The Wolverhampton Accountable Care System

Strategic Outline Case

March 2017
Foreword
As a NHS provider chief executive of over 30 years I believe that the NHS as a whole has risen to the challenge of increasing demand, rising public expectation and cycles of financial constraint. However the current challenges faced by the NHS are unprecedented in scale and compel us to think very differently about how we provide services. The NHS Five Year Forward View set a blueprint for disruptive innovation and the need to integrate primary care services with community, acute and mental health services.

In June 2016 the Royal Wolverhampton Hospital Trust (RWT) and a group of GPs came together in a ground breaking Vertical Integration (VI) Programme. Our ambitions were to provide a new value proposition to patients by:

- supporting, championing and investing in primary care
- redesigning service delivery with the combined intelligence of an unified clinical workforce of primary, secondary and community clinicians with aligned financial incentives under one umbrella
- redistributing resources away from hospital based services to primary and community care services

In the intervening period the VI programme which is clinically assured by NHSE has started to deliver and provides a glimpse of what can be achieved in a short space of time when everyone is working together in the best interests of patients. Emerging data from national PACs and MCP vanguards further supports this.

This document sets out the rationale for a provider led Accountable Care Organisation (ACO) in Wolverhampton and surrounding areas. The Next Steps to the NHS Five Year Forward view published in March 2017 calls for accelerated integrated working and ACO progression where there is the leadership to do so. This document is RWT’s response to the Next Steps.

The working definition of an ACO is a provider led organisation responsible for the delivery of healthcare for a defined population under a capitated budget. One of the major reasons and strongest arguments for capitating providers is to align financial and clinical incentives. This transfers risk to large organisations like ours and forces us to start to think about cost of care received by patients, where it is received and the appropriateness of it. Under the current system of PbR and the internal market the incentive is to provide more care rather than better care.

If the NHS is to survive another 30 years we need to provide better integrated care in a more efficient and timely manner. This document sets out a vision of developing an Accountable Care Organisation (ACO) in Wolverhampton and surrounding areas and it will mean that many conversations will need to be had with a range of stakeholders. The conversations need to be wide ranging, challenging, thought provoking and but must lead to taking action quickly. I look forward to having these conversations with you.

David Loughton CBE
Chief Executive
This report was prepared by EY. In carrying out its work and preparing this report, EY has worked solely on the instructions of Royal Wolverhampton NHS Trust and for Royal Wolverhampton NHS Trust’s purposes. Our report may not have considered issues relevant to any third parties. Any use such third parties may choose to make of our report is entirely at their own risk and we shall have no responsibility whatsoever in relation to any such use.
Introduction
This Strategic Outline Case (SOC) considers potential options for the development of an Accountable Care Organisation (ACO), serving the people of Wolverhampton and parts of South Staffordshire. This is the area served by the Royal Wolverhampton NHS Trust (RWT).

The SOC:

- describes the local health economy
- provides a case for change
- carries out an initial options analysis against defined criteria
- describes an emerging service model
- considers accountability and governance arrangements
- sets out the next steps towards implementation

Strategic Context: The local health and care economy
This section provides context on the health and care economy of Wolverhampton and South Staffordshire.

Wolverhampton CCG
Wolverhampton CCG serves a registered population of 265,636\(^1\) made up 46 practices within the city. The city has high levels of poverty and 52% of the population live in the 20% most deprived areas in England and about 30.2% (15,000) children live in poverty. Local Public health priorities include reducing alcohol and drug abuse, managing dementia effectively, mental health and urgent care.

The CCG operates in partnership with the City of Wolverhampton council, working together on a five year lifestyle prevention plan for the population. The CCG is in discussions about the formation of a strategic CCG covering the Black Country area. It has opted to join the Black County and West Birmingham Partnership footprint in developing a Sustainability and Transformation Plan.

Cannock Chase
Cannock Chase CCG has a population of 132,019\(^2\). Deprivation is lower than the national average. However, life expectancy for men and for women is also lower than the national average. Local health priorities include the reduction of smoking and alcohol intake, reducing levels of obesity, reducing the number of early deaths from cancer, reducing the number of people with diabetes, increasing physical activity and promoting better nutrition.

\(^1\) Wolverhampton CCG Primary Care Health Strategy, 2016-2020
\(^2\) Number of patients registered at a GP practice, January 2017, NHS Digital
South East Staffordshire and Seisdon Peninsula
South East Staffordshire and Seisdon Peninsula CCG serves a population of 217,450.

- Life expectancy for both men and women in Lichfield is better than national average and there are relatively low levels of deprivation. Priorities include addressing inequalities in health, addressing the impact of alcohol, and supporting the ageing population.

- Life expectancy for both men and women in Tamworth is broadly similar to the England average. Deprivation is lower than the national average. Priorities include promoting healthy lifestyles, supporting young people, and ensuring young people and children have a good start in life.

- Life expectancy for men in South Staffordshire is higher than the national average. Deprivation is lower than the national average. Priorities include reducing obesity levels in children and adults, improving mental wellbeing and reducing social isolation.

Primary Care in Wolverhampton
There are 46 general practices in Wolverhampton. There has been an increasing drive to bring primary care together at scale to offer improved access to care.

In June 2016, RWT established a Vertical Integration programme, working with five general practices to provide more joined-up services to a population of 23,500. The programme is clinically assured by NHS England.

*Figure 1: Benefits of the Vertical Integration programme*

By vertically integrating, the trust and its partner practices looked to:

- Align incentives across the primary, secondary and community care. International experience has shown that this type of alignment can contribute to high levels of attainment of quality targets and over time reducing unwarranted clinical variation.

- Pool collective resources, providing budgetary flexibility across primary, secondary and community care.

- Act at scale on a defined population, managing long term conditions in a unified basis.

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3 Number of patients registered at a GP practice, January 2017, NHS Digital
• Improved ability to invest in staff and infrastructure in primary care
• Allow novel extended clinical and managerial roles across primary, secondary and community care

Through the programme, RWT has invested significantly in primary care. This has included:

• The development of analytical insight linking primary, community and secondary care data into a single live database
• Rationalisation of back office functions which has already released resources that have been re-allocated to patient care
• Enhanced use of Pharmacists, Allied Health Professionals (AHPs) and Physiotherapists
• Introduction of social prescribing clinics in all practices
• Enhanced cross-practice working
• Networked Patient Participation groups
• Appointment of dedicated RWT GP Primary Care Directors
• Development of a PhD programme in primary care

The early benefits include:

Improvements in Primary Care Access

• Full 5 day GP services- An important objective for VI practices is to improve patient access. The VI practices have increased opening days from 4.5 days to 5 days. The overall impact on primary care access is on-going but for illustrative purposes for the Alfred Squire practice (8,400) list size an additional 171 appointments per month have been offered

• Improved booked access in practices- the number of booked appointments per 1000 population has increased by 2.37%

Secondary Care Indicators (VI)

• There is a downward trend in ED attendances from these practices since September 2016 and Statistical Process Control (SPC) shows that 5 continuous data points of improvement at the VI practices. However further analysis is required to understand this apparent trend

• Emergency admissions from the practices are showing a reduction since post integration of circa 7%. When applying SPC to determine whether this reduction is statistically significant, it can be seen that 7 data points out of the last 8 are below the average which indicates some statistical shift. Further analysis is required to understand this apparent trend

The Vertical Integration programme has expanded and now covers nine practices serving a population approaching 70,000.

