# DRAFT

# BERKSHIRE WEST ACCOUNTABLE CARE SYSTEM STRATEGY

## 1.0 Introduction

The Berkshire West Accountable Care system comprises all the NHS organisations in Berkshire West: Royal Berkshire Foundation Trust, Berkshire Healthcare Trust (which serves the whole County of Berkshire) and the four CCGs. It also includes primary care providers, represented by four primary care provider leads. The ACS has been in operation in shadow form since 2015.

The ACS works with the three unitary local authorities through a well established integration programme: the Berkshire West 10. From April 2017 one of the local authority Chief Executives will join the ACS Leadership as a step towards the long term vision of bringing the two programmes into a single ACS covering health and social care serving the people of Berkshire West.

## 2.0 Aims

The purpose of the ACS is to bring together all partners to apply a single capitated budget to meet the health and care needs of the people of Berkshire West. The ACS will use the opportunity afforded by new contractual forms and payment mechanisms to incentivise the system to deliver optimal care pathways that improve outcomes and reduce overall cost. The new service model is underpinned by a collaborative and efficient approach to back office functions, estates and a common digital strategy. The system will work together to maximise the shared workforce in Berkshire West.

The high level aims of the ACS are:

- increasing the emphasis on primary prevention, health and well-being;
- improving the quality of care through better outcomes and experience for patients
- operating a financially sustainable system.

## 3.0 Service Model

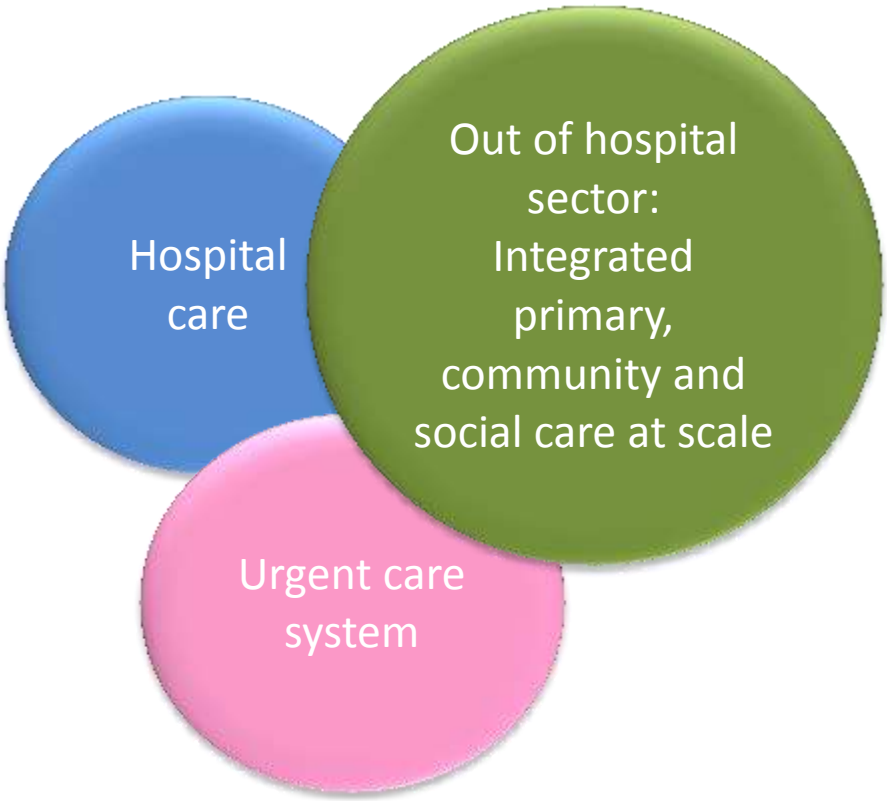
The ACS will deliver a programme of transformational change that seeks to impact on both physical and mental health service delivery in three key areas:

The out of hospital sector: primary, community and social care

The urgent care system

Planned hospital care

Mental health services




In delivering its aims the ACS will transform the ***out of hospital sector*** so that primary care is provided at scale by groups of practices working in resilient and cost effective hubs with wrap around community health, social and voluntary sector care. These hubs will be supported by consultants such as community geriatricians, community diabetologist and respiratory physicians creating a "channel shift" from hospital based to community based care.

