NHS
Northumberland
Clinical Commissioning Group

A New Model of Care Delivery for Northumberland
Rationale and Benefits

1.0 THE CASE FOR CHANGE

"We are not tinkers who merely patch and mend what is broken…..we must be watchmen, guardians of the life and the health of our generation, so that stronger and more able generations may come after."

Dr Elizabeth Blackwell (1821 – 1920), The First Woman Doctor

1.1 Context

Northumberland CCG (CCG) commissions services from a range of excellent providers, its main contracts for acute, community and mental health services being with Northumbria Healthcare NHS Foundation Trust, Newcastle Hospitals NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust and North East Ambulance Service. Community-based primary care services are delivered by 44 general practices.

In addition, the CCG commissions a range of other services jointly or with the local authority, such as continuing health care and through the Better Care Fund.

The population of Northumberland is over 316,000 and is projected to grow by 8.3% by 2033 with an increasingly ageing population and decreasing younger population[1] By 2033 31% of the total population of Northumberland will be aged over 65. Nearly half of the population live in a rural area (c19% regionally and nationally) with the remainder living in the 3% of urban land in the south east of the county. The County is one of the least deprived CCG areas in the North East of England, but stark inequalities persist within the County in relation to income, unemployment, education, training and skills. The economic downturn and welfare reforms in recent years are impacting on the income of residents with inevitable consequences for their health and wellbeing. In common with other large rural areas, extensive inequalities also exist in relation to barriers to housing and services and the living environment.

The CCG performs well in the vast majority of NHS constitution standards and of note is the portfolio of integrated care programmes developed (and developing) with its close partner, Northumberland Council, and overseen by the local Integration Board on behalf of Northumberland Health and Wellbeing Board. These programmes involve a collaborative working approach with partners committed to delivering 'New Models of Care' in Northumberland and are showing positive early results.

[1] Northumberland County Council Population Projections:
http://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Northumberland-Knowledge/NK%20people/Demographics/Population%20projections/Population-Projections-Bulletin-2012.pdf

However, Northumberland CCG's successful commissioning of high quality, safe and patient-centred care has been at times overshadowed by its financial performance, partly inherited from the former NHS North of Tyne. Whilst the CCG considers that its current arrangements have some important strengths, including its dynamic commissioning partnership with the local authority, the CCG has recently been issued legal directions to deliver financial balance by end of 2016/17.

1.2 Challenges facing Northumberland

1.2.1 The Health Gap

The Northumberland Joint Strategic Needs Assessment (JSNA) has identified that health inequalities are a major challenge. The gap between the most affluent and least affluent communities in Northumberland remains wide and has not narrowed in the last decade which means that we need to find new approaches that are effective in reducing the gap.

The key health challenges facing Northumberland are[2]:

- Life expectancy is 9.6 years lower for men and 7.2 years lower for women in the most deprived areas of Northumberland than in the least deprived areas
- Life expectancy at birth for females is greater than that in the north east but lower than that of England
- There were 1,030 deaths from conditions considered amenable to healthcare over the period 2012-14; two-thirds of these deaths were attributable to ischaemic heart disease and cancer.
- There were 2,020 deaths from preventable disease over the period 2012-14; the rate was significantly higher than the England average for women.
- Liver disease is one of the few areas in which deaths are increasing nationally. There are three underlying causes: alcohol, obesity (which is estimated to also contribute to half of the diabetes burden) and viral hepatitis. In Northumberland, the majority of indicators relating to alcohol use are significantly worse than the England average. Alcohol misuse can widen health inequalities and worsen problems of crime, anti-social behaviour and poverty.
- An ageing population is likely to be accompanied by a larger proportion of people living with long term conditions and an increase in the number of people with dementia, the prevalence of which is already high.
- Smoking remains the greatest contributor to premature death and disease across Northumberland. It is estimated that up to half the difference in life expectancy between the most and least affluent groups is associated with smoking. Whilst generally, smoking prevalence is about the same as that for England overall, admissions for and mortality from smoking attributable disease is significantly higher. COPD and deaths from respiratory disease is a particular issue in women.
- Estimated levels of adult excess weight are worse than the England average.