Other primary care initiatives in the Wolverhampton health economy include:

• “Primary Care Home One”, which brings together nine practices, serving approximately 55,000 people. It was chosen as one of 15 ‘rapid test sites’ across England to develop and
test the Primary Care Home model. This aims to redesign primary care around the health and social needs of local communities

- “Primary Care Home Two” brings together eight practices with an estimated population of 45,000 population

- 19 practices are aligned to the “Unity” Medical Chambers Model, with a population of just over 100,000. This model is a federation of primary care with practices developing federated working and shared care arrangements

- Four practices are unaligned to any collective initiative

A number of additional practices have expressed interest in joining the RWT Vertical Integration programme, extending the VI population base.

**Primary Care in South Staffordshire**

Cannock Chase CCG has 25 practices. The CCG has been taking forward a strategy to improve primary care. Issues include a shortage of GPs and a smaller number of registered patients per practice than the national average.

South East Staffordshire and Seisdon Peninsula has 29 member practices. The CCG has established a primary care committee to act as a decision making body for issues related to primary care, reporting directly to the Governing Body. The primary care committee will oversee the development of a primary care strategy to improve capacity, quality and capability.

A number of practices in South Staffordshire have also expressed interest in joining the RWT Vertical Integration programme.

**Royal Wolverhampton NHS Trust**

With an operating budget in excess of £521m for 2016/17 Royal Wolverhampton NHS Trust (RWT) is one of the largest acute and community providers in the West Midlands. The trust is the main acute and community provider for Wolverhampton and main acute provider in South Staffordshire. It is also a significant acute provider for Walsall.

The trust provides acute and community services from the following locations:

- New Cross Hospital- secondary and tertiary services including cardiothoracic surgery, cardiology (including primary PCI), oncology, haematology, gastroenterology, gynaecology, paediatrics, ophthalmic, renal, respiratory, urology, trauma and orthopaedic, stroke, care of the elderly, maternity, Accident & Emergency, critical care and outpatients

- West Park Hospital- sub regional neuro rehabilitation centre and day care services, therapy services and outpatients

- More than 20 Community sites- community services for children and adults, Phoenix Walk in Centre and therapy and rehabilitation services; and

- Cannock Chase Hospital- Minor Injuries Unit (MIU) Walk in Centre general surgery, orthopaedics, breast surgery, urology, dermatology and medical day case investigations and
treatment (including endoscopy). Cannock Chase was acquired in November 2014 as part of the disaggregation of Mid Staffordshire Hospitals NHS Foundation Trust and has since been re-developed as an elective centre.

**Associated NHS community and mental health providers**
The following organisations have a potential role in the development of an accountable care system in Wolverhampton and South Staffordshire.

**Black Country Partnership Foundation Trust**
Black Country Partnership Foundation Trust (BCPFT) is provider of mental health, learning disability and community healthcare services in the Black Country. In December 2015, BCPFT entered a "Transforming Care Together" partnership with Birmingham Community Healthcare NHS Foundation Trust (BCHFT) and Dudley and Walsall Mental Health NHS Partnership Trust (DWMH). The three organisations are exploring actively how they might integrate as a single organisation. They have set up a number of clinical workstreams, including: CAMHS and early intervention; Children's. Early Years and Health Visiting; Learning Disabilities; Older Adults Mental Health and Adults Mental Health.

**Staffordshire and Stoke-on-Trent Partnership NHS Trust**
The Staffordshire and Stoke on Trent Partnership NHS Trust is the UK’s largest provider of community health and adult social care services and is responsible for adult social and community healthcare within Staffordshire. The trust serves a population of 1.1m people and employs more than 5,000 staff.

**South Staffordshire and Shropshire Healthcare Foundation Trust**
South Staffordshire and Shropshire Healthcare Foundation Trust (SSSFT) provides mental health, learning disability and specialist children's services across South Staffordshire, including Cannock. It also provides some services on a wider regional and national basis.

Staffordshire and Stoke-on Trent Partnership NHS Trust and South Staffordshire and Shropshire Healthcare Foundation Trust are in discussions about a merger.

**Local authorities and other partners**
Wolverhampton CCG operates in partnership with the City of Wolverhampton, working together on a five year lifestyle prevention plan for the population. The CCG is in discussions about the formation of a strategic CCG covering the Black Country area. It has opted to join the Black County and West Birmingham Partnership footprint in developing a Sustainability and Transformation Plan.

Cannock Chase CCG and South East Staffordshire and Seisdon Peninsula share a single management team with Stafford and Surrounds CCG. The three CCGs were part of an integrated Sustainability and Transformation Plan with Stoke-on-Trent CCG. Across Staffordshire, a partnership has been developed to provide strategic leadership across the local health and care economy. CCGs work in a locality approach with partners such as the district council, public health and the police. Cannock
Chase CCG is aligned to Cannock Chase District Council. South East Staffordshire and Seisdon Peninsula CCG serves localities of Tamworth Borough Council, Lichfield District Council and South Staffordshire District Council.

The Case for Change

NHS struggling to manage demand
The NHS is struggling to respond to rising demand for its services and its senior leaders are increasingly concerned about service provision. The King's Fund Quarterly Review published in March\(^4\) reported that 63% of trust finance directors and 56% of CCG finance directors believe that care in their local area has deteriorated over the past year.

A recent King’s Fund report\(^5\) concluded that “General practice is in crisis”, reporting a substantial increase in workload over recent years which has not been matched by growth in either funding or workforce:

- Total direct face-to-face and telephone contacts with patients increased by 15.4% across all clinical staff groups between 2010/11 and 2014/15
- During the same period, the average patient list increased by 10 per cent. However, the GP workforce grew by only 4.75% and the practice nurse workforce by 2.85%
- Funding for primary care as a share of the NHS overall budget fell every year in the period

Practices are finding it increasingly difficult to recruit and retain GPs. GPs reaching the end of their careers are choosing to retire early in response to unprecedented workload pressures. They have also been affected by changes to the tax treatment of pensions which create disincentives to work when the lifetime allowance for pensions has been reached.

The acute sector is also facing a rising demand for emergency services. A&E attendances and emergency admissions from A&E increased by 3% between the third quarter of 2015-16 and 2016-17. This equates to an additional 186,300 A&E attendances and 36,180 emergency admissions across England, a continuation of a long-term trend. At RWT, emergency attendances went up by 19% in the three year period July 2014-July 2016\(^6\), although the number of emergency admissions has stabilised and decreased slightly following the introduction of a new clinical model. There are also recruitment and retention issues among nursing and medical staff which now represent a significant risk for acute hospital providers in many parts of the country.

\(^4\) “King’s Fund Quarterly Monitoring Report” by Richard Murray, Joni Jabbal and James Thompson, published by the King’s Fund in March 2016

\(^5\) “Understanding the pressures in general practice” by Beccy Baird, Anna Charles, Matthew Honeyman, David Maguire and Preety Das, published by the King’s Fund in May 2016

\(^6\) A new Urgent Care Centre was opened in August 2016, so the dates chosen for comparison were for July
Further demographic and financial pressures

Demographic projections suggest that the NHS will need to manage more patients with multiple co-morbidities.

- The Office of National Statistics (ONS) estimates that the population of Wolverhampton will grow from 253,000 in 2014 to 260,000 in 2019 and 268,000 in 2024, an overall increase of 6%. The population of Cannock Chase will grow slightly from 99,000 in 2014 to 100,000 in 2019 and 102,000 in 2024, an increase of 3%.

- There will be particularly significant growth in the number of older people. ONS projects that the population aged over 65 in Wolverhampton will increase from 42,000 in 2014 to 45,000 in 2019 and 47,000 in 2024, an increase of 12%. The Cannock Chase population aged over 65 will grow from 18,000 in 2014 to 20,000 in 2019 and 22,000 in 2024, a 22% increase.