The primary care hubs will take a population management approach providing universal services to the whole population to:

- help people stay well and manage their own health
- use a risk stratification approach to identify and pro-actively manage people with ongoing physical and mental health needs, such as diabetes or dementia, ensuring the coordination of care between partners
- build on award winning diabetes programme to develop a community respiratory service
- provide an extensive range of services, including end of life care, to the small group of patients who have very high health needs and are at risk of emergency admission using the current anticipatory care panning approach
- continue to ensure that everyone in a nursing or care home has an anticipatory care plan and maintain and further develop community geriatrician and rapid response services to help people remain within their care setting
- co-ordinate a resilient and integrated community health and social care service
- provide bookable appointments 7 days per week

- respond to people with urgent care needs, potentially evolving to a system where are all urgent care needs are triaged by NHS 111 and referred to the primary care hubs as required

The ACS will transform the delivery of ***urgent care*** by:

- the reprocurement of a new NHS 111 service which will commence in October 2017. This will provide a single point of entry for anyone with an urgent care need. It will be supported by an extensive clinical team who can robustly assess, advise and discharge or onward refer patients to the most appropriate service.
- the expansion of access to primary care and the "streaming" of urgent care within the primary care hubs.
- proactive management in primary care of high intensity users, supported by digital tracking of this cohort
- Review of the current MIU and WIC in line with national Urgent Treatment Centre protocol
- maintaining and increasing hear and treat and see and treat by the ambulance service
- maintaining streaming at the front door of the hospital and further developing ambulatory care
- ensuring the right bed stock across the system to support patient flow
- ensuring swift discharge by implementing the trusted assessor and discharge to assess approaches and providing a range of resilient community health and social care options

The ACS will transform the delivery of ***planned hospital care*** by:

- ensuring that those patients most likely to benefit are offered surgical intervention and that they are fit for surgery at the point of referral/treatment
- fundamentally reviewing the purpose of out patients and developing alternative delivery models with a view to reducing current out patients by 10%
- taking a "prime provider" approach to large specialties, starting with MSK, so that the prime provider can provide an optimally efficient patient pathway coordinating a supply chain of providers and making best use of all the assets in the health economy
- transferring current hospital activity to the primary care hubs through consultants working alongside GPs and nurse specialists
- ensuring the ACS delivers the requirements of the national cancer strategy and the national maternity review

Whilst the same principles of promoting well being and supporting people in primary and community based settings apply to mental health, the ACS will further transform ***mental health*** by:

- Expanding availability of direct access talking therapies
- Establishing a 24/7 mental health liaison service in A&E
- Expanding crisis response and home treatment services
- Developing a café haven service in the community
- Use secured transformation funding to develop perinatal mental health services
- Reduce delayed transfers of care from Prospect Park Hospital and in turn reduce out of area placements
- Develop a Berkshire wide Tier 4 CAMHS service co located with adult services

**4.0 Governance**

The ACS operates within the existing statutory framework which means that the CCGs and foundation trusts currently remain the statutory accountable bodies in the health system. To develop a new approach to working together that transcends organisational boundaries health partners work within a Memorandum of Understanding. This describes the principles of collaboration agreed by partners. These include delivery of the aims of the ACS, an agreement to collaborate and co-operate through agreed governance structures to deliver change collectively, operate on a financial open book basis and develop a "group account", be accountable to each other and the local population.

The ACS has established a system of governance which comprises:

The ***ACS Leadership Group*** whose members are the Chairs and Chief Executives of each organisation, chaired by an independent Chair, set the ACS strategy, commit resource to deliver the ACS programme, monitor progress of the programme and take remedial action as required. From April 2017 a local authority Chief Executive will join the Leadership Group

The ***ACS Management Team*** whose members are the chair of the Clinical Strategy group, Directors of Finance and another executive director from each organisation, chaired by the CCG Chief Officer, are responsible for the operational leadership, management and delivery of the ACS programme.

