Barking and Dagenham, Havering and Redbridge Strategic Outline Case for an Accountable Care Organisation*

November 2017

**Subject to official sign off through democratic processes and local scrutiny*
Pictures courtesy of Studio 3 Arts and NELFT

Strategic Outline Case Contents

	Common Introduction	3
	Executive summary	4
1.0	Introducing Barking and Dagenham, Havering and Redbridge	7
1.1	The people and places	7
1.2	The health and wellbeing economy	12
1.3	History of collaboration	14
2.0	Challenges and gap analysis	15
3.0	Evidence and best practice	17
4.0	Outputs from resident and staff engagement	19
4.1	Telephone surveys	19
4.2	Summary of the engagement programme	20
4.3	BHR residents survey findings	21
4.4	All staff survey	21
4.5	Voluntary sector engagement	22
4.6	Clinical engagement	22
5.0	Delivery model and commissioning arrangements	23
5.1	New model of service delivery	23
5.2	Key features of the locality delivery model	23
5.3	What would the new locality model give us	26
5.4	Why localities?	26
5.5	Proposed fast track locality approach	27
5.6	New joint strategic commissioning arrangements	30
5.7	Our approach; governance	30
6.0	Our devolution ambitions	33
6.1	Commissioning levers and financial flows and new payment models	34
6.2	Regulation and governance	34
6.3	Changes to workforce	35
6.4	Focusing on prevention – supporting personal autonomy and community	36
6.5	Estates	36
7.0	Proposed roadmap	37

Barking, Havering and Redbridge University Hospitals NHS Trust

Common Introduction

Over the past eighteen months, local and sub-regional areas have been working to make rapid improvements to health and care within existing powers and exploring how more local powers, resources and decision-making could accelerate the improvements that Londoners want to see at the most appropriate and local level. Different parts of London have diverse communities, health challenges and quality of health and care services. It is therefore entirely appropriate that different solutions are developed for different areas and that enabling tools, such as devolution, be adopted at different pace and scale based on local appetite.

In this spirit, the approach to London health and care devolution has been for five 'pilots' to develop shared local plans for health and care transformation and then identify opportunities to accelerate these plans through devolution. Each pilot business case aims to describe this local transformation vision, priorities, governance and delivery plans. The pilots have wide partnerships including local authorities, Clinical Commissioning Groups, providers of health and care services, clinical leaders, the voluntary sector and wider public sector partners. The visions and plans developed by the pilots aim to further this collaboration and accelerate health and care transformation, not just through devolution but also by accelerating progress within existing arrangements. These business cases have been developed locally and are owned by the individual pilots.

Over the past eighteen months, the work of the pilots has demonstrated that the benefits of devolution are as much from indirect as direct effects. The potential of devolution has galvanised local plans, local ownership and local partnerships and made sure that the potential of existing arrangements has been fully explored and implemented. But it is also clear that devolution itself would provide significant benefits to enable the delivery of these local ambitions.

The pilots, London and national partners have worked together explore the proposals set out in these business cases. Where there was a clear case that proposals would assist, enable or accelerate improvements to the local health and care system, steps have been taken towards devolution, delegation or sharing of functions, powers and resources currently exercised by national partners. The London Health and Care Devolution MoU contains details of the specific devolution commitments made by Government and national partners.

Executive Summary

In December 2015 BHR was selected as a devolution pilot to test the viability of an Accountable Care Organisation (ACO) for the BHR system. This was one of several pilots in London, approved to test the boundaries of devolution following a call for pilot bids by the NHS and London Councils. BHR wanted to be in the forefront of piloting new ways of working across organisational boundaries to achieve a step change in health and social care outcomes in BHR in order to radically improve outcomes for local people and seek to mitigate the growing financial demands in the system.

Eight organisations across Barking and Dagenham, Havering and Redbridge (BHR) have worked together to develop a strategic outline case for an Accountable Care Organisation (ACO).

Delivering our vision

The ACO programme has been led by the BHR Democratic and Clinical Oversight Group comprising of leaders from across the system, with the objective of delivering the vision described below.

Our vision: To accelerate improved health and wellbeing outcomes for the people of Barking & Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services

Delivered by a system with the following aims:

- Enable and empower people to live a healthy lifestyle, to access preventive care, to feel part of their local community, to live independently for as long as possible, to manage their own health and wellbeing, which creates an environment that encourages and facilitates healthy and independent lifestyles.
- Where care is: organised around the patient's needs, involves and empowers the patient, is integrated between agencies, with a single point of access, is provided locally where possible, meets best practice quality standards, and provides value for money.
- In which organisations: share data where appropriate, work collaboratively with other agencies and maximise effective use of scarce/specialist resources (e.g. economies of scale).
- Where artificial barriers that impede the seamless delivery of care are removed, bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.

From a person's point of view:

- The system will feel seamless and responsive to their needs. There will be clear information and advice about how to access services to ensure that they receive the right support in the right place, all of the time. Those working in health and wellbeing (including other critical support services such as local authorities, community care, public health and the voluntary sector) will be members of a 'community of care' driven by a shared vision.

Through a new BHR model

The SOC describes a set of priority prevention and service interventions which have been identified to address the health and wellbeing, quality and financial gaps being experienced by the BHR population at present. It also describes the specific areas where the current health offer may not necessarily be the right one for local people and that it costs the system much more than it should do to continue to treat people in this way. The classic examples of this are too many people going to Accident and Emergency because they either can't or don't know how to access an alternative service, people being admitted to hospital when better management of their long term conditions could have prevented this, and emergency admissions because people have been unaware of a condition that presents as an emergency because their symptoms were not identified at earlier opportunities.

All of these pathways need to change, but delivering that change is complex as it involves reorientation and a significant change in the way that health and social care co-ordinate and operate. As the system is so large and complex, one of the first major challenges that arise is where to start. The proposition in the SOC is to build a new system around the population rather than around institutions. This would effectively develop a new model of local delivery (locality delivery model) where social care, other council services that can support people's social needs, the voluntary and community sector, GPs and community health providers form new local partnerships to deliver the vision and commitments as set out above.

The proposition is that this would be a very significant first step in bending the future curve of health and social care demand and would significantly shift investment and monies towards locally delivered health and social care and away from acute based services as people receive the right advice and care. As well as requiring a new single place based contract to be negotiated with the NHS and social care providers, it would also involve negotiating new and different contracts with the hospital provider. Once this first step has been delivered, and changes begin in earnest on the ground, further consideration could be given to a whole place Accountable Care Organisation, including the acute trust.