- As people age, they are more likely to develop long-term conditions. Obesity is an important predictor of long-term conditions a high number of people in the local area are obese. Published public health data\(^7\) reports that 30.3% of the population of Cannock Chase and 28.5% of the population of Wolverhampton are obese, against a national average of 23%. The Wolverhampton Cabinet Member for Public Health described the situation as “a ticking time bomb\(^8\)”.

The NHS and local authorities will not have the resources to meet this likely increased demand without radical and ambitious transformation.

The Black Country Sustainability and Transformation Plan estimates the financial shortfall across the area to be £521m by 2020-21. Local authorities in the area are anticipating a combined shortfall for social care of £188m in the same period. Similarly, the Staffordshire and Stoke Sustainability and Transformation Plan recorded a £286m financial gap by 2020/21, with an additional £256m deficit for social care.

The most likely prognosis is that, without change, NHS organisations will struggle to respond to demand and will not be able to address the long-term health challenges in the population. The failure to respond to those long-term health challenges will be a source of further pressure in the future.

NHS delivering fragmented care

There is significant evidence that the NHS is currently delivering fragmented care, which has an impact on a patient’s outcomes and on the sustainability of the health system.

The following illustration sets out the combined interventions for a single RWT patient over a period of two years. This analysis has been made possible through the Vertical Integration programme, allowing data to be shared between primary, community and secondary care.

The episodes represent a failure on multiple levels, including:

- poor experience for patient and family

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\(^7\) Public Health profiles for Cannock Chase and Wolverhampton, dated June 2015

\(^8\) Wolverhampton Express and Star, 21\(^{st}\) September 2015
- patient telling the story on many occasions
- multiple attendances to GP practice
- multiple attendances to hospital
- NHS being reactive in its response
- cost to the NHS in excess £35k over a two year period (just hospital activity subject to national tariff); it does not include the cost of primary care, community health care, social care or drugs
Figure 2: Breakdown of a single patient’s care interventions over a two year period
Alignment of incentives through integrating care

There is a clear realisation at the most senior levels of the NHS, and set out in the NHS Five Year Forward View and Next Steps documents, that the current NHS model requires reform.

The challenge of managing increased numbers of patients with long-term conditions can only be met through primary and secondary care clinicians working together effectively. The organising principle is redistributing resources from acute based care to primary and community settings which has been an overt ambition right from the outset of the Vertical Integration programme.

As Chief Executive of NHS England Simon Stevens has commented:

"We need to tear up the design flaw in the 1948 NHS model where family doctors were organised entirely separately from hospital specialists and where patients with chronic health conditions are increasingly passed from pillar to post between different parts of health and social services"

When analysing resource utilisation across the spectrum of healthcare primary and community care is modest compared to acute services, although primary care accounts for around 90% of NHS patient contacts. The trust reviewed total expenditure at its practices and found that General practice and community costs were between 20-30% with the remainder in the acute part of its organisation. As an example, the following chart shows the breakdown of spend associated with one practice in Wolverhampton.

Figure 3: Breakdown of spend associated with one practice in Wolverhampton, figures given in £000s

With unified clinical teams under a salaried model, underpinned by real time data and shared incentives the provider led ACO could work quickly to recalibrate expenditure to primary care and community where the bulk of patient contact occurs.

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9 [http://content.digital.nhs.uk/primary-care](http://content.digital.nhs.uk/primary-care)
NHS England has therefore set up a number of Vanguard initiatives to explore ways to bring care together, including Primary and Acute Community Systems (PACS) and Multi Specialty Community providers (MCPs). These care models encourage providers to work across traditional boundaries to deliver patient-centred care.

It is interesting to note that compared to their 2014/15 baseline both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England. Given sample sizes and duration it is important not to over-interpret the data currently available. However, comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%.

RWT has broken new ground by employing GPs and providing list-based general practice in addition to its traditional acute and community services. This has enabled the transfer of resource and capability from the acute to the primary care setting. As the trust also provides community services there is a real opportunity to deploy the unified clinical model rapidly in Wolverhampton. Early results are promising, with an apparent reduction in emergency admissions from the population served by Vertical Integration practices.

Accountable Care Organisations (ACOs) represent a further step-change. An ACO is a provider led organisation or collaboration responsible for the delivery of healthcare for a defined population under a global budget and with accountability to deliver agreed outcomes and quality measures. Simon Stevens has commented that several STP areas are moving to accountable care structures which will "effectively end the purchaser provider split".

A significant advantage of accountable care organisations is that they enable different elements of the NHS to work together within a shared financial envelope. Under the current arrangements, acute providers may not be financially viable if a significant proportion of their activity is transferred to primary and community care. Working within a single, unified structure provides a framework to transfer activity to the most appropriate setting, avoiding expensive specialist care by intervening early and co-ordinating care across care boundaries.

Properly executed, an accountable care system has the potential to reorganise care around a whole population approach, integrating the parts of the system which deal with the overall wellbeing and wider determinants of health, and thereby having a significant impact on long term health outcomes and expenditure, particularly in relation to chronic disease and lifestyle related conditions.

There is emerging evidence from US accountable care organisations that demonstrates that cost savings can be generated. While modest initially, these are likely to increase over time\(^\text{10}\). These savings are also associated with some increases in clinical quality and patient experience. There is

\(^{10}\) J.Michael McWilliams, Michael Chernew, Bruce Landon and Aaron Schwartz "Performance differences in Year 1 of Pioneer Accountable Care Organizations", New England Journal of Medicine, April 2015; and Zirui Song, Sherri Rose, Dana Safran, Bruce Landon, Matthew Day and Michael Chernew "Changes in Health Care Spending and Quality 4 Years into Global Payment", New England Journal of Medicine, October 2014.
also evidence that costs may be reduced by increasing the primary care orientation of medical groups within an ACO\textsuperscript{11} which is relevant to the efforts to integrate general practice into RWT.

\textbf{Alzira- case study of an Accountable Care Organisation}

In the Alzira Region of Spain, a concerted effort was made to integrate “La Ribera”’s hospital services into a new organisation “La Ribera-Health Department”. The new organisation provided services in a different way through health points, health centre primary care teams and integrated health centres. These services are provided at a lower per capita cost than the NHS.

The benefits include:

- a 13\% reduction in Accident & Emergency attendances over ten years
- an increase in the surgical day hospital rate of 10\% over the same period
- reduction in waiting periods for elective surgery and outpatient visits
- increase in patient and staff satisfaction

Alzira report that 80\% of their patients don’t know about the management scheme. Their conclusion is that the citizen is not concerned about who is managing but how it is managed.

“Before primary care was integrated with the hospital our model struggled. We were responsible for the health of the population but could not do it without full integration of primary and hospital care. Now that primary care, home care and hospital care are integrated we can fully manage our population’s health”. Alberto de Rosa Torner, CEO Alzira

\textbf{Options for an Accountable Care Organisation}

The scale of the challenges facing the NHS in the Wolverhampton and surrounding areas mean that radical change should be considered. As NHS England considers areas to develop as pioneers of accountable care organisations, local providers and commissioners can seek to place themselves in this leading group.

This section considers different organisational approaches to an accountable care system in the Wolverhampton and Cannock Chase area; assessing different service models against defined success criteria and considering the most appropriate geographical scope of a new model.

\textsuperscript{11} J. Michael McWilliams, Michael Chernew, Alan Zaslavsky, Pasha Hamed and Bruce Landon, “Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries”, Journal of American Medical Association, August 2013
Definition of success criteria
The following table sets out proposed metrics to assess the different options for proceeding.

