Leeds Health and Wellbeing Board

Report author: Rebecca Barwick (Head of Programme Delivery – System Integration, NHS Leeds CCGs)

Report of: Nigel Gray, Chief Officer System Integration, Leeds CCGs Partnership

Report to: Leeds Health and Wellbeing Board

Date: 28th September 2017

Subject: System Integration – a Blueprint for Leeds

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The Leeds Health and Wellbeing Strategy 2016-2021 sets out a clear vision that **'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'**. It highlights an ambition to make sure that care is personalised and more care is provided in people's own homes whilst making best use of collective resources to ensure sustainability. Work has progressed at pace to develop our Leeds Health and Care Plan.

Additionally the Leeds health and care system has committed to partnership values; to put people first; work as Team Leeds; and to deliver - moving to action over words.

People have told us that the lack of joined-up care is the biggest frustration for our patients, service users and carers. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.

A key part of delivering this change is for the system to work together to develop and implement a new model of integrated care where providers are jointly accountable for population outcomes. An example of this in Leeds could be the 'primary care home' neighbourhood model of health and care delivery in Leeds as **local care partnerships**.

Commissioners now need to create the conditions for integrated accountable care to happen at pace and scale by moving to commissioning providers to deliver population level outcomes.

Commissioning for outcomes will mean that providers can work together in integrated, innovative ways to most effectively deliver the outcomes. The opportunity for this to happen without a move to commissioning for outcomes is limited due to current contractual restraints, inconsistent payment methods, individual organisational priorities and system pressures.

Accountable care means that providers and services will need to work together to achieve improved outcomes for people focussing on what's best for them.

This overall approach for both commissioning and providing accountable care is called **Population Health Management (PHM).** PHM has the core principles of not differentiating between all age groups and has the whole person at its heart.

There are several key benefits to adopting a PHM approach for Leeds as, in addition to the triple aim, it will enable previously complex issues to be addressed more effectively because the system will not be as fragmented. For example:

- Parity of esteem between mental and physical health
- Better partnerships between adult and children's services e.g. work with vulnerable families to support the best start in life.
- A greater focus on the wider determinants of health to deliver outcomes.

The hypothesis is that by adopting this approach will not only lead to improving outcomes and patient experience, but it will also lead to a more sustainable health and care system. It will also, in the long term, improve system flow as the current fragmented system is one of the key reasons that patients can experience delays and issues whilst moving between services. In the future providers will be jointly responsible for improved flow across the health and care system.

Evidence to support this hypothesis is still emerging in the UK although nationally it is seen as the key solution to the 'triple aim' described in the NHS Five Year Forward View[i1]. Many UK health and care systems are further ahead than Leeds on their accountable care journey however none have yet fully implemented. In support of the hypothesis there is a range of transferrable evidence from well-known examples internationally.

In Leeds we have the flexibility to do this in the way that is right for local people and services. So we have developed a blueprint with stakeholders and consultants from BDO[2] describing how the system will move towards accountable care through a PHM approach. A draft has been shared with key stakeholders and comments have been incorporated into a final version.

As well as proposing a plan for Leeds it also sets out challenges to the system if we are to be successful. A key challenge is how we work with current regulatory frameworks which could be a barrier to change and this is now articulated in the final Blueprint (Appendix 1).

In order to implement this new way of working at pace, a process has been developed to select an 'accelerator' grouping or groups of the population. This will allow testing of the approach before moving on to other, and eventually all, population groups.

A process has taken place to assess population groups against a set of criteria appropriate for the Leeds heath and care system. A key criteria was the impact of the triple aim on the

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] BDO – Public Sector Consultants (secured through an existing CCG contract)

segments and analysis was undertaken to provide this evidence. In addition, scale of ambition, strategic alignment and prevention opportunities were also considered.

A group of commissioning and provider stakeholders considered this criteria in August 2017 and have agreed that **frailty (including end of life)** should be recommended as the first population segment.

