Report for: Health and Wellbeing Board – 8 December 2016

Title: Developing an Accountable Care Partnership across Haringey and Islington

Organisation: Haringey Clinical Commissioning Group, on behalf of the Wellbeing Partnership

Lead Officer: Charlotte Pomery, Assistant Director, Haringey Council
Rachel Lissauer, Acting Director of Commissioning, Haringey CCG

1. Describe the issue under consideration

1.1 On the 3 October the Haringey and Islington Joint Health and Wellbeing Board endorsed further work to consider the development of an Accountable Care Partnership (ACP) that supports the outcomes sought by the Haringey and Islington Wellbeing Partnership.

1.2 This report provides an update to the Haringey Health and Wellbeing Board. It outlines how an Accountable Care Partnership could support delivery of our aims for the Partnership as well as providing a vehicle for delivery of the North Central London Strategic Transformation Plan (STP). It then reviews the key options and decisions that need to be made on organisational form and on the scale and pace of change.

2. Recommendations

2.1 The Haringey Health and Wellbeing Board is asked to:

a) Note progress with the Wellbeing Programme and the continued work to explore how an Accountable Care Partnership can support the Wellbeing Partnership's aims of taking a preventative approach to maintaining population health and wellbeing.

b) Discuss options on organisational form, governance and pace of change and consider what arrangements are most likely to enable the Partnership to drive efficiency and improve outcomes in the long term.

c) Discuss the role of the Health and Wellbeing Board in shaping the Wellbeing Partnership.

3. Timings

3.1 Work is underway to further explore the different aspects of developing an Accountable Care Partnership: finances; governance; pace of change and level of contractual formality.

3.2 A further update will be taken to the next Joint Health and Wellbeing Board in January. The Joint Health and Wellbeing Board will be asked to make recommendations which will be taken to statutory decision-making boards before April 2017.

4. Background information

4.1 Nationally and internationally health and care economies are challenging payment systems and organisational structures that present barriers to co-ordinated care; create a tendency towards treatment in expensive settings and prevent recognition of the inter-dependencies of health, mental health and social care. Across Haringey and Islington, there is an acknowledgement that these issues are shared and the organisations involved in the Wellbeing Partnership have already committed to a set of principles which begin to set out the basis for a new way of working.

- Partner organisations will work together for the benefit of local people;
- We will involve local people in our design, planning and decision-making;
- Partner organisations will find innovative ways to cede current powers and controls to explore new ways of working together;
- We will be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates;
- Partner organisations have agreed to find ways to 'risk share' during transformational change;
- We will find ways to share joint incentives and rewards;
- Partner organisations will make improvement by striving to be the best, together;
- We will be rigorous in ensuring value for money and financial sustainability

4.2 Our goal in designing an Accountable Care Partnership is to move to a position where councils, healthcare commissioners and providers take collective responsibility for meeting the health (physical and mental) and care needs of our population across the two boroughs in the long term.

4.3 The Wellbeing Partnership has established a set of workstreams to explore the costs and opportunities of working together for particular high need population groups: children and young people; people with mental health needs; older people with frailty; people with learning disabilities; people with cardio-vascular disease and diabetes and people with muskelo-skeletal conditions (MSK). We are also looking at cross-cutting issues such as prevention and tackling the wider determinants of health.

4.4 These workstreams have begun to identify ways in which Islington and Haringey might work together to improve outcomes and value in our health and care system.

We are using this as the basis from which to consider whether a different organisational form is required to support delivery. We have also considered the emerging evidence from Accountable Care entities and vanguard sites nationally and internationally.

4.5 These lessons, together with our emerging priorities from the workstreams, are informing our priorities for developing an Accountable Care Partnership. However, there remain some key decisions to be taken which will influence the pace and nature of our work.