Table 1: Proposed metrics to consider options

<table>
<thead>
<tr>
<th>Area</th>
<th>Proposed metrics</th>
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<tbody>
<tr>
<td>Health outcomes</td>
<td>• Reduction in health inequalities</td>
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<td></td>
<td>• Reduction in obesity over the life-course</td>
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<td></td>
<td>• Early identification and management of dementia</td>
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<td></td>
<td>• Reduce number of early deaths from cancer</td>
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<td></td>
<td>• Management of Long Term Conditions (LTCs)</td>
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<td></td>
<td>• Increase life expectancy</td>
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<tr>
<td>Quality of Care</td>
<td>• Reduction in A&amp;E attendances</td>
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<tr>
<td></td>
<td>• Reduction in Non Elective Admissions</td>
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<td></td>
<td>• Improved access to primary care, and increased satisfaction with primary care</td>
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<td></td>
<td>• Patient satisfaction with the end-to-end care experience</td>
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<td></td>
<td>• Staff perception at all levels that the quality of care in their area has got better, worse or stayed the same over the previous twelve months</td>
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<td>Financial benefits</td>
<td>• Financially sustainable local health economy</td>
</tr>
<tr>
<td>Ability to implement and derive benefits quickly</td>
<td>• Can the changes support the delivery of benefits in a meaningful timetable?</td>
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</table>

Options relating to the scoping of services within an ACO

i. **CCG-led devolution model:** This option would continue the mixed approach to service development in Wolverhampton, with local models developing independently. Over time, Primary Care Home One and Primary Care Home Two might develop as a Multi-Specialty Community Provider (MCP) with a delegated budget, working closely with RWT as the main acute and community provider in the area. RWT would continue to develop its Vertical Integration programme with practices

ii. **Provide an integrated acute, community and primary health system:** This option would focus on developing integrated community and acute services across the population. It would enable secondary care clinicians to work effectively with primary care clinicians to manage patients in the community. The main difference between this option and option i is that it would support a more consistent proposition across Wolverhampton and South Staffordshire. It would also engage RWT fully, so moving the model towards a Primary, Acute and Community System (PACS) where secondary clinicians brought their expertise to bear in a meaningful way in the community

iii. **Provide a full accountable care system through incorporating all of the different services, including mental health and learning disability:** This option would include mental health services within the accountable care system approach outlined in option ii above. This would increase the degree to which care was patient-centred. In particular, it would allow the ACO to address the care boundary between physical and mental health where there are
numerous opportunities for patient and financial benefit (for example, by improving mental health support at A&E, improved flow through the hospital for patients suffering from dementia and improving long-term complex disease management within community settings)

iv. **Incorporate social care into option iii**: This option would incorporate social care within the accountable care system, working in a totally integrated way with the local authorities. It is the most radical of the four options and has the advantage of bringing together the full range of health and care services
Assessment of the options against success criteria

This table then provides an initial assessment of the extent to which the options meet the defined success criteria.

Table 2: Assessment of the impact of different options against success criteria

<table>
<thead>
<tr>
<th></th>
<th>Option I- CCG-led devolution model</th>
<th>Option II- Integrated Primary, Acute and Community system</th>
<th>Option III- Accountable Care System, including mental health and learning disabilities</th>
<th>Option IV- Accountable Care system incorporating social care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health outcomes</td>
<td>Groupings of primary care would support improved health outcomes, though with a potentially fragmented offering</td>
<td>Support improved management of patients with long-term conditions</td>
<td>Would support delivery of integrated care around patient need, recognising link between physical and mental health</td>
<td>Would support delivery of integrated care around patient need</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Would support improvements in care quality through improved working between practices</td>
<td>Improved patient management would lead to improved quality of care</td>
<td>Significant reductions in hand-offs between different systems</td>
<td>Significant reductions in hand-offs between different systems</td>
</tr>
<tr>
<td>Financial sustainability</td>
<td>Would provide some financial benefits through efficiencies in primary care and managing patients out of the acute setting</td>
<td>Financial benefits from managing patients out of the acute setting</td>
<td>Has potential to reduce duplication and manage patients in the most effective care setting</td>
<td>Has potential to reduce duplication and manage patients in the most effective care setting</td>
</tr>
<tr>
<td>Ability to implement and derive benefits quickly</td>
<td>Iterative consolidation of primary care would develop over longer timescale</td>
<td>RWT already well placed to begin implementation</td>
<td>Mental health services would be block-contracted with existing provider, so would not complicate implementation significantly</td>
<td>Significant challenges of achieving full integration across health and social care</td>
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Based on the success criteria presented the preferred option at this stage is option 3. This is an accountable care system which supports physical and mental health across the different care settings. The complexities of implementing Option 4 make it not the preferred option at this stage. However, the consolidation of health services into a new delivery structure would facilitate joint working with social care.
Options relating to the scale of population encapsulated by an ACO

The next consideration is the appropriate scale of the accountable care system. The following table considers three options:

i. Concentrating on the practices in partnership with RWT (approximate population 70,000)

ii. A partnership across the City of Wolverhampton as a clearly defined geographical area (serving 265,000 people)

iii. An accountable care system covering Wolverhampton and South Staffordshire, where general practices in South Staffordshire wished to participate.

<table>
<thead>
<tr>
<th>Table 3: Assessment of options around geographic scale</th>
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<tbody>
<tr>
<td><strong>Option i</strong></td>
</tr>
<tr>
<td>Impact (so maximising reach)</td>
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<tr>
<td>Strategic fit</td>
</tr>
<tr>
<td>Deliverability</td>
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The proposed option at this stage is option 3, developing an accountable care system around the Wolverhampton, with general practices in South Staffordshire having the opportunity to join the new accountable care model.
Delivering the new service model

The move to an accountable care system must enable the delivery of improved services to patients that support improved health outcomes, improve the quality of care and deliver a financially sustainable health system. There must be a transfer of resource and capability from acute care to primary care, building on the success to date of the Vertical Integration programme. This transfer aligns with the principles of place-based commissioning, where the commissioning of services is coordinated in an area to achieve maximum benefit for the local population.

The development of the preferred option should take account of:

- The service model, which should build on existing initiatives but be further designed by clinicians and patients
- The implications of that service model for the workforce, information technology and estates
- Accountability and governance frameworks
- Delivery, financial and benefits plans

Delivering services in the new accountable care organisation

RWT has developed initiatives with the CCG and with local clinicians for improved multi-disciplinary working. These initiatives would be continued through the accountable care system as part of a new care model:

- A stronger emphasis on population health management, addressing the key public health challenges faced by the population. Public health would have a critical leadership role in the development of the accountable care organisation, focusing attention on issues such as obesity, smoking, alcohol and the high level of infant mortality in Wolverhampton

- Primary care services operating at scale, working in a coordinated way to improve access and to offer extended services. In Wolverhampton it is proposed that the existing primary care collaborations would be embedded into the accountable care system, developed further through improved multi-disciplinary working with RWT

- Service hubs which draw together primary, community and acute services. Four locations have been identified across Wolverhampton, in the City Centre, at Bilston, Warstones and Showell Circus. Each of these hubs will be built on land owned by the local authority. A further consideration is the identification of potential locations in South Staffordshire
Clinical multi-disciplinary teams will work together seamlessly from home to community hubs to hospital. This will build on the Vertical Integration programme between RWT and general practices which are already achieving significant benefits.

Deployment of academic excellence and research at pace and scale to deliver benefits on the ground for the population. RWT will develop a research programme working with the National Institute of Health Research (NIHR) of which RWT is the host organisation West Midlands Local Clinical Research Network (LCRN).