[2] Public Health England Northumberland Health Profile 2015 and Director of Public Health Annual Report 2015

- Over 25% of adults are classified as obese which is higher than England average.
- The suicide rate is significantly higher in Northumberland than for England and suicides in men is the largest contributor to the gap in life expectancy against the England average.
- The rate of people killed and seriously injured on roads is worse than average.
- Some indicators for children and young people are particularly poor in Northumberland such as A&E attendances in under 4s, admissions for accidental injuries, self harm and alcohol and the proportion of young people not in education, employment training. Infant mortality is slightly worse than the north east and England averages.
- Levels of breastfeeding and smoking at time of delivery are worse than the England average.
- Northumberland's rurality is associated with high levels of fuel poverty which may impact on both physical and mental health but also more widely, for instance on educational attainment in children.
- The rate of long term unemployment is worse than average.

The `Five Year Forward View` sets out a need for a radical upgrade in prevention to improve people's lives, achieve financial sustainability and tackle health inequalities. The challenge for the healthcare system's current and future efficiency goals is that new solutions are needed to reduce demand through delaying or preventing the onset of need, or supporting people so that their needs do not escalate unnecessarily. The Plan argues for the creation of a health and care system geared towards promoting health and reducing inequalities rather than just the delivery of health services. These health challenges will not be addressed by the existing service model with an over reliance on hospital based services at the expense of those delivered within the community.

1.2.2 The Financial Gap

The current cost of local healthcare provision is not sustainable in the long term. Northumberland CCG has faced a number of challenges since its inception but despite starting with a legacy underlying deficit position of £17m it recorded a small surplus for 2013/14 and 2014/15. During 2015/16, however, a financial deficit of £5.04m was recorded due mainly to significant activity and cost over performance against contract towards the end of the year. As a direct consequence, the CCG has recently been placed into formal financial recovery.

Initiatives have been identified to implement a Financial Recovery Plan for 2016/17 to deliver £20m total QIPP against a backdrop of the main acute provider also needing to deliver a £29.3m surplus. This combination of competing financial pressures means that the CCG needs to create a recovery plan that delivers a step change in the way health and social care services are organised and delivered. The Northumberland health economy has been in a position of continual financial recovery since 2006/07 and subject to formal turnaround programmes during that time which means that all obvious cost saving programmes have been implemented

in full. The plan to meet the ongoing challenge therefore needs a paradigm shift.

Medium term financial planning shows how the CCG will recover the position – from delivering a challenging QIPP programme in 2016/17 to securing a balanced out turn in 2017/18 and then achieving business rules in full from 2018/19.

The recent government funding cuts for Local Authorities requires Northumberland County Council to make total savings of £58m by 2019-20 on top of £148m already lost from the budget in the past 5 years. The adult social care budget is under significant spending pressure mainly due to the growing numbers of increasingly frail residents and exacerbated by the new national living wage. The Council has increased Council Tax and plans to continue doing so in future years to help fund the social care budget shortfall, but risks to social care provision and associated impact on healthcare provision remain.

The national requirement for the NHS provider sector to return to financial balance and conditions related to sustainability and transformation funding access requires local foundation trusts to return significant surpluses in 2016/17. The imperative is that any surplus is generated as a result of a focus on cost reduction rather than on income growth.

Despite the excellent work on service integration and demand management over the years, significant inefficiencies and fragmentation remain within the current system ranging from limited preventative care in some areas, inappropriate financial incentives and unaddressed social and behavioural issues, to the more operational such as repeat admissions, delayed exchange of patient information, duplication of tests, and many more.

Doing more of the same is not an option. The significant financial pressures within the Northumberland health and social care system, linked to increasing service demand, longer life and medical advances, require a different approach to the delivery of good health and well-being for the population of Northumberland.

The financial challenge requires a response that ensures financial investment is aligned to improving health outcomes and maximising value by pooling the limited financial resources.

1.2.3 The Care and Quality Gap

Although the quality of care in Northumberland compares favourably with many parts of the country there remain significant gaps. There is unwarranted variation in cancer, mental health, learning disabilities, dementia care, urgent and emergency care. Improving the care, quality and experience for the residents of Northumberland requires a reduction in the over reliance on bed-based services and the enabling of people with physical and mental health needs to remain well and independent for longer. The care needs of the population require redesign of emergency and urgent care services and increased capacity and resilience of primary care. People with learning disabilities need improved health outcomes and

quality of life experiences.

1.2.4 Commissioning Challenge

The CCG's commissioning goal is to improve individual and population health, promoting primary and preventative care and lessening the need for expensive services in order to remain within the financial envelope available. This will manifest itself through the achievement of:

- Enhanced partnership working between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations, and collective provider responsibility.
- Financial stability.
- The objectives and targets of the Health and Well Being Board as set out in the Northumberland Joint Strategic Needs Assessment and Northumberland Joint Health and Wellbeing Strategy.
- Enabling and empowering patients with long term conditions to take responsibility for their own care.
- Better use of alternative approaches such as social prescribing, linking patients with sources of non-medical support in the community.
- Corporate social responsibility and the positive contribution this has in communities.