STP and other contextual implications

It is acknowledged that this is a pragmatic first step towards transforming the BHR system, but it is offered on the basis that so much else is changing in NHS systems at present that building locality based provision seems the safest building block for the future. It places the power and focus on local services as opposed to acute services; something that the BHR system has been in need of for a long time. Attempting integration with BHRUT while they are still in special measures and being pulled into closer working with the STP does not seem a viable alternative. Creating real local multi agency integrated care providers offers the best chance of making swift progress and delivering real change within the next 18 months to two years. It also provides a powerful contribution to the STP planning process because very strong multi agency delivery organisations in BHR localities will have power and influence as they demonstrate real change and impact, focussing on where people live, experience the majority of their care and have their needs met as the primary driving force and focus of transformation.

While BHR put together its outline case, more clarity has emerged from the NHS nationally about new models of care and about the STP planning process. Emerging thinking on options for care models has been informed by other pilots and vanguards throughout the country. One

of the consequences of this is that the original ACO model on the sort of boundaries represented by BHR is more difficult and other models are now being considered and evaluated. At the same time, particularly within London, the STP footprint has been agreed to be on a wider footprint than BHR. This has had the consequence of particularly pulling the acute sector into much closer working across STP footprints than was the care hitherto. Detailed discussions about devolution and what it could actually mean in practice are also still ongoing across London.

As the STP process was emerging, the work undertaken by the BHR ACO business case was able to be fed directly into the funding and gap analysis required for the NEL STP submissions. Work was also accelerated through the STP with regard to how to bridge the very large funding and demand gaps within the acute sector both within BHR and the wider NEL patch. The ACO business case has fed back into its financial analysis the savings that the acute trust within BHR now believe they can make in working across the NEL patch. Thus the NEL STP and the BHR ACO business case are now inextricably intertwined in that both need the other for delivery of the maximum amount of improvement in health and social care outcomes and the maximisation of efficiencies and savings.

Next steps

Given all of the above, the best way forward to deliver the health and social care changes BHR residents want and need is to adapt our original BHR ACO plan to capitalise on our BHR strengths to take advantage of the wider planning processes ongoing within NEL and beyond. In summary these would make our next steps:

- To recognise that the strategic outline case prepared for the ACO represents the best base line case, outline plan and roadmap to improve health and wellbeing in BHR
- To consolidate the strong partnership, including democratic and clinical leadership into a formalised commissioning and leadership group to drive forward change and delivery
- To ensure BHR have a strong, democratic as well as professional voice within the emerging NEL governance structure
- To push forward with a locality delivery model involving all partners in new ways of working to deliver the best pathways of health and social care in our local communities
- To further consider the emerging new models of care over the next few months with a view to considering the best model or models for BHR for the future
- Submit our case formally to the STP for release of transformation funds to deliver BHR's part of the NEL STP
- To undertake further work to clarify the specific devolution asks that might be required to deliver the BHR plans in full, and submit further business cases as appropriate. Through this process became an exemplar for London

We have set out a clear vision, service model and roadmap for delivery for the BHR system over the coming year and every organisation is committed to doing its part.

While much can already be achieved with existing powers, devolution presents a key opportunity to deliver greater and faster transformation for the benefit of our population, as set out by the London Health and Social Care Devolution Memorandum of Understanding (MoU)

1.0 Introducing Barking and Dagenham, Havering and Redbridge

Barking & Dagenham, Havering and Redbridge are adjacent boroughs in outer north east London. They share a single major acute provider, Barking Havering and Redbridge University Trust, and a large community and mental health Trust, North East London Foundation Trust. This creates a natural alignment for health and local authority partners to work together to achieve the best outcomes for the whole population.

The three boroughs have distinctive populations: Barking and Dagenham has a younger and ethnically diverse, mainly deprived population; Havering an older, largely white population; and Redbridge an ethnically diverse, majority Asian, median income population. The variation between the three boroughs means that through working on a combined footprint, there is an opportunity to pool resources and redirect additional support to places where they are needed most.

Demographic change is an important driver of demand for health and wellbeing services. BHR's population has been increasing rapidly and is projected to rise for the next two decades. The current system will struggle to respond to the overall projected increase of 19 – 28% by 2031.

Key points:

- Our changing population profile means we need a new approach to preventing ill health and targeting people who are more likely to require health and social care in the future;
- The resources required per head increase with age, any new service model and resource allocation must be appropriately designed to address these challenges; and
- We have a proven track record of working together to improve the health outcomes for the people of BHR.

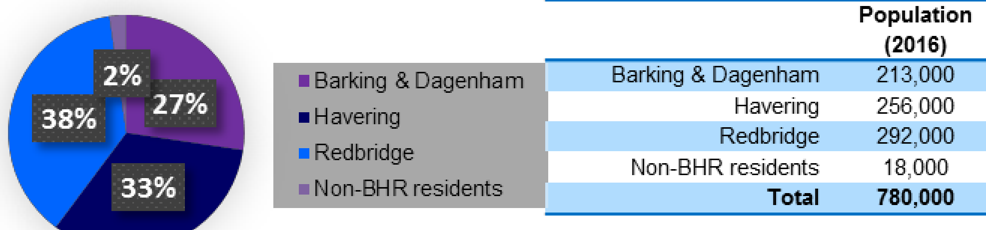
1.1 The people and places

Population growth will result in considerable increased demand for both health and social care. Adapting our service delivery model must be a priority, to ensure resources are directed to BHR residents in the most efficient way possible.

Figure 1: Population Growth

Population growth

BHR consists of an estimated 762,000 residents across the three boroughs. GP registrations (from Health Analytics) record that in mid-2015, 780,000 residents were registered with GPs in the 3 CCGS in the BHR health system. 213,000 were listed to Barking & Dagenham, 256,000 to Havering, 292,000 to Redbridge, and an extra 18,000 living in neighbouring boroughs were registered with BHR GPs.



	Population (2016)
Barking & Dagenham	213,000
Havering	256,000
Redbridge	292,000
Non-BHR residents	18,000
Total	**780,000**

The BHR population has grown rapidly in the last decade and is projected to increase further in the next 20 years. Population projections vary between GLA estimates and ONS estimates.