Engaging people and communities in pathway development

The ACO would develop a new, person centred care approach which:

- understands the position, needs and motivation of people and communities
- works with people and communities to hear their voices
- facilitates people and communities to increase knowledge, skills and confidence in managing their own health and care

Clinicians would work with patients and the broader community to refocus pathways around patient needs, taking both physical and mental wellbeing into account. The pathway development would build on existing work led by the RWT Medical Director as part of the Vertical Integration programme.
Current and potential pathways are:

- The Frail Elderly group, which would include the treatment of dementia
- End of Life care, enabling patients to die with dignity in a place of their choice
- Patients with multiple long-term conditions, including the support of patients with depression. A 2012 King’s Fund report identified that £1 in £8 spent on long-term conditions is linked to poor mental health and wellbeing
- Vulnerable adults, including support with learning disabilities
- Children, recognising the need for effective interventions to promote life-long physical and mental wellbeing

The pathways should also consider patient planned and emergency needs, and how patients navigate between the two. The following illustration sets out these different care settings.

---

12 Chris Naylor, Amy Galea, Michael Parsonage, David McDald, Martin Knapp and Matt Fosey "Long term conditions and mental health: the cost of co-morbidities", King’s Fund, February 2012,
Best practice research
In developing the new pathways, the service models will incorporate best practice research. A recent Nuffield Trust publication\(^\text{13}\) assessed the evidence base and identified a number of actions which had been found to impact positively on the number of hospital admissions:

- better GP access to specialist expertise
- ambulance triage in the community
- condition specific rehab
- clinical support to nursing/care homes
- better end of life care in the community
- remote monitoring of some long-term conditions
- support for self-care

Integrate with existing developments
The development of the ACO is an exciting opportunity to integrate existing initiatives that succeed collectively in transferring activity from the acute to the primary and community settings and address the long-term health challenges faced by the population. These initiatives include: CCG strategies and initiatives to develop primary care at scale; provider-led initiatives such as the “Transforming Care Together” mental health partnership; local area initiatives such as the Wolverhampton lifestyle prevention plan and Staffordshire Partnership; wider health economy initiatives such as the Black Country and Staffordshire and Stoke Sustainability and Transformation Plans and national initiatives such as the GP Forward View.

Changes to workforce, information technology and estates
As the new care models emerge, fundamental changes will be required to the way that healthcare is delivered. Significant work is already in progress and has delivered substantial benefits within the GP practices.

Workforce
A more flexible and competency-based workforce will be required in the future.

Individuals will be expected to work in multi-disciplinary teams, moving away from narrowly defined organisational silos. For many, this is a new way of working with a focus on shared outcomes rather than individual outputs.

The new workforce is likely to include more people in coordination roles and more clinical specialists in the community. Roles will include:

- Physician associates
- Care coordinators
- GPs with a special interest
- Enhanced primary care nurses and

\(^\text{13}\) Candace Imison, Natasha Curry, Holly Holder, Sophie Castle-Clarke, Dr Danielle Nimmons, John Appleby, Ruth Thorliby, Sylvia Lombardo “Shifting the balance of care: Great Expectations”, Nuffield Trust, March 2017
Allied Health Professionals (AHPs)

The trust’s experience of recruiting GPs is increasingly showing young doctors unwilling to take up traditional partnership roles but rather looking for portfolio careers across a range of specialities. RWT has developed a postgraduate fellowship programme with the University of Wolverhampton’s Academic Institute of Medicine (AIM) that offers portfolio careers across primary, secondary care and community care. This has impacted positively on trust locum expenditure in general medicine and a bespoke post CCT\textsuperscript{14} GP programme is being finalised. This new programme will significantly help address the workforce deficit in primary care.

Further work is required to scope out this workforce and to embed new ways of working. This can be achieved through training and development of existing staff and recruitment of new staff.

It is essential that the ACO is an attractive employer. The recent King’s Fund report on general practice\textsuperscript{15} reported that many practices are finding it difficult to recruit and retain GPs, practice nurses and practice managers.

A further factor will be the need to bring in transformation capacity and skills as the health economy transitions to a new service model. An ACO allows the concentration of transformation capacity across the system which will be necessary to deliver the scale of change required.

Information Technology

The emerging new model of care would be dependent on:

- investment in ensuring access to up to date patient information, using live unified data instead of static and historic data
- information being shared between clinicians and carers through effective data-sharing
- effective monitoring and pro-active care of patients with long-term conditions and of frail elderly patients - Live rules based alerting to care co-ordinators and clinicians
- opportunities to access care through digital technology, for example skype consultations
- development of predictive analytics to identify patients at risk of developing long-term conditions

The trust currently hosts all infrastructure and some software elements of ICT services for Wolverhampton CCG across 46 GP practices. This includes provision of the trust’s Electronic Patient Record (EPR) system which is accessible from every GP desktop enabling informed primary care decision making. Reciprocal provision of Wolverhampton GP Patient information is also captured within the trust’s Electronic Patient Record system, through a connection that the trust has established to a Primary Care data warehouse. This allows secondary care clinicians to see critical patient information for the likes of pre-admission medication, GP diagnosis, patient risks and allergies. The accessibility of electronic information is only possible due to the high level of integration from a robust ICT Infrastructure platform. This is a solid platform from which to build on.

\textsuperscript{14} Certificate of Completion of Training

\textsuperscript{15} “Understanding pressures in general practice” by Beccy Baird, Anna Charles, Matthew Honeyman, David Maguire and Preety Das, published by the King’s Fund in May 2016
Estates
Wolverhampton CCG has undertaken a baseline survey of local health service estate to identify the state of all facilities and vacant estate and is working with the city council and RWT to develop quality environments that will help to improve patient experience and access for the community.

The full implementation of the new service model would be likely to involve:

- investment in primary and community hubs - Four locations have been identified across Wolverhampton, in the City Centre, at Bilston, Warstones and Showell Circus. Each of these hubs will be built on land owned by the local authority and positive discussions have taken place. The hubs will look to deliver multidisciplinary multispecialty care including diagnostic and procedural facility for primary, secondary, community clinicians and mental health clinicians
- increased capacity in primary care
- reduced footprint on the hospital estate

Options for accountability and governance

Accountability and governance
A further area of development is the appropriate accountability and governance framework.

In an accountable care system, a capitated budget is passed from the commissioner to the provider. The CCG would be delegating operational commissioning responsibilities to the ACO (e.g. pathway design across multiple providers) and would focus on strategic commissioning, representing the public and population interests and holding the ACO to account.

There are two main options for managing the accountable care system:

- A lead provider model, where RWT takes on the delegated budget and responsibility for community services across the supply chain. With this responsibility comes the financial and delivery risks relating to the delivery of services within scope
- A “virtual alliance” contract where the organisations involved share responsibility and risk through a collaborative agreement
The following table provides an initial assessment of these options.

Table 4: Assessment of options around the accountability framework

<table>
<thead>
<tr>
<th></th>
<th>Option i- lead provider model</th>
<th>Option ii- “Virtual alliance” model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides the leadership required</td>
<td>Clarity of leadership and accountability</td>
<td>Carries potential risk of inertia and lack of effective decision-making</td>
</tr>
<tr>
<td>Has the active support of stakeholders</td>
<td>Concerns that RWT would be in too dominant a position and that other perspectives would not be taken fully into account</td>
<td>Some stakeholders may feel more in control of the activities of the ACO</td>
</tr>
<tr>
<td>Enables resource and activity to be transferred around the system</td>
<td>Establishing an effective budget structure within an ACO would facilitate transfer of activity</td>
<td>Alliance model carries potential risk of retaining organisational barriers or failing to agree financial transfers</td>
</tr>
<tr>
<td>Can be implemented quickly</td>
<td>System would require support to establish a local health and care economy</td>
<td>System would require support to establish a local health and care economy</td>
</tr>
</tbody>
</table>