The ***ACS Clinical Strategy Group*** whose members are the Nursing and Medical Directors of each organisation and the primary care provider leads, chaired by the acute trust medical director, set the direction for clinical service redesign, provide clinical leadership and oversight of the ACS programme and provide clinical advice to the ACS Management Team via the Chair.

The ***ACS Finance Group*** provides technical expertise to the ACS, leading the transformation of commercial arrangements and advising the Leadership Group on options for payment mechanisms that support delivery of the ACS programme and ensure that risk is effectively managed for all

parties. The Finance Directors prepare the group account for review by the Leadership Group. Appendix 1 shows the governance arrangements for the ACS.

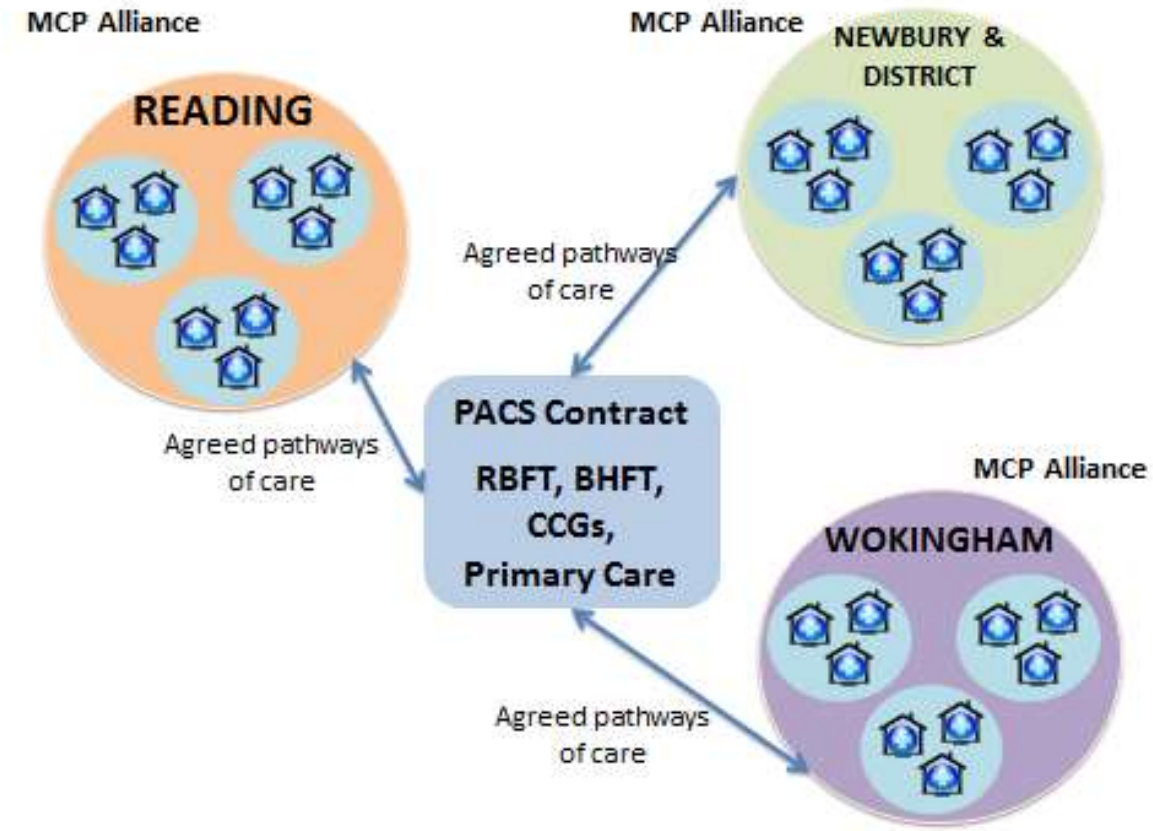
**5.0 Contractual form and payment mechanisms**

The Berkshire West ACS is actively assessing the new contractual options being developed by NHSE e.g. MCP and PACS. The ACS is working with the NHSE Commissioning Policy Unit to provide input and feedback as their work progresses.