Implications for the health and care system include: identify relevant service components to be pooled (following a period of scoping); outcomes framework to be developed for frail and end of life people in the city and new contract models agreed. Works for providers would include: formalising alliances and designing innovative delivery models to deliver the outcomes. A detailed system-wide programme of work will be developed to manage delivery of a range of workstreams.

Key next steps include developing a public facing narrative to describe these changes based on how people will experience health and care services in the future. We will also be developing an engagement plan will begin taking to citizens during the autumn, starting with each Community Committee in November/December 2017.

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the Blueprint for Population Health Management
- Provide challenge and feedback on appropriate engagement as we move through the process
- Champion Population Health Management principles as a key delivery vehicle for the system to deliver the Leeds Health and Wellbeing Strategy

1 Purpose of this report

1.1 This paper provides and update on progress to develop accountable health and care working in the city through a Population Health Management approach.

2 Background information

2.1 People have told us that the lack of joined-up care is the biggest frustration for our patients, service users and carers. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.

2.2 The Leeds and Wellbeing Board has heard about the proposal for the ‘primary care home’ neighbourhood model of integrated health and care delivery.

2.3 Progress is being made by providers to develop this model however in order to further facilitate the approach, action now needs to be taken by commissioners to create the conditions for this to happen at pace and scale.

2.4 The proposed approach is to change the way we commission from focussing on organisations, services and pathways to population level outcomes. This is in line with national and regional policy and is a supported direction of travel by commissioners and providers.

2.5 Moving towards such an approach will allow providers to work together to deliver accountable care and be jointly accountable for delivery of the outcomes. It will also facilitate integrated and joined up services for people that support all of their health and wellbeing needs and enable the ‘primary care home’ or neighbourhood model to be implemented across the city - as providers design service delivery to best meet the outcomes set by commissioners.

2.6 This overall approach for both commissioning and provision is called Population Health Management (PHM).

2.7 This hypothesis widely recognised nationally and internationally is that by adopting this approach we will not only improve outcomes and patient experience, but it will also lead to a sustainable health and care system. It will also, in the long term, address operational issues around system flow for which one of the key factors is our fragmented system with providers working on separate outcomes and priorities due to the way that we have traditionally contracted and commissioned services in ‘siloes’. Evidence to support this hypothesis is still emerging nationally.

2.8 Delivering the Leeds Health and Wellbeing Strategy

Delivering accountable care will support the overall vision of the Leeds Health and Wellbeing Strategy and contribute to all five of its outcomes. Specifically accountable care will support the following LHWBS priorities:

Leeds HWBS Priority		How Accountable Care will support this priority
1	A child friendly city and the best start in life	Better integration between children's services and adults services meaning that vulnerable families will be better supported as a priority to give children the best start in life.
2	An age friendly city where people age well	Services that support older people will be more joined up meaning that care will be coordinated and streamlined. This will enhance people's experience of care.
3	Strong, engaged and well connected communities	Services will be designed around people's local neighbourhoods with staff working as 'one team' to meet people's health and care needs holistically. This in turn will support the development of new and existing third sector organisations that work in communities as part of the wider team.
7	Maximise benefits from information technology	Providers will need to implement new technologies and innovations in order to meet the population level outcomes. They will also need to join up systems in order to work as 'one team' and this will lead to the availability to enable enhanced health and care information.
8	A stronger focus on prevention	A key foundation of the new model of accountable care will be a focus on prevention. As well as improving wellbeing through supporting better health for longer, provider incentives will also be aligned to make sure that the accountable care system is focussed on prevention at all levels of need.
9	Support self-care with more people managing their own conditions	Self-care is a key principle of an accountable model of care. Evidence shows that health outcomes are better where people have the confidence and knowledge to manage their conditions and provider incentives will be aligned to make sure there is a focus on this.
10	Promote mental health and physical health equally	Accountable care allows focus on whole person needs rather than disease or organisation. This will facilitate and true move towards parity of esteem between mental and physical needs as well as social and wellbeing needs.
11	A valued, well trained and supported workforce	The workforce is the system's greatest asset. Currently there is a level of dissatisfaction experienced by elements of the workforce due to the fragmentation of the system and the frustration caused by being constrained in care delivery by organisational boundaries. By working in an accountable care system and in integrated neighbourhood delivery teams staff will have more autonomy over the way they work and will be able to more tangibly make a contribution towards whole person outcomes and increase staff satisfaction. Additionally teams will need to widen their skill sets and will need training and support to work in new ways.
12	The best care in the right place, at the right time	Accountable care will facilitate more effective, person centred community based services. It will support the move of appropriate services from hospital to the community and allow the establishment of integrated community based team which build on the integrated neighbourhood team model already established in Leeds. Where people need to be treated in hospital the support will be there so that they are admitted and discharged back to the community as soon as they are ready.