It will be important to establish a structure that provides clear leadership and facilitates the transfer of resource from the acute sector to primary care. For this reason, the lead provider model is proposed. It is recognised that there are some issues associated with this approach that will need to be worked through with stakeholders. Staff with commissioning skills will need to be brought into the new accountable care organisation. RWT will need to develop its governance and culture to ensure that primary care clinicians have an active role in its leadership. RWT has already placed primary care clinicians on both its Trust Board and Trust Management Committee as a result of the Vertical Integration programme. Similarly, appropriate relationships will need to be developed with other organisations beyond primary care to ensure a coherent and system wide strategy that has wide stakeholder support.
The following considerations are important:

- The ACO would receive the full capitated budget on behalf of Wolverhampton CCG to commission and deliver the full range of health services across Wolverhampton.
- A further capitated budget would need to be agreed with the South Staffordshire CCGs as general practices apply to join the accountable care system.
- The ACO contract would focus on agreed outcomes. It would be awarded on a multi-year basis which allows the ACO the time to make savings and re-deploy them in improved services.
- The ACO would have contractual relationships with mental health and learning disabilities providers, with public health and with other providers, including pharmacists, optometrists and dentists.
- A separate arrangement would need to be developed with the general practices in Wolverhampton that choose not to be part of the vertical integration with RWT.
- The CCG would continue to manage the relationship with these general practices following the transfer of delegated authority from NHS England but it would be important that these practices and the ACO work closely to agree pathways that apply to the whole population covered by the ACO.

In sub-contracting services, the ACO would need to consider how best to incentivise the system. Some services will come under the direct control of the ACO but other parts of the system will remain as independent organisations subcontracted by or interacting with the ACO. Mechanisms for this include:
• Outcome based payments – bonus payments for delivering improvements in specific system wide outcomes
• Gain and loss share arrangements – flexing payments based on the performance of the system as a whole
• Budgeting for change: where pathway changes are being made, the ACO will need to understand the financial impact on its own services and on those of subcontractors
• Understanding system performance: developing system wide measures of clinical, operational and financial performance which will inform leaders in new system wide governance structures and be used as part of an accountability agreement between the ACO and the CCG
• The development of the ACO will need to include a clear plan for a financially sustainable organisation. Issues would include:
  o Scope of budget: commissioner budget for all services and cohorts delegated
  o Value of budget: delegated budget to include the target value of CCG surplus and contingency (1.5% of total)
  o Existing deficits: Hand over CCG budget which reflects the current cost of services
  o Gain and loss sharing: Any gain/loss share needs to be set in the context of the budget value – e.g. if the commissioner has retained its contingency and surplus margin, then the ACO might only share losses with the CCG, not gains to reflect this
  o Whether upfront investment is required for the transition costs, and where this investment would come from

An EY paper on hybrid-payment approaches is included as Appendix One.

Governance considerations
Whatever the formal contractual structures, a successful ACO must be underpinned by productive and collaborative relationships within the system supply chain and between the ACO and CCG

• Strong accountability arrangements would need to be in place between the accountable care system and the CCGs. The CCGs and ACO would need to develop a new contract with system-wide KPIs. They would also need to agree an approach to managing the migration to the new arrangements
• The shape of the CCGs would need to be re-considered as part of the move to new contractual arrangements. It would need to be agreed whether and which functions would transfer to the ACO and which would be retained
• Wolverhampton CCG and the Staffordshire CCGs would need to agree a shared approach to their governance of the contract with the ACO
• There would need to be a significant review and change of the governance of RWT as the ACO becomes the main vehicle to deliver and develop improved health services for the local population
• Specifically, RWT would need to develop governance approaches for the organisations directly managed by the ACO; the organisations contracted, particularly covering mental health and learning disabilities and the general practices which are not part of the Vertical Integration project
Development of ACO delivery, financial and benefits plans

The ACO would develop a delivery plan to implement the emerging service model, assessing how the initiatives would contribute to progress against outcome and care quality indicators.

The ACO’s plans will also set out how it would achieve financial sustainability, which could be linked to requests for additional funding over a transition period. Mechanisms to generate financial efficiencies include:

- consolidation of back-office functions and support staff
- reducing duplication and hand offs in the system
- increased self-care achieved through monitoring of patients
- appropriate re-alignment of the seniority of clinicians providing care
- reductions in hospital admissions and in length of stay of those admissions

Initiatives would be phased over a period of time and this phasing would determine when the associated outcome, quality and financial benefits would be realised. The illustration on the following page sets out the possible phasing of initiatives and the realisation of benefits over a five year period.

This will require further development in the Outline Business Case and Full Business Case.
Figure 7: Indicative delivery and benefits realisation plan

- **GO LIVE**
  - April 2017: Agreement on and implementation of new accountable care system
  - April 2018: Consolidate existing initiatives
  - April 2019: Investment in estate, workforce and ICT as required
  - April 2020: Develop and implement new pathways
  - April 2021: Full implementation of service model across Wolverhampton
    - Potential broader implementation of service model across South Staffordshire
    - Initial realisation of financial benefits
    - Reduced hospital admissions with accompanying financial benefits
Moving to Implementation

Engagement with stakeholders
This Strategic Outline Case is intended to initiate a discussion with stakeholders. Any move to an accountable care system will be delivered by the health and care system as a whole. The following table identifies the key stakeholders. RWT will continue to build relationships with these stakeholders and to develop the proposition with them.

A workshop with stakeholders is planned for 10th May.

Table 5: Main stakeholders

<table>
<thead>
<tr>
<th>Group</th>
<th>Stakeholder</th>
<th>Potential issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioners</td>
<td>NHS Wolverhampton CCG</td>
<td>Development of ACO raises fundamental questions about role of CCG. Would remain main commissioner of services from ACO</td>
</tr>
<tr>
<td></td>
<td>NHS Cannock Chase CCG</td>
<td>Development of ACO raises fundamental questions about role of CCG. Would remain main commissioner of services from ACO</td>
</tr>
<tr>
<td></td>
<td>Other CCGs (esp South East Staffordshire and Seisdon Peninsula CCG, Walsall CCG)</td>
<td>Would commission services from the ACO</td>
</tr>
<tr>
<td></td>
<td>NHS England specialised commissioning</td>
<td>RWT significant provider of specialised services, which should be integrated into new pathways</td>
</tr>
<tr>
<td>Regulators</td>
<td>NHS England</td>
<td>Would need to approve the creation of the accountable care system</td>
</tr>
<tr>
<td></td>
<td>NHS Improvement</td>
<td>Has oversight of RWT</td>
</tr>
<tr>
<td></td>
<td>CQC</td>
<td>Assurance over the quality of services being delivered, potential concern over maintenance of care quality during migration to new arrangements</td>
</tr>
<tr>
<td>Providers</td>
<td>Community Health Providers</td>
<td>Walsall Health Trust provider of community health services in the Cannock Chase area</td>
</tr>
<tr>
<td></td>
<td>Mental health trusts</td>
<td>Essential to embed mental health and learning disability in new service models from the outset</td>
</tr>
<tr>
<td></td>
<td>General practices</td>
<td>Necessary to consider how non VI Practices can support effectively the development of the new service models</td>
</tr>
<tr>
<td>Patients and the community</td>
<td>PALS</td>
<td>Important to engage and invest in patient leadership of new service models</td>
</tr>
<tr>
<td></td>
<td>Local groups</td>
<td>Important to engage local groups effectively in the development of new service models</td>
</tr>
<tr>
<td>Clinicians and staff</td>
<td>Clinicians</td>
<td>Multi-disciplinary leadership of the development of new service models will be essential</td>
</tr>
<tr>
<td></td>
<td>Staff groups</td>
<td>Staff will want to contribute and engage in new service models and to understand implications for them</td>
</tr>
<tr>
<td></td>
<td>Trade Unions</td>
<td>Will want to be involved in earliest stages, particularly on any changes to employment contracts</td>
</tr>
<tr>
<td>Group</td>
<td>Stakeholder</td>
<td>Potential issues</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Elected politicians</td>
<td>MPs</td>
<td>Significant interest in major reconfiguration of National Health Service in their constituency</td>
</tr>
<tr>
<td></td>
<td>Councillors</td>
<td>Significant local interest, and also concern for the implications for the local authority</td>
</tr>
<tr>
<td>Local Authority</td>
<td>Social services</td>
<td>Important partner in developing integrated pathways</td>
</tr>
<tr>
<td></td>
<td>Public health</td>
<td>Critical input to strategic direction of ACO</td>
</tr>
<tr>
<td>Media</td>
<td>Local newspapers</td>
<td>Significant media interest in reconfiguration of services</td>
</tr>
<tr>
<td></td>
<td>Regional BBC</td>
<td></td>
</tr>
</tbody>
</table>