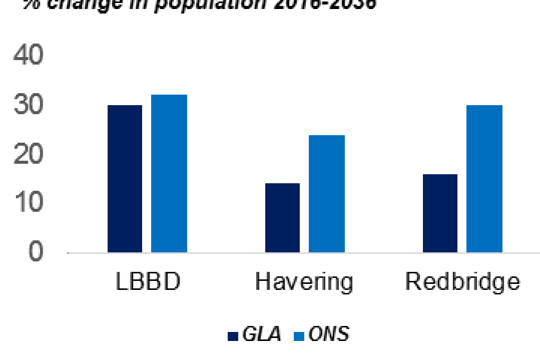
BHR population growth forecast

Source	Current All age (000s)	10 year All age (000s)	20 years all age (000s)	Increase over 20 years All ages
ONS	762	879	978	28% or 216k
GLA	758	844	905	19% or 147K
ACO responsible	780	869	931	19% or 151K

BHR has seen large increases of migration and high birth rates over the last 5 to 10 years. In 2014 Barking and Dagenham had the highest fertility rates in London, although rates have started to decline. Between 2011 and 2016 LBBD's population increased by 10%. LBR's population has also risen by 7% over the same period, whilst LBH grew at 5.4%.

GLA projections show the largest projected increases in Barking and Dagenham. ONS projections suggest that Barking and Dagenham and Redbridge will have similar rates of population increase over the next 10 and 20 years with Havering having slightly lower rates.

Population growth by borough

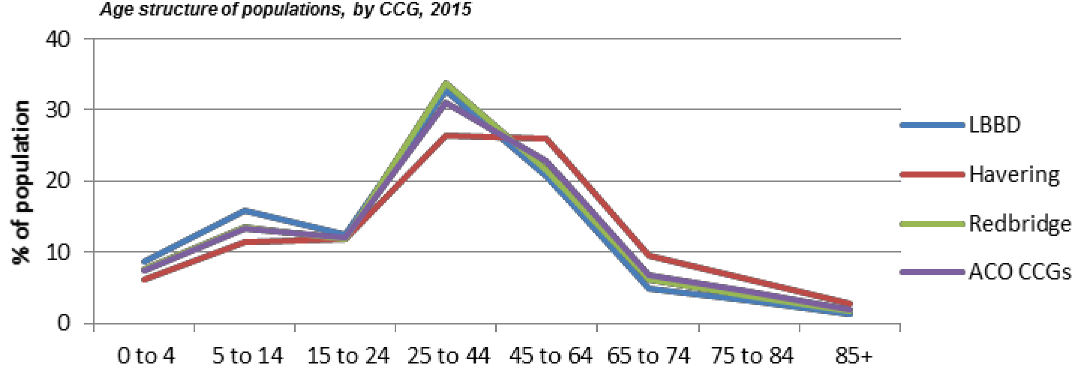


The range of age-specific population forecasts means that each borough in BHR has specific healthcare challenges that are associated with their own demographic forecasts. The prevalence of long term illness and demand for care increases with age.

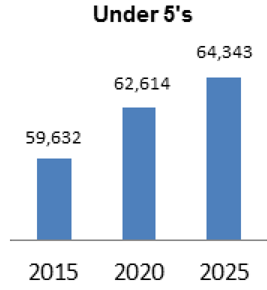
Figure 2: Age Distribution

Age distribution

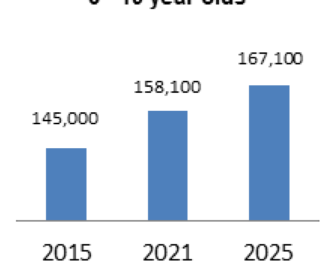
The population age distribution is varied across each of the three boroughs. Barking & Dagenham has a young population with 10% aged under 4 and 10% aged over 65 years. Havering has a much older population with 6% aged under 4 years and 19% over 65 years. Redbridge's age distribution is more in line with Barking & Dagenham than that of Havering.



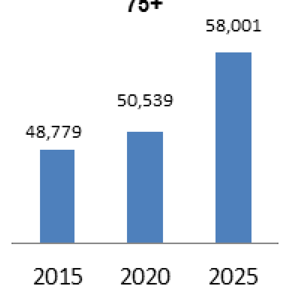
The older age groups are projected to show the greatest increase in the next 20 years with a projected increase of 45-51% in people aged 65+years across the ACO footprint. The biggest percentage increases in this age group are projected to be in Barking and Dagenham (56%) and Redbridge (48-56%), with Havering at 38-44%. For people aged 85+ years the largest increases are projected to be in Havering (72-85%) and Redbridge (67-82%) (Ranges represent different estimates between ONS and GLA).



- There are 11,590 births and 5,340 deaths in BHR per annum. By 2025, the number of births per year is projected to increase to 12,453 (+863) and deaths to fall to 4,983 (-357)



- The growth in numbers of those aged 5-19 is significantly higher than London and England (e.g. 50% higher than the growth forecast for London) and will increase by 15% in 10 years (2025)



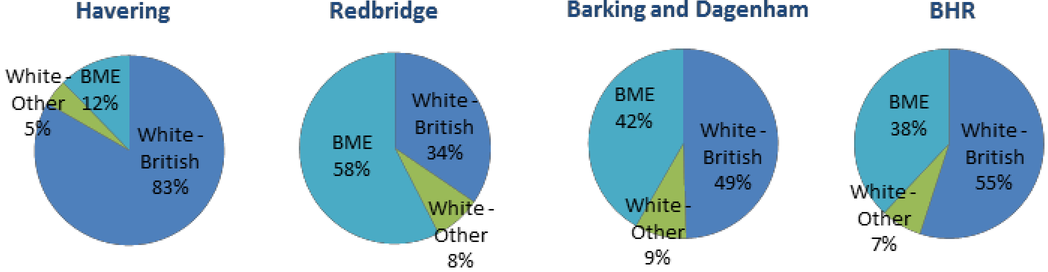
- The already substantial 75+ population of BHR will increase by almost 19% in 10 years (2025)

The ethnic diversity of populations can have an effect on the need and demand for health care as some conditions/diseases are more common in some ethnic groups.