3. Main Issues

3.1. System Blueprint for Population Health Management

To align the broad support in the system to move towards this new approach colleagues from System Integration have worked with external public sector consultants BDO and a range of key stakeholders to develop a System Blueprint and Roadmap for achieving accountable care and Population Health Management in our health and care system.

The draft Blueprint was shared with stakeholders in July 2017 and comments received have been incorporated into this final version.

It highlights 4 key challenges for the health and care system:

1. Rapid implementation of PHM
2. System level challenges
3. Leadership and governance
4. Evolution of the Leeds Plan

There are additional challenges to the system if we are to be successful. A key challenge is how we work with current regulatory frameworks which could be a barrier to change. For example, competition, choice, Integrated Support and Assurance Process (ISAP) etc.

3.2. Commissioning Reform

There is an opportunity to strengthen current commissioning arrangements in the city to
enable outcomes commissioning to facilitate integrated care. The Leeds CCGs are committed to strengthening arrangements and have implemented the 'One Voice' programme to streamline the way they work in partnership.

The Integrated Commissioning Executive (ICE) currently has a relatively narrow focus. In the light of commissioning moving towards more strategic outcomes, it has an opportunity to review its focus and breadth which could expand over time and, for example, should a focus on frailty be agreed consider more joined up older people's commissioning between health and social care partners (e.g. through the BCF). The ICE is crucial to have the oversight of investments and disinvestments made within its current remit or how this has expanded to include older people health care commissioning.

3.3. Provider Reform

There is strong clinical leadership in Leeds with effective driving of innovation and care pathway improvement.

Providers are coming together in terms of new working relationships and it is noted that formal alliance working has formed focussing initially on GP streaming in A&E. It was recognised Leeds has taken the first bold steps to become more strategic and outcome focused and integrated with the local authority.

The neighbourhood model has broad support as the key delivery vehicle as does development of local care partnerships. This aligns with the national requirements of primary care whereby ‘primary care networks’ have to be developed, with partnership agreements in place for 50% of localities by March 2018 and 100% by March 2019. In Leeds we have done much of the ground work to enable this to happen.

A Provider Network was established in 2016 and is recognised as a firm foundation to support provider collaboration and to manage and sign off plans for integrated working. It was noted to have a longer term aim to move to an Accountable/Local Care System or partnership to develop associated agreements such as MOUs and risk/gain sharing understanding. Since the Blueprint was drafted is has been agreed that the provider network will become the Accountable Care Development Board (ACDB).