In common with most systems it is unlikely that GP practices will be ready to give up their PMS and GMS contracts to become part of a fully integrated Multi Community Provider in the short term. However, the MCP Alliance Agreement is of interest to emerging GP hubs/clusters. This will bind the primary care sector to work together to deliver the primary/community care element of the ACS service model, co-ordinating community and social care resources and managing the elective and non elective interface with secondary care.

The ACS considers that the PACs contract may offer a more immediate opportunity to move to managing a single capitated budget or system control total. The partially integrated PACS would allow for a single contract for all services within scope holding a capitated budget, excluding core primary care budgets. The PACS would need to integrate with primary care, working along agreed care pathways, to ensure delivery of the ACS service model.

The diagram below illustrates how this might operate:



The ACS will review the new contractual forms, once published, with a view to moving to an innovative contract form in 2018. This will be contingent on the Integrated Support and Assurance Process (ISAP) run by NHSE and NHSI being completed in that time frame.

**6.0 Organisational form**

Existing NHS and Foundation Trusts can hold PACS contracts, possibly with one taking a lead role within the system. Other organisational forms such as Limited Liability Partnerships (LLP) or Community Interest Companies (CIC) can also hold PACS contracts but the VAT treatment remains unclear.

To date the BW ACS has determined that organisational merger is an unhelpful option as the transaction becomes the primary focus at the expense of the transformation of services. A further complexity is that BHFT serves a much wider catchment including Berkshire East.

In Berkshire West we have consciously used the term Accountable Care System (ACS) as the model includes some core commissioning functions as follows:

- Needs assessment
- Identification of priorities
- Service redesign
- Allocation of the capitated budget to care pathways
- Determining outcomes
- Performance management
- Quality monitoring

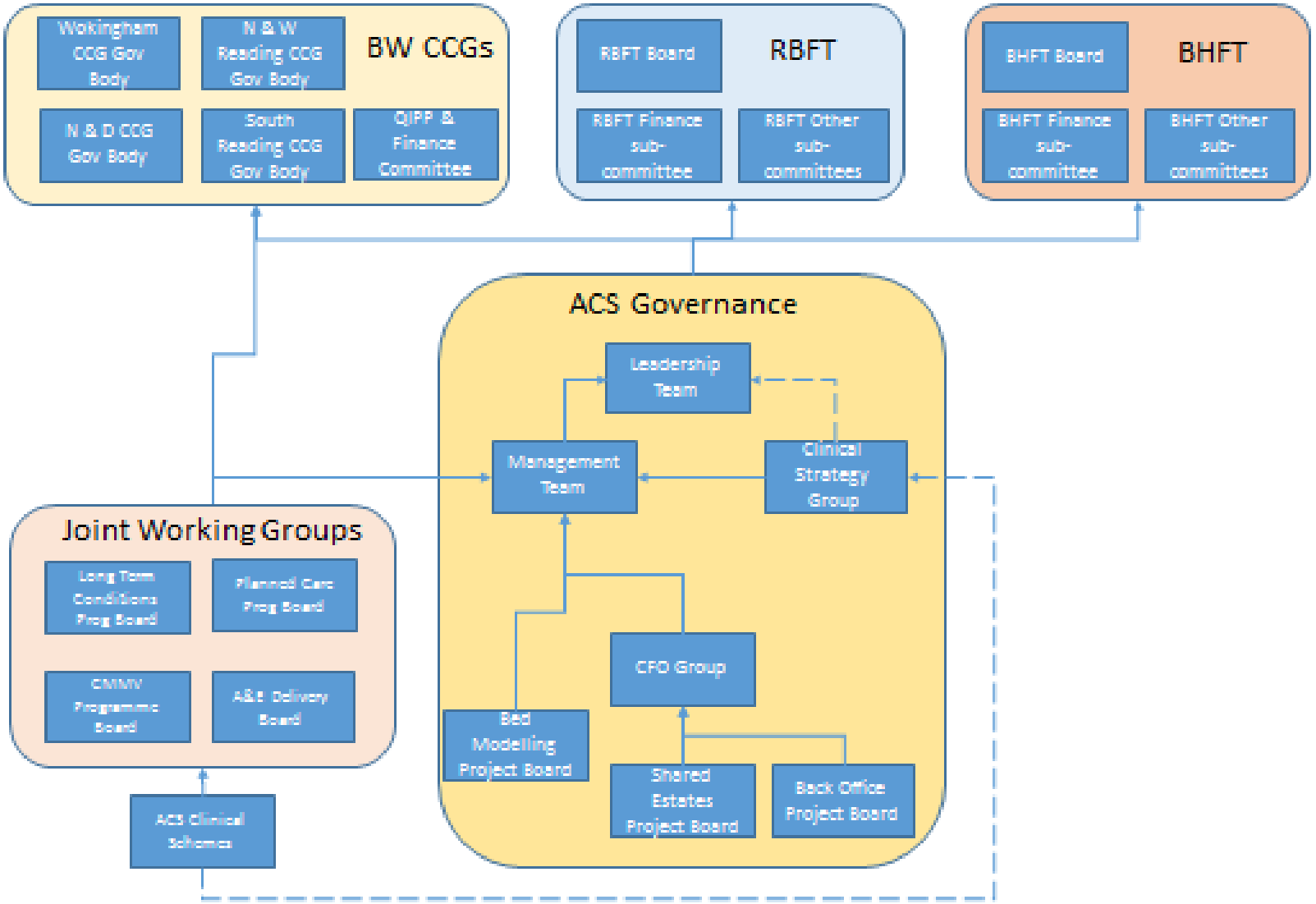
We believe that it is important for commissioners to play a key part within the ACS and not to stand to one side (as would be the case with a 'lead provider' or Accountable Care Organisation model). Commissioners will bring vital impetus and support including: strategic planning, needs assessment, identification of priorities, service redesign skills, setting and monitoring outcomes and quality and engaging with the public and key stakeholders.