Figure 3: Diversity

Diversity

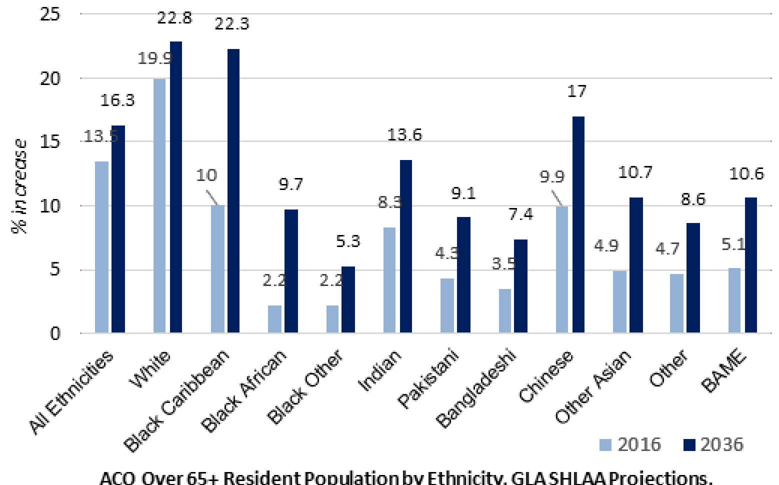
Barking & Dagenham has seen a rapid increase in the numbers and proportions of people of Black and Minority Ethnic (BME) origin; GLA estimates that 49% of population is BME, and this is projected to increase further in the next 10 years. Redbridge is correspondingly diverse, with the Black and minority ethnic group representing 63% of its population, but the predominant group is of South Asian origin. Havering is comparatively less diverse with only 16% of its residents in the BME group and 84% White-British.



Ethnic Diversity in BHR

The ethnic distribution of the ACO population is likely to change as patterns of migration change and the BME population is projected to increase in Baking and Dagenham and Redbridge. In addition, whilst the older population is currently predominantly white, the existing BME population is ageing and this will affect health needs of the population. The model of care in the ACO will need to respond to the specific needs which emerge.

- BHR has a high level of ethnic diversity - approximately four in 10 residents of BHR are from a BME background
- The ethnic diversity is projected to increase and is already evident in our young population as a result of migration and population growth.



ACO Over 65+ Resident Population by Ethnicity, GLA SHLAA Projections, *(2016-36)*

There is a strong correlation between deprivation, poor health outcomes, and the cost of health care. This presents an opportunity for our service delivery model to better target those who are more likely to require healthcare in the future.

Figure 4: Deprivation

Deprivation

- **Barking & Dagenham** is currently the 3rd most deprived area nationally and this is reflected in the poorer standard of health and wellbeing outcomes - life expectancy for both men and women is lower than the England average. Over half of the borough's population live in the 20% most deprived areas in England, whilst around one third of children in the borough are living in poverty.
- **Havering** is a more affluent area than the other two boroughs, being ranked 166th overall out of 326 local authorities for deprivation, however the borough still has pockets of poverty. Two small areas of the borough (situated in Gooshayes and South Hornchurch) fall into the 10% most deprived areas in England. When compared to Barking & Dagenham, Havering has a relatively small proportion of children living in poverty, however this has risen in recent years, bucking the trend seen in most other London borough of declining levels of child poverty. Unemployment levels in 2015 were lower than London and national rates (5.3%).
- **Redbridge** ranks 119th out of 326 boroughs but has areas of affluence and of poverty. In 2015 the unemployment rate was 8%, higher than London and national rates, but the proportion of children in workless households was lower than London and national rates at 12%.

As a collective ACO footprint, the rates of people claiming out of work benefits in the BHR population are similar to the London average, although rates vary from 12% in Barking and Dagenham to 7% in Redbridge.

Rank in order of most deprived boroughs in England

Redbridge 119th
Havering 166th
Barking and Dagenham 3rd

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
LBBD
Havering
Redbridge
ACO
10
9
8
7
6
5
4
3
2
1

Levels of deprivation, 2015, by national deprivation deciles

1.2 The health and wellbeing economy

The BHR health and wellbeing economy is comprised of Barking & Dagenham CCG, London Borough of Barking & Dagenham (LBBD), Havering CCG, London Borough of Havering (LBH), Redbridge CCG, London Borough of Redbridge (LBR), Barking, Havering and Redbridge University Hospitals Trust, North East London Foundation Trust and our academic partners UCLP; who have come together to improve outcomes for our diverse population. The coterminous nature of organisations across the BHR footprint lends itself well to partnership working.

BHR's health and wellbeing providers

Organisations	Key Facts
Barking, Havering and Redbridge University Hospitals Trusts (BHRUT)	• Run two hospitals - King George Hospital in Goodmayes and Queen's Hospital in Romford; • Serves a population of around 750,000; • Employs ~6,500 staff; • Annual budget of £505 million in 2015/16. • Queen's Hospital operates a full A&E service with trauma centre and a hyper- acute stroke unit. It has the largest maternity unit in the country, a renal dialysis unit and a specialist neurosciences centre and a joint cancer centre run with Barts Health Hospital London; • King George Hospital was built in 1993 and services provided here include an A&E department and a chemotherapy day unit; and • Barts health is a provider of specialist services and is the provider of choice for a number of BHR residents due to access, notably from Redbridge.
NELFT	• Provides an extensive range of integrated community health services for people living in BHR and Waltham Forest and community health services across Brentwood, Basildon and Thurrock; • Employs ~6,000 staff; • Care and treatment is provided to about 1.75 million people; • Annual budget of £330 million in 2015/16; • Acclaimed nationally for meeting the needs of people with mental health concerns; • Won numerous awards for its older people services; • Consistently provides high quality services particularly in memory services and London Ambulance services; • Strong record of financial management and governance control from the time it became a foundation trust; • It is the principal partner in The Care City Innovation Test Bed, addressing barriers to innovation within the NHS and Social Care, and remains at the forefront of innovation efforts in community services with models such as the community treatment teams.