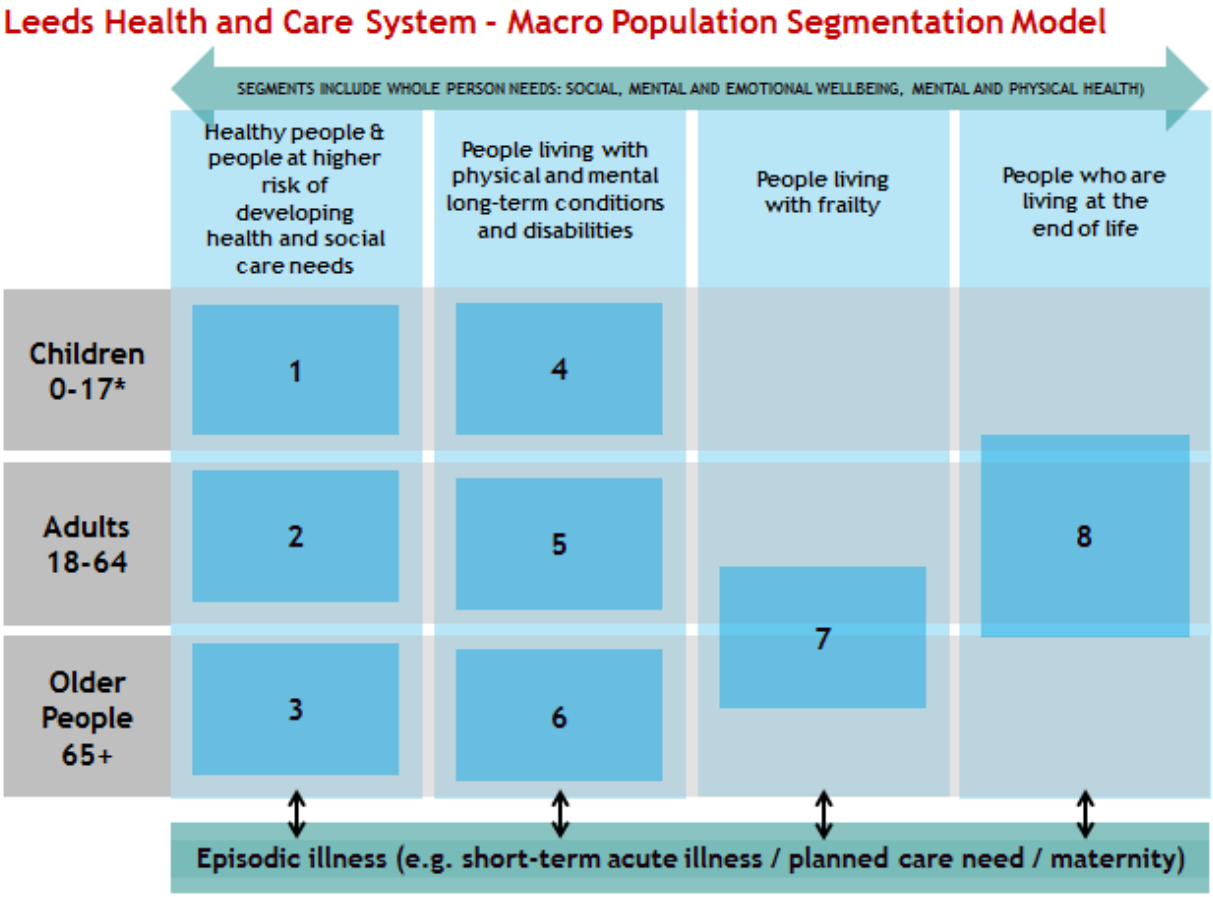
3.4. Population Groupings

In order to support the change to commissioning for outcomes in a manageable way it is necessary to divide up or ‘segment’ the population into reasonable sizes that are large enough to facilitate change but small enough to test the approach and manage risk.

Selecting a population segment will mean that service components will be pooled and outcomes will be developed for that segment and provide an opportunity for commissioners to contract with a group of providers in a way that they will be jointly accountable for delivery. Current financial flows will be matched to the segment and pooled budgets could be considered.

The segmentation model outlined in the blueprint for Population Health Management proposes eight high level population segments. A key principle is that whole person needs are able to be addressed for example physical, mental health and wellbeing and social needs. People of all ages, with all types of health and care needs are included in one segment only.

The ultimate aim is for the system to move to commissioning for population outcomes and integrated provision for the all the segments in due course. Selecting a segment allows the approach implemented and tested in a manageable way.