5. Lessons from Accountable Care Partnerships

5.1 The joint work that we have undertaken within North Central London, as part of the Sustainability and Transformation Plan, indicates that we face a significant affordability gap in the provision of health and social care now and over the next five years. We know that we need to work together systemically and systematically to improve efficiency and effectiveness. However, integrated care interventions such as multi-professional teams or case management, do not on their own improve outcomes and improve value. So, under strong leadership and mindful of our local needs, demand and resources, we need to be in a position to learn from other areas, to apply the lessons to our local landscape and to build on the characteristics observed in successful accountable care partnerships:

- Taking responsibility for the full budget associated with a population, with a risk / gain share in place to create incentives to address need, manage demand and share the risks of population growth or activity increases
- Using information and analysis about the population to predict health and care need and inform planning
- Developing strong and clear links between primary care physicians who can co-ordinate all medical care for high-risk patients and community services and specialist teams
- Focusing on the small proportion of people who account for a high proportion of use and targeting interventions
- Developing case management programmes for people with multiple chronic illnesses
- Sharing access to the clinical information about the patient, regardless of where previous treatments and care was delivered.

6. Learning from the workstreams

6.1 The way we organise health and social care across the system going forward needs to position us to respond to some of the very real pressures we face. The fragility of the care market, for example, is putting considerable pressure on the availability and affordability of high quality domiciliary, residential and nursing care. This in turn is having a significant impact on some of the most vulnerable people within the population and is particularly affecting those at risk of requiring hospital care or

needing to be safely discharged from a stay in hospital or an inpatient mental health unit.

6.2 Workstreams within the Wellbeing Partnership are considering how we best respond to these present and growing pressures. Overall our approach must be to work together to build strong communities; focus on prevention; improve sign-posting to and availability of non-statutory services and to improve the pathway into high quality, efficient services for those who need them.

6.3 **Building strong communities through taking a whole population approach:** We are adding further strands of work to the outcomes identified in the Sustainability and Transformation Plan for children and young people, notably Reducing Childhood Obesity and Achieving a Good Level of Development, to create a programme focused on ensuring that our work with children and young people both supports better outcomes for families in the short term and builds a healthier population for the longer term. This work will engage with early years providers and schools, for example, to strengthen health and wellbeing for all children and young people.

6.4 **Managing demand by building communities around practices:** In 'vanguard' sites and internationally there is an emerging tendency to focus on relatively small populations (c 50,000) as the basis of planning and as the locus for multi-professional teams. This is reflected as a strong ambition within the North Central London STP through the plan to establish 'Care Closer to Home Integrated Networks'. These are designed both to 'house' and coordinate multi-professional community services and to provide a practical locus of support for individual GP practices to support the delivery of a consistent quality standard and offer to all patients.

6.5 The emerging thinking from our work-streams for diabetes/CVD, for frailty and for mental health is that a key goal of the Wellbeing Partnership would be to test and learn from the establishment of hubs. These hubs would be responsive to the particular requirements and demographics of the population served. They would have a focus on supporting the delivery of a common standard of care across general practice. They would carefully test the impact of a more pro-active; preventative and co-ordinated offer for patients. The costs of care and outcomes for the population within the network would need to be managed carefully and monitored over a number of years to evaluate impact.

6.6 **Consolidating the services available outside hospital:** Haringey and Islington would work together to maximise the availability of our care for people who are at risk of admission to residential care or hospital, both mental health and acute. This is likely to involve extending services (such as rapid response) that are effective and considering scope for efficiencies in how they are provided. It will involve sharing capacity to manage and develop the market for domiciliary and residential care. Together we will take a strategic and joined up approach to Intermediate Care, to improve the resources we have for assessment and to share access to

step down and rehabilitative facilities. This common approach would apply across a range of population groups, for people with learning disabilities as well as for people with mental health needs and the frail elderly.

6.7 **Prevention**: A shared approach towards prevention could allow us to scale up the work that is happening across both Boroughs. We would look to work together on mental health and employment; extending the scope of the obesity alliance and working jointly on case finding and preventative approaches towards cardio-vascular disease and diabetes. Working together could involve public health teams working together to deliver shared schemes and combining analytical resources and expertise where appropriate.

7. Emerging points for discussion

Formalising the partnership

7.1 The Wellbeing Partnership is currently based on a community of interest and agreement between organisations of a set of principles and common approaches. It has grown out of a shared understanding of local need, demand and the impact of increasingly pressured resources. It constitutes a programme of work that has been approved by the Health and Wellbeing Boards as well as Governing Bodies and Trust Boards. The programme is overseen by the Chief Executives of the organisations involved.

