Brent	Health and Wellbeing Board 2016 Report from NHS Brent Clinical Commissioning Group
For information	
Report Title: Update on the development of an Accountable Care Partnership	

1. Introduction

1.1 This paper updates the Brent Health and Wellbeing Board on forms of Accountable Care Partnership (ACP) and local work to progress towards this model of service provision and delivery.

1.2 'ACP' is the term we use in North West London (NWL) to describe a group of providers jointly accountable for the planning and management of care and delivery of a set of shared population outcomes within a defined budget, for which they are held collectively accountable.

1.3 The ACP model developed drew on example and evidence of similar integrated care systems and provider models in place in Europe, USA and New Zealand. There are many models – with the Accountable Care Organisation (ACO) the most prevalent; however they all share a minimum set of characteristics – defined population, outcomes based contracts, capitated budget with risk/reward share agreements with commissioners.

1.4 An ACP is therefore a provider model designed to support the delivery of integrated health and social care – a partnership between providers offers opportunities to align objectives, overcome fragmentation in delivery systems and organise care around patient and carer needs (not service or geographical boundaries).

1.5 The commissioner role in developing an ACP model is to identify the challenges the partnership is being asked to overcome (and translate these into meaningful outcomes) and to consider how we might use contracting and payment mechanisms to incentivise joined up working and shared accountability, and ensure funding flows to where it is needed most in the system.

1.6 Below we summarise our work to date in Brent for the Health & Wellbeing Board:

- Background
- What model are we seeking for Brent?
- Progress to date
- Next steps for commissioners and providers
- Conclusion

2. Recommendations

2.1 The Brent Health and Wellbeing Board are asked to:

- Note the progress made towards an ACP/MCP in Brent.
- Confirm that the direction outlined in the report is appropriate and affirm organisational commitment.
- Agree the need for development of a detailed scope and plan
- Provide any initial comment on this and other next steps outlined - which will need to be undertaken during the period covered by the STP (2016/17-2020/21).
- Provide direction on any key messages that need communicating to Brent residents.

3. Background

3.1 The ACP model was first designed by commissioners, providers and lay partners in NWL under the Whole Systems Integrated Care programme (WSIC) – an NHSE 'Pioneer' programme for integrated care. Work commenced in 2014 by CCGs, Local Authorities and Providers and was expected to deliver within a 5 year timeframe.

3.2 The concept of jointly accountable provider partnerships as key to delivery of integrated care outcomes is now widely used and accepted in national policy. NHS England (NHSE) 'Vanguard' sites are developing these models. The Five Year Forward View (FYFV) notes *'decisive steps to break down the barriers in how care is provided'* will be taken and presents new provider models as a way to overcome the 'traditional divide' in health and between health and social care. This is also reflected in Sustainability & Transformation Plans (STP) and national planning guidance.

3.3 Two new models (configurations of providers) are presented – essentially national versions of an ACP model – and a legal and contractual framework is being developed for each. The two models are:

- **Multispecialty Community Provider (MCP)** - a primary care led provider model based around the GP registered list. The MCP would develop out of hospital teams to deliver proactive care to people with complex needs and chronic conditions. The workforce 'wrapped around' primary care might include nurses, therapists, pharmacists, psychologists, social workers and potentially consultants (for example geriatricians). More outpatient consultations and ambulatory care could be delivered in out of hospital settings, community-based diagnostics and treatment could be expanded and out of hours care could be managed differently.

There is also an emphasis on partnership with the voluntary sector and on self-care. The MCP would eventually be asked to take delegated responsibility for a capitated budget.

- **Primary and Acute Care Systems (PACS)** – this builds upon the lead/prime provider model by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. Where primary care is unable to deliver sufficient capacity hospitals will be permitted to open their own GP surgeries and registered lists with Foundation Trust investment supporting expansion of new style primary care. Again, a PACS could eventually take delegated responsibility for a capitated budget.

3.3 In either case, new provider models must deliver expanded and strengthened primary, out of hospital care and integrated care. They are frameworks through which we might achieve key outcomes e.g. moving beyond single unconnected 'episodes' of care to models that address a full range of needs, new career pathways and workforce models, improving quality and reducing variation, managing demand, reducing duplication/streamlining processes and achieving a financially sustainable system.

4. What model are we seeking for Brent?

4.1 The model of care designed under WSIC envisioned multidisciplinary teams wrapping around patients and carers in primary and community settings to deliver a proactive and coordinated end to end care pathway for adults with LTCs.

4.2 To achieve this primary care staff need to become adept at working with and securing input from different partners within a multidisciplinary team, operational managers must design and implement policies and procedures that work across traditional boundaries and leaders must develop a model of management and governance through which they effectively support and hold each other to account. The codesigned model aligns most closely to an MCP, however local areas will need to adapt and tailor these frameworks.

