated Development Programme** designed to support progress in areas that show innovation and potential for integrated working and the CCG and Programme Director have been regular attenders at these workshops.

- **IT and interoperability**; NWL dashboard is being rolled out and used as part of risk stratification, Hillingdon hospital care record in place with CMC flag, working on how CIE can support integrated clinical service design.

**What are the current opportunities and risks?**

Is should be noted that whilst the Local Authority is not currently formally within the ACP partnership we would expect to work very closely to design and develop the outcomes and are very aware that the current pressures facing the social care system are going to be a key consideration in the design and delivery of integrated care for older people in Hillingdon. We are keen to have officers involved at all stage of our plans and to look at all opportunities to work more effectively and productively together.

**Financial issues**

- Primary care GP services that can currently be included are only those which the CCG directly commissions from our local practices. This limits their scale of involvement at this stage.
- The four providers are current contracts are different and the financial risks to each organisation for this partnership are different. Ongoing work is taking place to identify these and see how they can be best mitigated.
- The two FTs are both currently in deficit and therefore how the proposed capitated budget model is developed over a 5 year period to address QIPPs, inflation, demographic growth etc. will need to be considered.
- The more limited size of the proposed pooled budgets will limit the degree of transformational change that might be achieved and not be seen as sufficiently ambitious.
- We need to be able to model and measure/evaluate the impact of changes within this element of services on the wider health economy.
- The length of the contract will affect how much ambition there is to take risks on investment into radically new ways of working.

**Governance issues**

- The ACP providers are working towards an alliance partnership but recognise there is a lot of development work required to design the way it will actually work. It is a national area of learning and development and no defined model that is well tried and tested. Areas we are working through include:
    - risk share,
    - dispute resolution,
    - relationships with 'sovereign' boards,
    - lay involvement including the relationship with FT governors.
- Very tight timescale to get the Alliance contract agreed by April 17 – we have to take arrangements through the four sovereign boards and the CCG.
- HCCG will need to be assured that the ACP can meet the requirements of commissioners and will be able to deliver the contract and outcomes framework for integrated, high-quality and cost effective services. Commissioners also need to be assured that any alliance agreement is robust and sustainable over the proposed life of the contract agreement and enables substantial progress in ACP development and capability. This will involve the CCG carrying out a 'due diligence' assurance process prior to signing a contract for the 2017/18 testing year, addressing a number of key development areas in partnership during that year, including service integration and quality improvement, finance and capitation, risk and reward and capturing new developmental outcome measures, as well as carrying out a robust 'most capable provider' procurement process throughout 2017/18.
- Need to ensure robust clinical governance structure that works in integrated services
- Engaging and establishing relationships with the Council to consider how social care can become fully signed-up partners in the model going forwards.

**Clinical and workforce challenges**

- Capacity of stretched clinicians to be involved in service re-design.
- Making sure everyone knows what's going on and feels involved.

- Developing existing staff and recruiting, training and developing the new type of workforce needed to work in the new ways of delivering care.
- Involving service users/residents in service design.
- Individual organisational interests v commitment to a more integrated whole.
- The engagement challenge – to get all levels staff involved in integration and seeing this as part of how the ‘’day job’ is done.
- No new extra bridging funds to develop new models so have to ascertain appetite for risk to develop new arrangement within existing limits with expectation of significant savings in year 3-5.
- Need for more capacity to design and test the business case for the care model-modelling activity and costs.
- Ensuring services such as mental health, pharmacists etc. know about and join the integration.

## 4. FINANCIAL IMPLICATIONS

None in relation to this update paper.

## 5. LEGAL IMPLICATIONS

None in relation to this update paper.

## 6. BACKGROUND PAPERS

None but the Board is also referred to reports on this same HWB agenda on STP and the Hillingdon CCG update which reference the development of the Hillingdon ACP.