In particular, the Northumberland Health and Wellbeing Board statutory partners have set out their priorities as being[3]:

- A focus on children and families, who without some extra help and support early on, would be at risk of having poorer health, not doing as well at school and not achieving their full potential.
- A focus on tackling some of the main causes of health problems in the county including obesity and diet, mental health and alcohol misuse.
- Supporting people with long-term conditions to be more independent and have full choice and control over their lives.
- Ensuring all partners in Northumberland work well together and are clear about what they themselves need to do to help improve the health and wellbeing of local people.
- Galvanising all public services to support disabled people and those with long-term health conditions to stay active for as long as possible.

Addressing the significant health and social care challenges in Northumberland will require all key partners to work together differently, in particular through providers acting collectively and collaboratively towards common goals.

[3] Achieving Health and Wellbeing in Northumberland 2014

1.2.5 Barriers to Change

The current system and legal framework raises a number of challenges to having collective and collaborative working between providers within a single, integrated model of care and these will all need to be addressed locally and/or with NHSE and NHSI in order to move forward:

Legislation and Regulation - existing legal rules and regulations around NHS service provision frameworks can be perceived as making partnership working more difficult:

- Individual organisations being held to account for their own performance by NHSI, NHSE and CQC rather than their contribution to system performance.
- Individual provider organisation risk ratings encouraging providers to have a short term view and potentially to strengthen their own financial stability to the detriment of other NHS organisations.

Payment System - currencies to support integrated care within the tariff system are still being developed and, depending on the integrated model, may create an obstacle. In addition, despite moves towards co-commissioning of primary and specialised care, the healthcare budget is split between CCGs, local authorities (public health) and NHS England (primary and specialised care) which can make it more difficult to shift funding between different types of provision.

Information Systems – limited interoperability between provider information systems in health and social care can prevent the timely sharing of up to date patient information, leading to duplication, gaps and delays in care provision resulting in lack of continuity and poorer patient experience for patients transferring from one service provider/care pathway to another.

Workforce - clinical staff shortages - for example consultants in certain specialties including emergency medicine, GPs and nurses – compounds the problems of achieving 7 day working, moving more services out of hospital and increasing the focus on primary prevention.

Organisational culture – everyone in each organisation needs to understand that they are operating in a single system with a single budget; this requires long term and sustained transformational change and strong leadership.

1.3 A Model of Care for the Future

1.3.1 Service Delivery Options

It is acknowledged that 'cost pressures associated with ageing populations and an increase in the numbers of people with chronic illness create a need for more accountable and integrated forms of delivering health services'[4].

The 'Five Year Forward View' (2014) set out a strategy for responding to the challenges facing the health service, which included a number of "new models of care". The CCG considered alternative arrangements for the future commissioning of affordable and sustainable quality health care that is fit to meet the future needs of its communities in line with the Five Year Forward View. These included a 'simple' primary and acute care system (PACS), multi-speciality community provider (MCP), and prime contracting, appointing a prime system integrator and alliance contracting.

The CCG concluded that it should develop the concept of commissioning services through a Primary and Acute Care System (PACS) – a "vertically integrated" organisation that would provide NHS list-based GP and hospital services, together with mental health and community care services.

When proposals were then sought for Vanguard sites to pilot the new models, Northumberland's proposal for a PACS, led by Northumbria Healthcare NHS Foundation Trust and Northumberland CCG, was selected as one of the Vanguards with the intention of developing this over time into an Accountable Care Organisation (ACO). This means that under a contractual arrangement with the CCG, a group of providers will collectively agree to take responsibility for all care for the Northumberland population for a defined period of time within a single fixed budget.

1.3.2 Principles for ACO Development

The preferred ACO model will be a partnership of the key health providers. Northumbria Healthcare is expected to host this partnership, and will hold the formal contract under which the total budget for core health services will be transferred to the ACO. The host organisation will agree arrangements with other providers to share funding and risks. Currently, the Northumberland Tyne and Wear Foundation Trust is expected to be a member of this partnership, and primary care providers will also be fully represented. Newcastle Hospitals FT has been a full participant in the planning process, but has not at present confirmed an intention to join the ACO partnership.