4.3 The MCP model is well suited to models of community based care for those with complex or chronic long term conditions. The MCP offers a framework through which to integrate a range of providers / services across health and social care. The 'whole systems' model of case management for adults with LTCs could evolve using the MCP framework. The MCP requires significant 'horizontal' integration – and learning from the last 18 months suggests this is challenging to deliver, with a large number of providers at the table, complex contracting and potentially complex leadership and governance structure. However, if delivered successfully with buy-in from stakeholders, an MCP is perhaps more likely to deliver partnership working, out of hospital outcomes & joint accountability.

4.4 The PACS model may be more suited to a new integrated urgent and emergency model of care. It may be easier to implement - working with a smaller number of large providers and a simpler financial model and operating model; however, it risks feeding demand for traditional hospital based care and our complex acute landscape

in Brent (with 4 acute trusts delivering services to Brent patients) could present implementation and delivery challenges not found in other areas of NWL.

4.5 Commissioners should revisit questions of function and form with providers and stakeholders as national contract templates become available. The draft MCP framework has already been released (with full contracts due to be released soon).

5. Progress to date

5.1 In 2014/15 and early 2015/16 there was a lack of partnership working between Brent GP Networks. Separate WSIC contracts were held (LTC care planning and case management) and 'shadow ACP' meetings were hosted by individual GP Networks. This made it extremely difficult for other partners to engage efficiently and effectively and jeopardised the development of a consistent offer to patients and carers.

5.2 Commissioners agreed a single contract for 16/17 aligned more closely to the strategic objectives of WSIC and Primary Care Transformation - which requires primary care providers to work together and develop the infrastructure / capability for at-scale 'accessible', 'proactive' and 'coordinated' care.

5.3 In response primary care providers formed a new joint venture - *Brent Care Ltd*. This primary care 'federation' represents the first stage of the 'horizontal' integration required for an MCP model. It means primary care can mobilise to provide services at scale and in common, make decisions on resource allocation and monitor quality and performance as a partnership.

5.4 *Brent Care Ltd* also offers a single route through which partners such as Social Work, IAPT and the voluntary sector might align.

- Social Work colleagues from the local authority Support Planning and Review team are now attending weekly/monthly multidisciplinary meetings.
- IAPT are building relationships & seeking to participate in weekly multidisciplinary meetings.
- Three local voluntary sector organisations (Living Well, Sufra, Mencap) have been subcontracted to provide Care Navigators and support the development of self-care and social prescribing within the model of care. CVS Brent is also involved, providing a 'front door' to the wider voluntary and community sector.

5.5 There is significant work to do, but important steps have been taken. WSIC is a platform on which providers can develop commercial relationships, come together to shape and manage multidisciplinary teams and develop a shared leadership and governance model, as a precursor to a more formal ACP/MCP model.

5.6 The CCG and Local Authority have committed to this model as part of Sustainability & Transformation Plan (STP) and are working closely together to explore a roadmap for Brent. There is work underway in the NWL Local Services team.

6. Next steps for commissioners and providers

6.1. The provider landscape in Brent is complex and we have to date lacked the bottom-up push for an ACP seen from providers in other areas of NWL. Our 'roadmap' to an ACP must therefore utilise and align to 'business as usual' commissioning, market shaping and systems leadership activity.

6.2. There is no additional funding to deliver the transformation required (with the exception of any STP funding that may be allocated); so we must align wider commissioning and contracting to deliver 'accountable care' objectives. Joint commissioning plans need to reflect an agreed scope, timetable and key messages to the market.

6.3 The end state for an ACP/MCP is a single contract and budget for a specific population defined by the GP registered list, with the provider partnership accountable for end-to-end care and inclusive of all functions required to deliver that. This requires a clear scope.

6.4 There has been high level exploration of scope, but further definition of outcomes and benefits sought, and mapping of services, pathways, activity, spend is required. Early example of MCP procurement (for example Dudley) seek a provider partnership to deliver multi-disciplinary teams that support people within homes and communities, enhance individual independence, prevent unnecessary admissions and facilitate prompt discharge. Once further defined, a Brent scope will need to be tested, communicated and agreed.

6.5 The Brent Community Services Review will be the vehicle through which we determine options to secure better integration between primary, community, social care and mental health services, as well as refine the scope of an ACP/MCP model.

6.6 It may be helpful to consider a local diagnostic for the provider market in Brent, examining the baseline position against key skills provider partnerships would need to deliver, for example:

- Planning and design of services,
- Internal 'procurement' capabilities e.g. subcontracting & due diligence
- Effective operating models and management frameworks
- Access to & use of data for quality and performance monitoring
- Governance processes - to allocate funds effectively and hold partners to account.

6.7 It may also be helpful to review implications for our commissioning cycle and processes across the CCG and Local Authority. The release of the MCP contract provides a next step for commissioners - it enables use of a formal process of competitive dialogue, or a mix of collaborative and competitive procurement, to procure end to end pathways. It also provides a framework through which we might shape the market (shaping a partnership and formally identifying providers who want to deliver this model).

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