BHR CCGs	• The three CCGs have their own governing bodies which include experienced GPs, other healthcare professionals, senior NHS managers and a patient representative; and
Primary Care	• Barking and Dagenham: Three GP Networks established and meeting monthly, Memorandum of Understanding agreed. GP Federation 'Together First' established with 100% membership from the 46 GP Practices, of whom 25 are shareholders. • Havering: Three GP Networks established and meeting regularly, terms of reference agreed. GP Federation 'Havering Health' established with 100% membership from the 44 GP Practices, of whom 40 are shareholders. • Redbridge: Four GP Networks established and meeting monthly, terms of reference agreed. GP Federation 'Health Bridge Direct established with 100% membership from the 44 GP Practices, of whom 17 are shareholders. • Each of the GP Networks have identified leads who are being supported through a UCLP RCGP accredited leadership programme.
The three local authorities across BHR	• Social care services have statutory responsibilities to safeguard vulnerable children and adults, and to provide a range of services to meet assessed needs in line with the Care Act and Children's Act; • For adults they focus on prevention, re-ablement and maintenance of independence; • For children they focus on prevention and early intervention to support children and families, care plans to support families while protecting children, and the Council's role as a corporate parent where required. This involves development of integrated health, care and education plans for children and young people; • Councils also provide a range of health and wellbeing interventions focused on promoting healthy living, preventing illness and supporting patients with long-term conditions; • Since 2013 Councils have been responsible for public health services like drug and alcohol treatment and recovery, contraception and sexual health, quit smoking, heath visiting and school nursing; and • They have a key role in housing, leisure and culture, education, work and the benefits system and so in the widest sense are intrinsically linked to the development of the locality delivery model outlined in

The voluntary sector	• Barking and Dagenham and Redbridge Voluntary Sectors are headed by a CVS in each borough which supports individual organisations to develop and act as a conduit between organisations on the ground and commissioners; • In Havering there is a Concordat which performs a similar function; and • There are some fantastic examples of best practice care being delivered in the community through the voluntary sector and our dialogue with this group as part of the ACS programme development has highlighted an appetite to evolve as required to meet need across BHR.
Academic Partners	• UCLPartners, our academic health science partnership, has over 40 higher education and NHS members, delivering improved health outcomes and wealth through discovery science, innovation into practice and population health; • The partnership covers a population of over six million people in North East and North Central London, South and West Hertfordshire, South Bedfordshire and South West and Mid Essex; • UCLPartners facilitates the improvement of population outcomes through: Academic Health Science Centre, Academic Health Science Network, Education Lead Provider and aligned with the NIHR Collaboration for Leadership in Applied Health Research and Care and the NIHR Clinical Research Network North Thames; • It is the only academic health science partnership in the country to align these NHS and Department of Health designated roles under one umbrella; and • UCLPartners brings links to the academic community, and delivery of innovation

1.3 History of collaboration

There is a strong history of successful collaboration across health and social care in Barking & Dagenham, Havering and Redbridge, leading to real improvements for our local population.

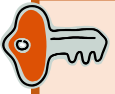
This is exhibited through the BHR Integrated Care Coalition (ICC) which was established in May 2012. The ICC brought together the lead organisations in our health and wellbeing economy who are committed to working together in a (guiding) coalition of strategic partners to develop a joint approach to integrated care. This was in response to significant pressure experienced across the system, particularly at BHRUT, resulting in non-delivery of key access targets.

The Coalition is a leadership group which makes recommendations to, and works closely with, the local health and wellbeing boards, CCG governing bodies and provider organisation boards. The ICC states their purpose as "Improving outcomes for local people through best value health and social care in partnership with the community" and has the following responsibilities:

1. *Developing recommendations for a system wide integrated care strategy for consideration by the system's health and social care commissioners: the Health and Wellbeing Boards and CCGs.*
2. *Developing the systems 5 year strategic plan (delegating authority for the co-ordination of the plan to the Coalition sub group: Integrated Care Steering Group*
3. *Driving improvement in urgent care at a pace across the BHR system (delegating authority to the Coalition sub group: Urgent Care Board)*

Our status as an Urgent and Emergency Care Vanguard, the excellent partnership working through the ICC, and our work with UCLP and Care City demonstrate our commitment to the vision and complements our joint ambitions.

The Coalition has led the development of a significant number of transformational programmes that have contributed to dramatic improvements across BHR. We know that this is just the start and the scope of our partnership has now increased to address the numerous challenges that BHR health and wellbeing system currently faces, and the implications these challenges will have in the future.



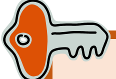
We have a robust understanding of the people and place we service and a track record of delivery. We have had a number of transformational programmes that have contributed to dramatic improvements in service delivery and outcomes across BHR.

2.0 Challenges and gap analysis

The BHR system has significant challenges to tackle including; poor health and inequalities, care and quality and financial sustainability. We have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs. Healthy life expectancy in Redbridge (63.0 years for women, 63.0 years for men) and Barking & Dagenham (54.6 years for women, 59.3 years for men) is significantly below comparable figures in London (64.1 years for women, 64.0 years for men) and nationally. Patients have often found it challenging to access the right service, in the right place, at the right time. Our acute provider - Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) - was placed in special measures in 2014 and is two years into a transformational improvement programme. It has seen significant improvement in emergency flow, staff engagement and financial performance, however, broader system wide partnership is needed to address longstanding access issues including increasing A&E attendances, admissions and reducing waiting times for elective care. Primary care also faces significant challenges with a large proportion of GPs nearing retirement, difficulty in attracting new talent and a number of practices across BHR operating in siloes. All of this together has added to an already significant financial challenge - in order to continue providing services