An ACO contract will be developed on the basis that it includes the full budget for all core health services, including those which have historically been delivered by providers outside the ACO partnership; the actual payments will however be reduced

[4] Accountable care organisations in the United States and England. Testing, evaluating and learning what works (March 2014) Kings Fund, Stephen Shortell, Rachael Addicott, Nicola Walsh, Chris Ham

by the amount which is spent on payments to providers outside the ACO partnership (whether at tariff rates or on a new contract agreed nationally for ACO use). The ACO will also be contracted to administer all payments to other health providers as an agent of the CCG.

The management of CCG functions, where appropriate, will be provided on its behalf by the ACO, reducing CCG overheads.

This type of arrangement has potential for greater consistency in service provision and enhanced integrated care due to increased collaboration between providers. Effective senior representation across all providers in the decision making body will

ensure joint, equitable and active strategic management.

The CCG strategic commissioning function that remains will be delivered through a shared officer support structure with Northumberland County Council, maximising the opportunities for an integrated approach across NHS services, social care and public health. While there are some technical issues that need to be resolved, the current expectation is that there will be no separate CCG officer structure, but that a small number of postholders will be jointly employed by the CCG and the Council, to meet statutory requirements.

The development work culminated in the majority of key partners signing up to a Memorandum of Understanding agreement to develop the model in further detail during 2016/17. Subject to agreement, the aim is to achieve shadow ACO operation for all services in scope from April 2017 onwards.

2.0 BENEFITS TO NORTHUMBERLAND POPULATION

2.1 Evidence

There are two reasons for developing an ACO model in Northumberland. One is specific to the English health system and the local situation, and is about the misalignment between funding mechanisms and objectives, and between financial risk and responsibility, within the existing arrangements. The other is about the benefits of ACO models more broadly. The existing evidence base, being based on international experience, is primarily about the broader issue; within England there is no substantial experience of an ACO model, and one purpose of an ACO in Northumberland is to contribute to developing an evidence base about how well this model works within the current English health system. The decision to proceed with this model necessarily reflects a judgement about its benefits and risks within the specific local and national context. However we have also taken account of international evidence.

Although early results from overseas have been mixed, there is some evidence that ACO type models can in the right circumstances both improve quality of care and reduce the rate of increase in healthcare spend. A Kings Fund report on ACOs in the US[4] identified the strongest evidence in support of the ACO approach coming from Massachusetts where the longest running contract-based programme produced a 2.8% saving against control group in its first two years, primarily due to shifting procedures to lower cost settings, doing fewer imaging scans and tests, and reducing overall utilisation of services. The quality of care improved by 3.7 per cent on selected chronic care management measures. Both savings and quality improvement were greater in the second year than the first year providing some evidence of sustainability.

The Alzira model introduced in Valencia, Spain in 1999[6] is reported to have produced the following benefits in comparison with hospitals outside the model in the same region:

- 27% decrease in healthcare cost per capita.
- 34% reduction in hospital readmission within 3 days.
- 54% reduction in average A&E waiting time for patients.
- 55% reduction in average elective waiting time.
- 20% reduction in average length of stay.
- 91% patient satisfaction.
- Electronic patient records for all patients.
- 93% staff satisfaction.

[6] The Alzira Model (2014) PricewaterhouseCoopers LLP.

The key lessons identified by the Kings Fund if introducing ACO type models in England are:

- The need to focus on the small proportion of people who account for a high proportion of use and cost through risk stratification (which could be by including only this group of people in the arrangement or by prioritising reconfiguration of support for this group within a broader arrangement).
- The need to put in place case management and care co-ordination to support these people – critical to this is the involvement of primary care.
- The need to support the development of integrated care through information sharing and investment in information technology.
- The need to engage patients and to support them to play a bigger part in managing their health and well-being.

In taking on collective contractual accountability for achieving population health outcomes within a fixed budget and measured against a single performance framework, ACO partners should be highly motivated to prioritise collaborative working:

- Streamlining care pathways across organisational boundaries with increased focus on access, reduced care transitions, discharge planning.
- Moving away from treating the patients physical or mental or social care needs to addressing the needs of the 'whole person'.
- Speeding up learning and quality improvement through development of mechanisms for shared data, exchange of information, and system-wide patient engagement in care redesign.

2.2 Proposition

Transferring financial risk from the CCG to the ACO will incentivise the ACO partners to address system inefficiencies across health and social care at pace:

- Shifting system resources towards primary and early preventative care to keep people healthy, reducing incidence and future need for expensive service utilisation.
- Reducing cost by treating people in the most appropriate setting for their condition.
- Better cross-organisational, multidisciplinary working to develop complex care management packages for identified high risk patients with multiple chronic illness – frail older people, people with mental illness - to reduce avoidable A&E visits/admissions/lengths of stay/expensive treatments.
- Reduced system cost and bureaucracy through ensuring appropriate mix of inputs (eg staff), management of CCG functions and reporting/monitoring once against a single performance framework.