7.2 If we are to move towards taking responsibility for population health and for the overall budget associated with health and care, we are likely to need to formalise this relationship and the roles and responsibilities within the Partnership.

7.3 The Wellbeing Partnership has a number of options before it about the degree of formality with which organisations come together and the timescales for any new developments. If organisations wanted to achieve a degree of shared accountability and responsibility whilst taking a 'light touch' approach and leaving existing contractual arrangements largely intact, we might look towards a 'virtual' alliance. Here, organisations would agree a shared vision; shared commitment to how we use resources together; agreements of how service delivery will be implemented and shared governance. New contracts could set out which services and budgets would be approached together and could define common outcomes that we are working towards. However, we would not be setting up a 'new' or distinct organisation or entity.

7.4 There are more radical approaches. Some vanguard sites are now moving towards establishing an Accountable Care Partnership as a distinct entity, taking on a contract for the management of the budget associated with health and care, with responsibility for delivering improved outcomes. This has implications across the board and would require significant input from statutory boards, residents and stakeholders who would need to be able to shape and influence this over time. It has advantages of conceptual and contractual clarity and may well be the clearest

way of achieving impact. However, it carries risk of failure due to complexity, particularly the difficulty of agreeing budgets, outcomes and how to apportion risk. It also puts a focus on the task of defining contracts and roles rather than working together on delivery.

Governance

7.5 If organisations were prepared to move from a programme approach into working together in a more formal way on implementation and delivery as well as making shared decisions about spending, then decision-making and accountability structures need to support this approach.

7.6 If the Wellbeing Programme were to start functioning like an Accountable Care Partnership, consideration would need to be given to an executive structure that could take responsibility for any shared functions, such as the delivery of 'care closer to home networks' or consolidation of out of hospital services. This might require the formation of a board which would be likely to need non-executive, independent as well as clinical or professional input. It would need to be clear whether a board had any areas of delegated responsibility or whether it was advisory and remained accountable to statutory bodies in all decisions.

7.7 Over time, certain budgets might be identified to be aligned (managed alongside each other transparently) or pooled (fully merged). If budgets were to be brought more closely together, roles are responsibilities for budget managers would need to be set out. In all cases it would need to be clear exactly how decision-making would be scrutinised.

Engagement

7.8 Residents, stakeholders and service users must be able to influence the shape and direction that is taken with this work. There have been several events held with clinical staff to discuss the Wellbeing Partnership and it has been discussed within the Haringey patient forum, the Haringey Voluntary and Community Sector Forum and the Co-Production Steering Group. There has also been stakeholder involvement through the workstreams. However, further discussion and engagement would be needed around any plans to alter structures for delivery; budgets or routes for decision-making.

7.9 Communication leads from all organisations involved in the Wellbeing Partnership are now meeting regularly to plan and structure this engagement

Health and Wellbeing Board Role

7.10 It is key that the Health and Wellbeing Board, as the statutory body that brings together health and council decision-makers, continues to influence and steer the path of the Partnership.

7.11 The Wellbeing Partnership has a potentially significant role to play in supporting delivery of the Haringey Health and Wellbeing Strategy. It is important that the Haringey Health and Wellbeing Board is assured that any Accountable Care Partnership is shaped so that it increases the pace and degree to which the strategy can be delivered.

8. Conclusion

8.1 Between January and April 2017 there are some key decisions to be made about the degree of ambition for the Wellbeing Partnership. Organisations would need a clear mandate to move towards becoming 'accountable' for health and care outcomes and spend.

8.2 The views of the Haringey Health and Wellbeing Board are sought on the degree of ambition and the pace of change that is required.

8.3 To date, work on organisational form and structure has been undertaken by the Strategy Leads from organisations represented in the partnership. Sub-groups are now being established to work in December and January on the detailed proposals around governance, finance and engagement.

8.4 The Health and Wellbeing Board is asked to discuss its priorities and to consider its role in relation to the Wellbeing Partnership.