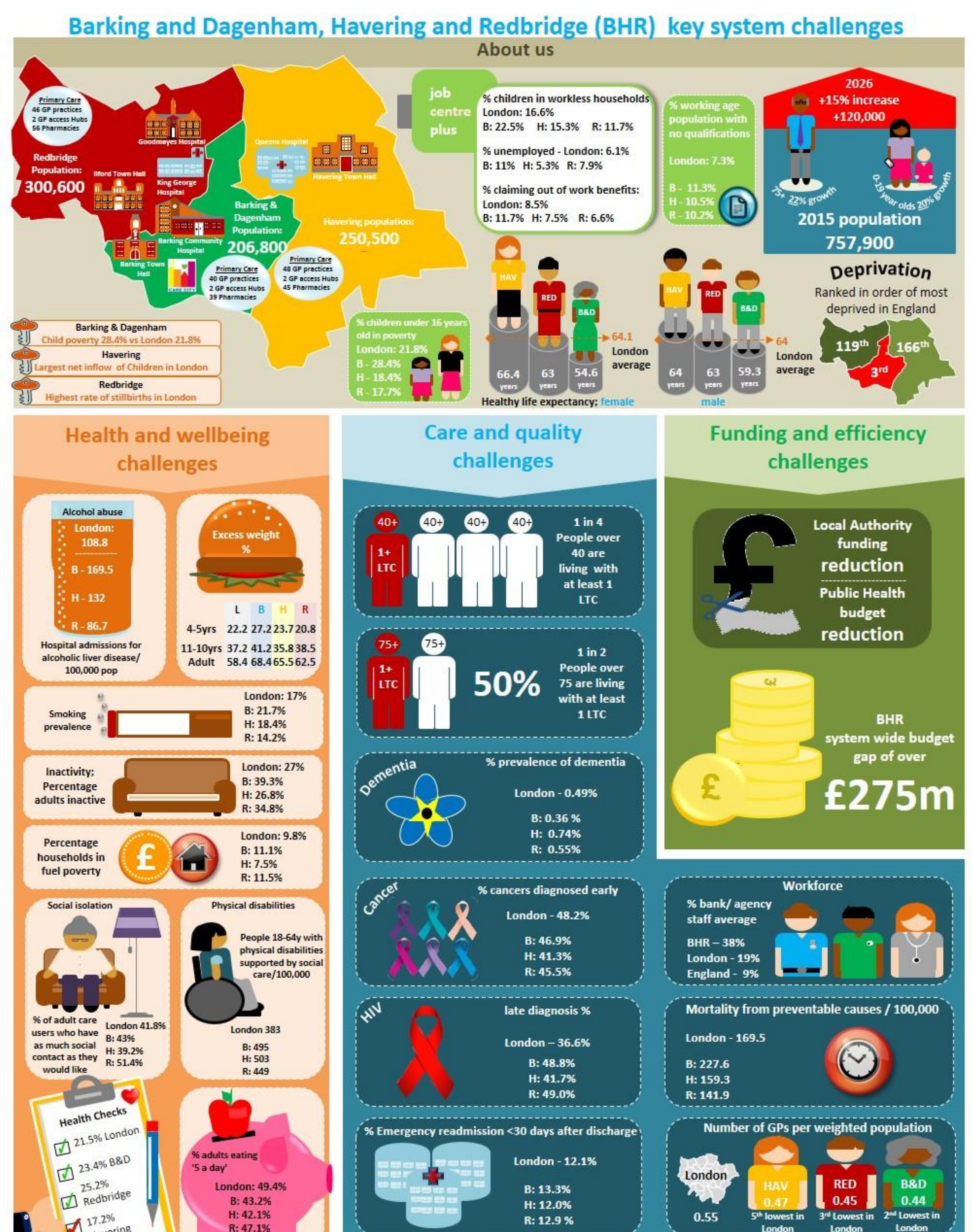
consistently and if the system were to deliver care in the same way that it does today without achieving any efficiencies, expenditure in 2020/21 is forecast to exceed income by £614 million.

The infographic below provides a quick view summary of our key system challenges.



We have a robust understanding of the challenges we face across BHR. Detailed analysis of the key health and wellbeing, care and quality and finance and efficiency challenges can be found in section 2; 'recognising our challenges' of the supporting information pack and demonstrated in figure 5.

Figure 5: BHR key system challenges



3.0 Evidence and best practice analysis signalling priority service and pathway areas that need to change across BHR

The SOC process drew on both national and international evidence to identify best practice to compare the BHR position and make recommendations for change. This included the following:

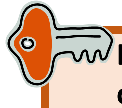
1. **Right Care:** Compares the cost and effectiveness of services by specialty for each CCG against a cluster group of 10 CCGs comparable in terms of population. Identifies and quantifies how much money can be saved and how much health can be improved for each specialty if local performance were to match: a) the average of the cluster, or b) the average of the best 5 in the cluster
2. **Commissioning for Prevention (Healthy London Partnership review):** Set up to identify how much money could be saved by focusing on prevention and thus reducing the cost of healthcare treatment downstream. Based largely on the costs of lifestyle to the NHS
3. **Research evidence:** A review of the academic literature for effectiveness of interventions tested in the service where results identified and quantified benefit
4. **Review of national and international documents:** Including programmes relating to Devolution, Integrated Care, and ACSs
5. **Reviews of the effects of:** social determinants on health, workplace interventions.
6. **Review of work from UCL Partners**
7. **Stress-Testing** of service interventions by PwC

From this extensive research the following interventions were identified:

Investing in prevention		
	Interventions/Actions	**Impact**
Housing	• Home improvement schemes • Home adaptations • Fall prevention schemes e.g. Safe at Home	Demand for health and social care services is expected to fall leading to reinvestment cost savings.
Employment Schemes	• Clear focus on getting people back to work • Effective healthy workplace schemes to reduce sickness.	People are empowered to take care of themselves and are taken care of by employers. This will lead to a reduced strain on health and social care services and cost savings for the system.
Lifestyle Interventions: • Smoking • Obesity • Alcohol • Physical inactivity	• Primary care and A&E interventions (to target smoking and alcohol) • Weight management programmes • Birmingham Be Active Programme	Cost savings in primary care and reduction in number of health problems among population.

Improving person pathways		
	Interventions/Actions	**Impact**
Diabetes	• Implement the National Diabetes Prevention Programme • Screening for pre-diabetes • Better control in 1 care • Weight control bariatric surgery for targeted groups	Early indicators are detected and treated as soon as possible.
Chronic Obstructive Pulmonary Disease (COPD)	• Primary care clinics • Smoking cessation programmes	People are provided with the most effective treatments leading to improved outcomes at a lower cost.
Genito Urinary (GU)	• Better testing and control for kidney disease • Treatment for UTIs in primary care	Co-ordinated care with the most effective treatments provided to people.
Gastro Intestinal (GI)	• Reducing liver disease through alcohol interventions	Coordinated care with the most effective treatments provided to people.
MSK	• ESCAPE knee pain programme • CBT interventions for back pain, • Testing for Bone Marrow Density • Improved pathways	Co-ordinated care with the most effective treatments provided to people.
Mental Health (MH)	• Improved access to IAPT services • Internet delivered CBT • End of Life Care for people with dementia to reduce deaths in hospital	Empowering people to manage their own conditions and providing the most effective and suitable treatment.