**Assurance process**

As the proposals for the accountable care system are developed, then approval would have to be sought to proceed. NHS England and NHS Improvement have developed a new assurance process: “Integrated Support and Assurance process: an introduction to assuring novel and innovative contracts”. Approval would be sought through this route.

NHS England and NHS Improvement will prioritise the following main questions in the development of the assurance process:

- Will the service model produce net benefits?
- Are the provider and commissioner capable of managing the contract and risk?
- Have the consequences for other providers been thought through?
- Does the proposed service model merit considering adjustments to the regulatory approach?

The assurance process includes early engagement, plus a series of formal checkpoints:

**Table 6: Overview of Assurance process**

<table>
<thead>
<tr>
<th>Checkpoint</th>
<th>Key Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Engagement</td>
<td>Does ISAP apply and what is the anticipated procurement lifecycle?</td>
</tr>
<tr>
<td>Checkpoint One: Readiness</td>
<td>Does the proposal represent the correct strategic solution for the local health economy and has the necessary preparatory work been completed for the proposed procurement?</td>
</tr>
<tr>
<td>Checkpoint Two: Selection</td>
<td>Has the procurement process been robust? Are the contract and preferred bidder(s) appropriate for the complex contract? Is the financial envelope appropriate for services being bought?</td>
</tr>
<tr>
<td>Checkpoint Three: Go-Live</td>
<td>Is it safe for the service to go-live?</td>
</tr>
</tbody>
</table>
Implementation Plan
An indicative implementation plan has been developed, with a target go-live date of April 2018.

Figure 8: Initial implementation plan for the new accountable care system

The timeline is ambitious and would require the sustained commitment of all parties to be successful. The period between April 2017 and July 2017, in developing this Strategic Outline Case into an Outline Business Case, is therefore essential in developing a shared proposition across the local health economy.
**Risks and Issues**

An initial assessment has been carried out of potential risks and issues.

**Risk Log**

*Table 7: Risk Log*

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Counter-Measure/ Contingency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sheer complexity of moving to new organisational forms means that ACO is undeliverable</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Clear scoping of implementation plan. Consideration of what resources are required</td>
</tr>
<tr>
<td>2</td>
<td>Difficult prioritisation choices not made, so financial costs not contained</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Clear understanding of financial envelopes and of potential investment and disinvestment choices</td>
</tr>
<tr>
<td>3</td>
<td>Lack of support from primary care clinicians, with some GPs dissenting</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Progressively deploy innovation developed through VI to all practices in the city. Develop ACO infrastructure to actively support non VI practices in the delivery integrated care. Develop contractual mechanism to incentivise system wide provider engagement.</td>
</tr>
<tr>
<td>4</td>
<td>Continuity of service in moving to new arrangements</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Careful implementation plan</td>
</tr>
<tr>
<td>5</td>
<td>Judicial challenge to new arrangements</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Careful discussion of legal issues, particularly around consultation processes</td>
</tr>
<tr>
<td>6</td>
<td>Lack of support from Health and Wellbeing Boards</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Continued dialogue using Strategic Outline Case as a communications tool. Provide organisations with meaningful opportunities to influence the design</td>
</tr>
<tr>
<td>7</td>
<td>Lack of CCG backing for ACO</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Lack of support from NHS England or NHS Improvement</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Lack of support from other organisations (eg Black Country Partnership Foundation Trust)</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>CMA Review will delay implementation</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Discuss potential issues with regulators and agree on approach to manage them</td>
</tr>
<tr>
<td>11</td>
<td>Unable to demonstrate active involvement of patients and community</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>Develop robust engagement and communications strategy</td>
</tr>
</tbody>
</table>
## Issues Log

### Table 8: Issues log

<table>
<thead>
<tr>
<th>No.</th>
<th>Issues</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Need to articulate clear benefits case</td>
<td>Communication around the Strategic Outline Case</td>
</tr>
<tr>
<td>2</td>
<td>Need to develop the right governance arrangements which secure effective leadership while enabling stakeholders to contribute in a meaningful way</td>
<td>Development of governance proposals</td>
</tr>
<tr>
<td>3</td>
<td>Need to establish clear financial position, with understanding of implications for different organisations</td>
<td>Development of clear approach to work through the financial issues</td>
</tr>
<tr>
<td>4</td>
<td>Clarify accountability arrangements when a service e.g. mental health is “block-backed” to the existing provider</td>
<td>Development of carefully worked through approach</td>
</tr>
</tbody>
</table>
Appendix One: Consideration of hybrid payment approaches
A case for hybrid payment approaches

For ACOs, capitated payment approaches can often be presented as a panacea for realigning the incentives in a care system.

However, pure capitation can result instead in replacing one set of market failures with another

- It can limit patient choice and undermine centralisation of specialist services
- It can encourage skimping on care if not linked to outcomes
- It can too rapidly transfer risk to a provider not ready to take it on
- It does not resolve issues of how to manage and incentivise the system, but simply pushes them down to the lead provider
- Services are either inside or outside of the arrangements, influence over broader services is challenging (e.g. primary care and social care in the short term).

A hybrid payment approach which augments capitation with more nuanced features can generate better outcomes for the NHS

Transitioning to a capitated payment approach will take time, and in our view there will always need to be a blend of capitation and other payment arrangements. For example, we may always want to retaining an element of fee for service/case for areas such as specialist care and high cost drugs and devices.

Gain and loss sharing arrangements and outcomes based payments can be used to offset some of the less desirable features of capitation and FFS/C both in a transitional period and as part of an end state solution.
Gain and loss sharing arrangements are an overlay to existing payment approaches. They are used in a number of sectors, usually to incentivise a whole system to manage activity/volume risk.

In the NHS they will involve a number of parties agreeing to have adjustments made to the payments they would have made or received based upon the performance of the wider Local Health Economy (LHE). Many LHEs have already implemented payment arrangements which feature some aspect of gain and loss sharing. This includes bilateral risk share agreements between providers and commissioners, and year-end contract settlements which retrospectively adjust payment levels to reflect the financial position and performance against non-financial targets.

However, gain and loss sharing in the context of ACOs are:

- **Being multilateral in nature** – with multiple organisations sharing the risks and rewards of LHE performance.
- **Being formally and prospectively agreed** – with principles, rules and parameters set in advance in order to remove ambiguity or the risk that excessive time is spent agreeing payments at year end, liberating commissioners and providers to concentrate on delivering service improvements and efficiencies.
- **Often being multi-year arrangements** – with pre-agreed principles regarding how the arrangements will change over time and/or be adapted to reflect changes in the external environment.