A set of criteria has also been developed by which to assess the segments and identify an 'accelerator' segment with which to test the approach before moving onto the second segment – and ultimately the whole population.

3.5. Process to recommend an accelerator segment

A process has been undertaken with stakeholders from commissioner and provider organisations to consider the segments alongside the criteria and evidence. Following this process it is recommended that **frailty including end of life** is selected as the first segment that is used to test this new way of working at scale in the Leeds Health and Care system.

Stakeholders who were part of the process considered data for each segment relating to the triple aim – health outcomes, cost and quality levels of ambition, strategic alignment and prevention opportunities and had were invited to vote for a segments after the discussions for each of the criteria.

One of the factors that was important during the process was discussions around scope and feasibility which took place towards the end of the process. Although the evidence / data pointed to people with long term conditions, or 'healthy' adults as the segments with the most opportunities ultimately the practicalities of selecting either a segment which was very large or a segment which would need to have a very wide scope felt quite overwhelming. Frailty / end of life was identified as the segment(s) where there was a good opportunity to do something different and make an impact across the system but was small enough in terms of population numbers to manage some of the associated risk.

3.6. Implications for the Health and Care System

3.6.1 Programme Plan

By committing to implementing a PHM approach for frailty / end of life the system is signing up to a reasonably large scale and long term programme of change. This programme will be led by the System Integration function and will include providers and commissioners of health and care initially, however as PHM is implemented the scope could be expanded to include other organisations such as housing, education, employment etc as the wider determinants of health.

In the first instance it is intended to develop a programme plan with workstreams, however existing groups will be used as far as possible. A high level programme plan or roadmap is included in the blueprint.

Workstreams will need to include (not an exhaustive list):

- Financial modelling and incentives alignment
- Communications and engagement
- Organisational development
- Outcomes framework development
- Contractual options appraisal
- ISAP (Integrated Support and Assurance Process – national Gateway process)
- Regulation appraisal
- Alliance agreements
- Delivery model agreement and development

3.6.2 Roadmap and timescales

Delivering PHM is a long term piece of work and more work is needed to plan a detailed timeline. The below table shows the initial timeline for the implementation of the accelerator segment, moving on to the second segment.

Key activity	Timescales
Sign off blueprint including system level changes and macro segments	Sept 2017
First accelerator segment selected	Sept 2017
Agree methodology to identify financial envelopes for all segments and produce ‘first cut’ of budget for initial accelerator segment	Dec 2017
Overarching outcomes framework developed	Mar 2018
Budgets confirmed for all segments	April 2018
Governance and contractual mechanism for outcome based commissioning of segment agreed. Regulatory support acquired.	Jun 2018
Shadow running of first segment & agree second segment	Jun 2018 – Mar 2019
Implementation of ‘real’ outcomes based contract with payments	Apr 2019 (TBC)
Next segment implemented	Apr 2019 (TBC)

3.6.3 List of boards and forums where accountable care, PHM and the Blueprint have been discussed to date

Meeting	JUNE	JULY	AUGUST	SEPTEMBER
Healthwatch Leeds Strategic Board Meeting	29-June			
Leeds West CCG Primary Care Network		20-Jul		07-Sept
Leeds South and East CCG Lead GP Group Board			01-Aug	06-Sept
Leeds North CCG Council of Members		04-Jul		12-Sept
CCG SMT		26-Jul	02-Aug 09-Aug 23-Aug	
Population Health Management (PHM)		18-Jul	15-Aug	
System Integration Board		21-Jul	25-Aug	
Leeds CCGs Partnership – Strategic Commissioning and System Integration Board		26-Jul		
Finance and Commissioning Committee		20-Jul		
Health and Wellbeing Board Workshop		20-Jul		
Provider Network (Accountable Care Development Board)		21-Jul	25-Aug	15-Sept
LTHT Board		27-Jul		
Integrated Commissioning Executive (ICE)		25-Jul	22-Aug	
Leeds Health and Care Partnership Executive (PEG)		06-Jul		08-Sept
Leeds Plan Delivery Group		26-Jul	31-Aug	
Leeds CCGs Patient Assurance Group		17-Jul		
St Gemma's Staff Conference		19-Jul		
Leeds Health and Care Board to Board Summit				12-Sept