The combination of these benefits should provide greater certainty of achieving the Health and Wellbeing Board objectives and targets than through current arrangements, and in a shorter timeframe.

2.3 Examples of Benefits from an ACO

The benefits of an ACO can be best demonstrated in those areas where there is a requirement for whole system working and where all or multiple parties to the ACO are involved in the delivery of care.

Examples of some areas where the CCG believes an ACO model can support system-wide delivery of quality and/or financial savings delivered more quickly are:

- Primary Care Development
- Learning Disabilities Transformation
- Urgent Care

In addition there a number of areas where Northumberland CCG benchmarks high in costs compared with its peer group and national statistics. It is believed by adopting a whole system approach the ACO will be able to improve benchmarking costs considerably. These include (but not exclusively):

- Planned and Unplanned admissions
- Community Services
- System-wide and Right Care Opportunities eg Musculoskeletal, Circulation, Respiratory, Cancer, Trauma and Injuries, prescribing

The ACO would be able to identify additional system wide opportunities with all partners to improve pathways and reduce activity and cost. Using Right Care benchmarks against its comparator group there is an opportunity to:

- Increase thresholds for Procedures of Limited Clinical Value elective procedures.
- Develop pathways to have a tangible impact on new to review and consultant to consultant referrals.
- Review prescribing for specific pathways.
- Review Urgent Care Pathways in the light of Right Care Opportunities.

Rightcare opportunities are valued in total at c£16m.

2.4 Benefits Realisation

Nationally there is an increased recognition that the Payments by Results system works as a disincentive to the delivery of a genuine integrated systems of healthcare. Therefore, the requirement to move to a fixed budget is seen as a prerequisite for the development of the ACO.

With the move away from Payments by Results for ACO partners and the traditional contract levers, there is a need for strong mechanisms to ensure that the planned benefits of the development of an ACO are realised. These mechanisms will include strong contract documentation, clear objectives and single performance monitoring systems, proper governance within the ACO for decision making and review mechanisms in order that actions take place to ensure the benefits of the ACO are delivered.

2.4.1 Contract documentation

As one of the major benefits is the transference of financial risk and benefits to the ACO it is important that the contract documentation ensures that this risk is properly transferred. The documentation will cover how the financial flows work and will detail what happens if outcomes are not achieved.

2.4.2 Clear Objectives/benefits

The full range of benefits the ACO will have to deliver will be a matter for ongoing discussion/negotiation between the CCG and the ACO and will include financial, quality improvement, health outcomes and strategic benefits:

a. Financial
   - Management of costs within CCG's available funding leading to overall reduction in current healthcare costs per capita.
   - Reduction in transactional/overhead cost.
   - Shift of resources from secondary care to primary/community.
   - Reduction in Estate costs.
   - Agreed split of commissioning costs to direct provision costs.

b. Quality improvement
   - Improvements in national metrics (or in some cases, maintenance of metrics, if financial pressures are expected to limit the scope for improvement).

c. Health Outcomes
   - Health outcome measures are in the process of being developed jointly with the Kings Fund and will be used in conjunction with the measures in the Joint Needs Assessment. They are a mixture of absolute targets and delivery of key milestones to provide assurance that the long term health outcomes will be achieved.

d. Strategic
   These will include the delivery of a number of key strategic issues which will include, but not exclusively:
   - Implementation of the Northumberland primary care strategy
   - Implementation of IT/information strategy to deliver integrated patient records and allow clinicians access to data records regardless of location

- Estates strategy
- Urgent care Strategy

Due to the nature of these benefits, in that they are only likely to be achieved over a number years, progress will have to be measured against key milestones as laid out in the individual strategies.

In developing these benefits the CCG will engage with all its stakeholders to ensure the proposed benefits meet the needs of the local population. This will be undertaken through a series of workshops planned to take place in Autumn 2016.

3.0 Conclusion

In line with the national Five Year Forward View (and subsequent supporting guidance), the CCG, its provider partners and the Council believe that the overall value of benefits from the ACO approach will be considerable and that without this approach improved outcomes and financial stability will not be realised at the speed required. The ACO contract will link the budget available, including incentives, to the achievement of key health outcomes for the population of Northumberland which will be used by the CCG to monitor overall operational performance of the ACO.

The CCG has considered the ACO option in the round and firmly supports it as a mechanism for delivering the anticipated benefits, subject to any and all necessary legally compliant engagement and consultation on service change.