It is acknowledged that this leaves a residual "thin" commissioning function, allocation of the system control total and assurance of delivery of the FYFV and constitutional standards, which could be delivered on a wider geography than the ACS. The emerging view is that this could be the STP footprints. This confirms the importance of the ACS of being in a geographically and strategically aligned STP. Greater clarity on the future direction of commissioning is expected during 2017/18 and the ACS will need to respond to this.

**7.0 Road map: Deliverables for 2017/18**

1. Begin implementation of the ACS service model by delivering the 17/18 agreed ACS programme
2. Implement robust programme management arrangements
3. Embed new governance structures
4. Monitor the impact of the 17/18 risk share with RBFT ( implemented via the marginal rate mechanism) to inform the payment mechanism for 18/19
5. Undertake an option appraisal and determine the most appropriate contractual form and payment mechanism to support delivery of the ACS strategy
6. Work with NHSE and NHSI to plan and undertake the Integrated Support and Assessment Process (ISAP)
7. Develop "group account" reporting in readiness for a system control total or single capitated budget
8. Review the organisation of commissioning as CCG functions shift to the ACS
9. Determine and commit to an STP configuration
10. Through the expanded membership of the ACS and the BW10 governance, review the opportunities for accelerated integration with social care from 2018 onwards
11. Develop an ACS OD programme to engage the wider workforce, primary care providers, partners and the public
12. Assess the programme against the ACS maturity assessment criteria: scope, population health, organisational form, culture of quality improvement, governance and leadership, primary care at scale, payment reforms, performance measures and digital transformation.

# Appendix


Wokingham CCG Gov Body
N & W Reading CCG Gov Body
BW CCGs
N & D CCG Gov Body
South Reading CCG Gov Body
QIPP & Finance Committee
RBFT Board
RBFT
RBFT Finance sub-committee
RBFT Other sub-committees
BHFT Board
BHFT
BHFT Finance sub-committee
BHFT Other sub-committees
ACS Governance
Leadership Team
Management Team
Clinical Strategy Group
CFO Group
Bed Modelling Project Board
Shared Estates Project Board
Back Office Project Board
Joint Working Groups
Long Term Conditions Prog Board
Planned Care Prog Board
CMMV Programme Board
A&E Delivery Board
ACS Clinical Schemes