For an ACO, Gain/Loss Sharing arrangements offer:

1. **Allocative efficiency:** resource drawn to the part of the system where it does the most good

2. **Shared risk:** the whole system wins or loses together

3. **Relatively easy to implement:** benefits can be achieved quickly and supports transition
Gain / Loss Sharing Approach (2)

Key features which can be included in a gain and loss share agreement

- **Baseline** - a level of activity or expenditure against which gains and losses are measured
- **Minimum savings rate** - the minimum level of system savings vs. the baseline which need to be achieved before gains and losses are distributed
- **Caps and collars** - limiting the level of gains and losses parties can receive in a given year
- **Transitional fund** - a transitional fund compensating for stranded or transformation costs may take a first call on gains before remaining gains are distributed
- **Shares** - the agreed proportion of savings each party receives (note, some small parties who cannot tolerate risk may only be asked partake in gain sharing, especially in early years)
- **Outcome/quality adjustment** - meeting or not meeting agreed non-financial measures of quality or outcomes increases or decreases share of gains/losses
- **Backfill adjustments** - offset gains on in scope services against increases in activity on other services. E.g. if NEL admissions are decreased, but the provider has already earned a margin on EL activity which has increased to take up this capacity, this might be deducted from their gain share

The diagrams below show illustrative examples of horizontal and vertical gain and loss sharing under different contractual structures

What would a gain and loss sharing arrangement look like in your system? With commissioners? Between services?
**Principles behind novel financial frameworks for ACOs (1)**

**Managing system resources**

The systems we have worked with - in England and beyond - have allowed us to consider the insights and tools required to support effective change and understand the true potential of moving to an ACO model supported by a novel financial framework, which benefits both the group of providers / single provider entity and commissioners -whilst achieving the desired outcomes.

In particular, two such enablers are:

- **Cost modelling**
  - Detailed data on treatment costs which allow robust, clinically meaningful forecasts of how costs are impacted by demographic changes and new care models

- **Integrated financial plans**
  - Models which truly integrate the financial forecasts of organisations within a system

**Cost Modelling:**

ACOs have implications for managing cost in the following ways:

- Reducing non elective admissions through enhanced primary and intermediate care
- Changing length of episodes though early discharge
- Episodes split across settings and long pathways which might be split between specialist and aftercare

For all of the above changes, ACOs are likely to target very specific cohorts of patients with different levels of complexity and acuity. This will have a significant impact on the cost per patient of providing the residual and new services which will require precise analysis in order for resources to be allocated efficiently. Current tariffs are unlikely to be sensitive enough.

The NHS is moving towards patient level costing, and NHSI is investing heavily in improving costing, assuring reported costs and creating the infrastructure to analyse them. We believe that insights will need to be rapidly mined from the leading producers of this data and shared across the system.
Principles behind novel financial frameworks for ACOs (2)

Integrated Financial Plans

The NHS now has a set of STP level control totals. These will be a key building block for new care models that are founded on whole system thinking, including ACOs. It is an opportunity to begin reaping the benefits of system collaboration and service integration. Measuring compliance with this system control total will be a key measure.

However, our observations of STP development in the NHS suggests that the usefulness of control totals as a management tool is limited by a number of important challenges. Specifically:

- Overlaps in assumptions around activity changes between providers or misalignment of assumptions between provider and commissioner means forecasts against these totals may be over-optimistic or over-pessimistic.
- They are dominated by a commissioner view of budgets and can exclude big inflows of income such as education, private patients, other commercial revenue and R&D (on which providers may make a profit or a loss).
- Cross boundary flows are not always adequately accounted for and can be significant.
- Local authority activity and resource is not always included but is very significant for whole system operation.

EY ‘Group Accounts’ Methodology

We have developed an approach to system level financial management which aims to instil a more commercial discipline. We ask systems to think of themselves as “My Place PLC” - each organisation a subsidiary of the same company, which trades internally and externally.

We produce an I&E account for the “group”, accounting for all income into the group - NHS funding, social care budgets, trade with other care systems and commercial revenues - and net off “inter group trading” to give a true and fair picture of the health of the business. The benefits are:

- Non-NHS revenues are recognised as part of the solution.
- The “gap” can be properly understood as a proportion of true group revenue.
- System leaders are encouraged to focus on the collective good.
- One version of truth at system and organisational levels.

See example overleaf.
In an ACO model, the provider or group of providers take on an increasing degree of risk.

What tools, insights, resources and support from commissioners / national bodies do you need to gain an enhanced understanding of cost dynamics?

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 0</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Commissioner funding</td>
<td>1,548</td>
<td>1,574</td>
<td>1,622</td>
<td>1,649</td>
<td>1,678</td>
<td>1,706</td>
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<tr>
<td>Social care funding</td>
<td>463</td>
<td>460</td>
<td>454</td>
<td>443</td>
<td>433</td>
<td>427</td>
</tr>
<tr>
<td>Provider revenue</td>
<td>1,037</td>
<td>1,063</td>
<td>1,031</td>
<td>1,044</td>
<td>1,054</td>
<td>1,052</td>
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<tr>
<td><strong>Subtotal: care economy income before internal trading adjustment</strong></td>
<td>3,048</td>
<td>3,097</td>
<td>3,107</td>
<td>3,136</td>
<td>3,164</td>
<td>3,184</td>
</tr>
<tr>
<td>Intra care economy trading adjustment (income)</td>
<td>(846)</td>
<td>(874)</td>
<td>(845)</td>
<td>(859)</td>
<td>(870)</td>
<td>(868)</td>
</tr>
<tr>
<td>Total care economy income</td>
<td>2,202</td>
<td>2,223</td>
<td>2,262</td>
<td>2,278</td>
<td>2,295</td>
<td>2,316</td>
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<tr>
<td>Commissioner costs</td>
<td>(1,531)</td>
<td>(1,554)</td>
<td>(1,592)</td>
<td>(1,628)</td>
<td>(1,663)</td>
<td>(1,688)</td>
</tr>
<tr>
<td>Social care costs</td>
<td>(463)</td>
<td>(459)</td>
<td>(452)</td>
<td>(440)</td>
<td>(427)</td>
<td>(421)</td>
</tr>
<tr>
<td>Provider costs (pay)</td>
<td>(670)</td>
<td>(676)</td>
<td>(650)</td>
<td>(648)</td>
<td>(640)</td>
<td>(634)</td>
</tr>
<tr>
<td>Provider costs (non pay)</td>
<td>(351)</td>
<td>(369)</td>
<td>(368)</td>
<td>(378)</td>
<td>(391)</td>
<td>(387)</td>
</tr>
<tr>
<td>Provider costs (other)</td>
<td>(53)</td>
<td>(53)</td>
<td>(53)</td>
<td>(53)</td>
<td>(53)</td>
<td>(53)</td>
</tr>
<tr>
<td><strong>Subtotal: care economy costs before internal trading adjustment</strong></td>
<td>(3,067)</td>
<td>(3,111)</td>
<td>(3,115)</td>
<td>(3,148)</td>
<td>(3,173)</td>
<td>(3,184)</td>
</tr>
<tr>
<td>Intra care economy trading adjustment (cost)</td>
<td>846</td>
<td>874</td>
<td>845</td>
<td>859</td>
<td>870</td>
<td>868</td>
</tr>
<tr>
<td>Total care economy costs</td>
<td>(2,221)</td>
<td>(2,237)</td>
<td>(2,271)</td>
<td>(2,289)</td>
<td>(2,304)</td>
<td>(2,315)</td>
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<tr>
<td>Health &amp; care economy surplus (deficit)</td>
<td>(19)</td>
<td>(14)</td>
<td>(9)</td>
<td>(11)</td>
<td>(9)</td>
<td>0</td>
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</tbody>
</table>

| Individual provider forecasts | Individual NHS commissioner forecasts | Individual social care commissioner forecasts (carved out from LA accounts) |