Delivering integrated health and social care pathways		
	Interventions/Actions	**Impact**
Social Prescribing	• Social prescribing projects using voluntary sector agencies to signpost people to various support programmes. • Programmes will be commissioned and co-ordinated to engage a range of stakeholders	Reduced hospital admissions leading to cost savings for the system.
Falls prevention	• Co-ordinated strategy and pathway across all relevant agencies to reduce the risk of (repeated) falls.	Reduction in the number of falls in older people and savings in emergency admissions.



Implementation of these service interventions could potentially lead to savings of circa £27 million which would go towards addressing the financial challenge in these areas as well as helping to close the health and wellbeing and care and quality gaps.

4.0 Outputs from resident and staff engagement

As part of the programme, we chose to engage with critical stakeholders including residents, our staff and the third sector. Over 3000 residents and 750 staff were surveyed. The results are summarised in the pictorial below. They emphasised the current complexity and need for change.

4.1 Telephone surveys

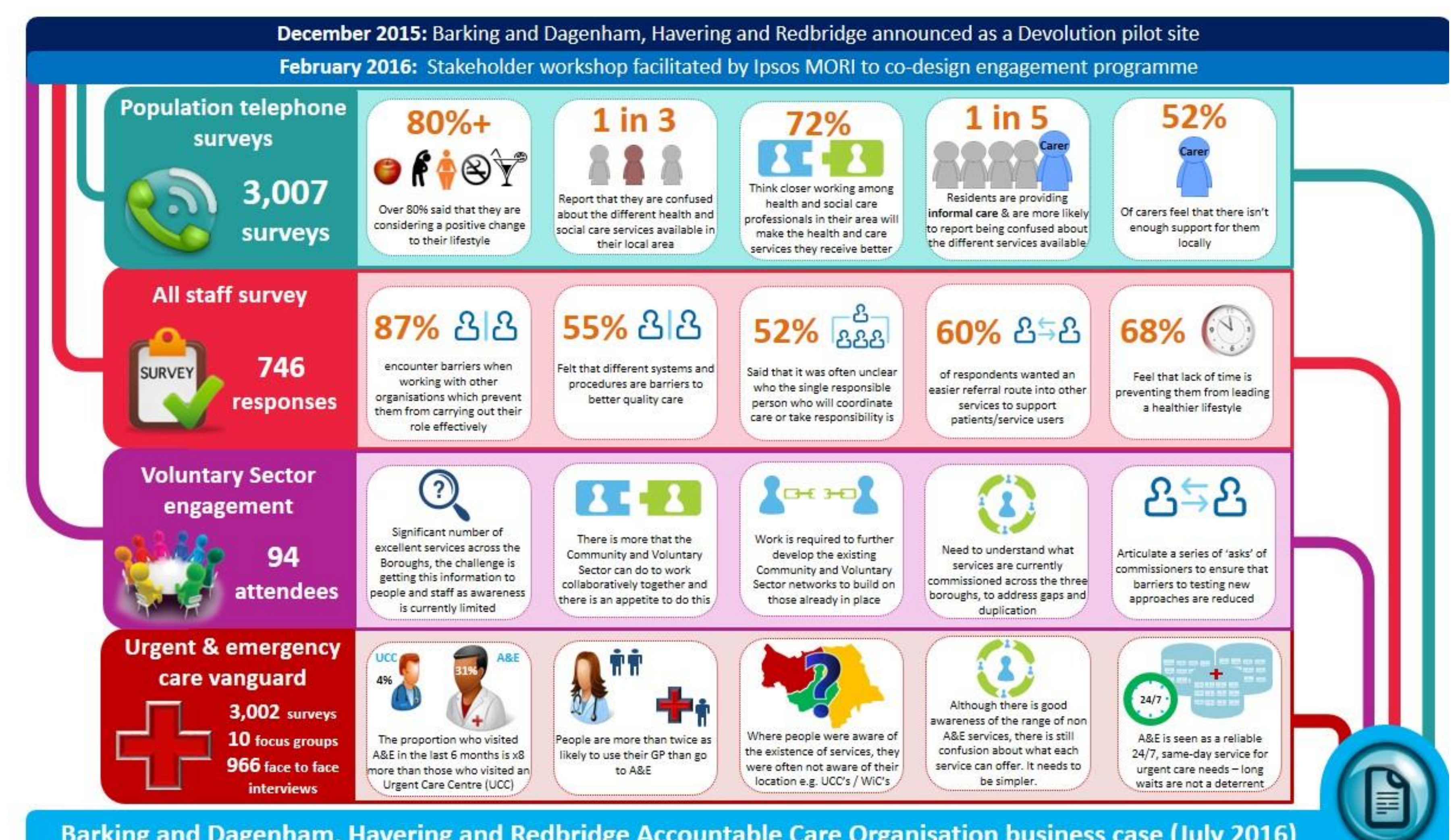
Ipsos MORI completed 1,000 telephone surveys per borough, 3,007 in total across Barking and Dagenham, Havering and Redbridge.

Each survey lasted approximately 15 minutes with a focus on:

- Attitudes to health and social care at both borough and locality level;
- What our population feels they need to support them to live healthier lives;
- If people feel they receive enough information regarding the services available to them and how they would like to receive this information; and
- What people feel would improve their experiences of health and social care

The purpose of the telephone surveys was to gain a rich cache of information around the attitudes of our population and what we can do to support them to live longer, healthier lives. The survey questions were developed alongside, and align to, the Vanguard programme questions to provide a whole system view of our population.

4.2 Summary of each element of the engagement programme



4.3 BHR residents survey findings

People want a more responsive, joined up system that delivers timely care closer to their homes. There is an appetite for doing things differently:

- Residents recognise the positives of more integrated working;
- There is an appetite for services that support healthy living, but better promotion is needed;
- Access to and quality of information about services is key (arguably even more so for those in poorer health).
- Carers in particular feel that they need more support to navigate the system and to support their own health and wellbeing;
- There is a geographical and demographic dynamic to attitudes, but this exercise means that we understand more about these groups and what drives them to assist with better targeting.

4.4 All staff survey

Staff working for BHR CCGs, the three local authorities, NELFT, BHRUT, LAs (those in BHR only), PELC, and the CSU along with GPs across BHR participated in the survey. This was developed by communication leads from across BHR alongside clinicians in collaboration with a group of operational and back office staff. The purpose was to understand their views on how health and social care services in BHR can be improved and how all of us can be supported to live healthier lifestyles.