4. Health and Wellbeing Board governance

4.1. Consultation, engagement and hearing citizen voice

4.1.1. A range of feedback from citizens spanning a number of years was taken into account when developing this approach. People have consistently fed back through engagements and complaints that despite the commitment and dedication of front line teams the system is fragmented, that it is complex to navigate, that there is duplication of process which can cause anxiety, stress, a poor experience and even harm.

4.1.2. A key task for autumn and winter 2017-18 is to develop the engagement approach to accompany this programme. Feedback has said that the blueprint in its current form is not a public facing document and therefore a public facing narrative will be developed and will align fully with the Leeds Plan narrative.

4.1.3. The public facing version will focus on the neighbourhood delivery model and will be around where the public and service users interface with health and care as that is where they will experience change and improvement.

4.1.4. A key opportunity for public engagement to take place will be the forthcoming community committees planned for the autumn where this will be discussed as a key element of the Leeds Plan.

4.2. Equality and diversity / cohesion and integration

4.2.1 This approach means that the needs of diverse groups can be better met in individual communities and also allows outcomes to be set for the population that take account of specific needs of people with protected characteristics or other minority or groups where identified.

4.2.2 With regard to integration this is a key principle of this approach and full implementation will lead to whole service integration.

4.3. Resources and value for money

4.3.1 This programme seeks to address the triple aim described in the Leeds Plan and therefore greater sustainability, use of resources and value for money is a key outcome of full implementation.

4.4. Legal Implications, access to information and call In

4.4.1 There are a number of legal implications to be worked through, not least procurement, regulation and contracting. These issues are key and will be picked up within the programme plan currently under development.

4.4.2 There are no access to information and call-in implications arising from this report

4.5. Risk management

4.5.1 The System Integration Programme Team at the CCG are managing risk via a risk register.

5. Conclusions

5.1 The further development of integration though commissioning for outcomes and accountable care has been discussed in Leeds for some time. Additionally there is strong support for development of the neighbourhood model and services that wrap around local communities.

5.2 The development of a blueprint and plan for delivering accountable care through a Population Health Management approach gives our health and care system an opportunity to progress this ambition by testing the approach on the frailty and end of life population segments, moving on to implement the approach for all segments in the population in a managed way.

6. Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the Blueprint for Population Health Management
- Provide challenge and feedback on appropriate engagement as we move through the process
- Champion Population Health Management principles as a key delivery vehicle for the system to deliver the Leeds Health and Wellbeing Strategy

7. Background documents

None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

Leeds Health and Wellbeing Board

Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

This approach allows outcomes to be set for the population that providers across the health and care system would be jointly accountable for delivering. One of the key principles of developing the outcomes framework for the population will be reducing health inequalities.

How does this help create a high quality health and care system?

Based on feedback from services users over many years a fully integrated system and care based around neighbourhood will offer an improved patient experience.

How does this help to have a financially sustainable health and care system?

Through reducing duplication, variation and by embedding prevention at all levels of health and care a sustainable system should be able to be achieved.

Future challenges or opportunities

This is a long term transformation that requires commitment by the whole system. Full implementation will take 5-10 years. There will be many challenges and opportunities along the way and it is critical that learning is captured on the journey so that full implementation can be achieved and the benefits realised.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	✓
An Age Friendly City where people age well	✓
Strong, engaged and well-connected communities	✓
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	✓
A stronger focus on prevention	✓
Support self-care, with more people managing their own conditions	✓
Promote mental and physical health equally	✓
A valued, well trained and supported workforce	✓
The best care, in the right place, at the right time	✓