This was the first time that all health and social care staff and GPs working in BHR have been surveyed collectively. The key areas of focus were:

- The barriers between services that impede the delivery of good quality care;
- The ways in which clinical staff can be helped to support our population to live longer, healthier lives; and
- What our staff wants from us to support them to live healthier lives.

Survey findings:

- Health and social care staff need to be supported to work more closely together;
- There needs to be reduced duplication and more streamlining of services;
- There needs to be a shared vision and objectives which reflect the needs and wants of the public supported by organisational cultures that complement each other;
- A comprehensive electronic shared records and a single strong IT platform across the system is essential;
- There needs to be clear guidance around responsibility for service users/people;
- There needs to be work towards a more equitable service provision across the three boroughs;
- There must be a focus on outcomes as opposed to finance and activity;
- There is an urgent need to address front line staff workloads by ensuring that workforce levels meet current demand; and

- There are a number of ways in which employers can support staff to live healthier lives and reduce stress.

4.5 Voluntary sector engagement

We have engaged the thriving voluntary sector to explore ways of working that are mutually beneficial and discuss how they could support some of the key areas of focus that emerged from the programme workstreams. This included the importance of delivering holistic health and social care around key population groups such as those who are frail, complex cases, and a wider programme of prevention to support our population to live longer, healthier lives.

Outputs from workshops and meetings have informed the content and emerging proposals of the ACS business case.

There are a significant number of examples of best practice across the voluntary sector in BHR and these need to be better understood. We need to ensure that best practice is shared in a timely and efficient manner.

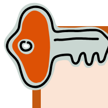
There needs to be a single approach to commissioning of voluntary vector services, this should be streamlined, with a clear vision of the needs of the population to ensure that gaps are addressed and that there is no duplication. Services need to be more consistent so that confidence in them can be built.

We all need to work to a single vision and to address a commonly agreed and prioritised set of needs, being clear of our roles within the wider system. This will make best use of limited resources and support people in BHR to live longer, healthier, happier lives.

4.6 Clinical engagement

We have conducted a number locality delivery model workshops with GPs, health care professionals and members of local authorities to get a collective vision for what the locality delivery model should achieve. The positive engagement with these groups have enabled us to better understand the barriers of working across organisations and the key enablers required for our vision of an integrated system.

- GPs want to work within the locality delivery model structure to develop primary care at scale;
- There should be a defined set of outcomes that the development of the service model can be measured against;
- We need to develop a clear strategy that communicates the benefits of moving to a new model to those who will be affected by it;
- There needs to be a common IT platform, or visibility over other organisation's IT platforms, to enable a single view of the people record.



The results of this engagement work have given a strong insight into the key system challenges as well as some of the behaviours driving this activity and have shaped the initial design of the Locality Delivery model of care. Further engagement with key stakeholders including our population and the community and voluntary sector will continue to ensure that our emerging model is co-designed by all stakeholders.

5.0 Delivery model and commissioning arrangements

All of the challenges and evidence outlined so far (including engagement work) have informed and shaped proposed plans for a new service design and delivery model.

It is evident from the evidence outlined above that our existing model of commissioning and providing prevention and care is struggling to meet the current levels of demand. With future pressure from rapid demographic changes including population growth, rising levels of long term conditions and variable levels of deprivation, the SOC recommends a new model of service delivery supported by more effective joint strategic commissioning arrangements.

This approach is recommended following an extensive period of consideration of potential business and service models (including an Accountable Care Organisation). At this stage leaders have taken the view that form must follow function. The process of considering the ACO option has created a desire to further develop the system but in a phased and measured way. Going forward the programme is being framed in the context of an accountable care system rather than organisation, focusing on the changes set out below.

5.1 New model of service delivery

A locality based delivery model is proposed built around the key principle of organisations working together to manage common resources to improve the health and wellbeing of a geographically defined population of at least 50,000 (as per the evidence set out by the King's Fund in *Place-based systems of care; A way forward for the NHS in England, Chris Ham Et al, November 2015)*. This model builds on our local experience with Health 1000.

The proposed locality delivery model of care is designed to radically alter the way that residents access health and wellbeing services across BHR. Prevention will be the bedrock of the model, with a focus on early intervention and support at the point where it is the most beneficial to individual, family or community.

5.2 Key features of the locality delivery model

We are acutely aware of the need to be more strategic in how we react to growing demand for health and care services. The key elements of the new model listed below illustrate how our approach to work as a system will enable us to be more tactical, efficient and responsive to the health and wellbeing needs of our people.

Ambition:	Universal health and wellbeing offer across BHR that focuses on self-care, prevention and integrated local services to improve local residents lives
Principles:	Remove organisational boundaries to promote organisations to collectively treat a person enabling better coordinated care; greater focus on early intervention and prevention activities; promoting individual empowerment and self-care
Scope:	Covering population of at least 50,000, providing primary, community and social care and local authority services that address the wider determinants of health such as housing, employment, diet and lifestyle, working together to form a highly effective extended team, providing local people with the majority of their care
Design features:	▪ Multidisciplinary teams, involving clinicians and professionals from every part of the system collocated and working together to provide holistic treatment of peoples conditions; ▪ Tailored and flexible in terms of staff levels and principles to respond to specific population needs; ▪ Centred on delivering primary care at scale (through GP Networks – highly productive GP practices working collaboratively to deliver care); ▪ Coordinated care through colocation of services where possible in community hubs (making best use of existing community spaces), creating a single point of access to assessment, support and treatment, supporting our population to feel confident when managing their own care or when looking for support; ▪ Targeted and coordinated care through the use of population segmentation/stratification tools (moving away from current system which is organisation around services and conditions to one that focuses on population need and risk, identifying people who are likely to avoid serious health problems if early support is offered). Enabling systematic screening, assessment and planning; ▪ Delivery of effective preventative interventions (screening, immunisation, proactive care, behaviour change support) at sufficient quality and scale to make a demonstrable contribution to improved outcomes and reduced demand amongst local people in that community; ▪ Fully utilising a single care plan developed with people and their carers enabled through, common protocols and shared information platforms; ▪ Implementing best practice, prioritising service change in pathways identified as requiring change to close BHR system gaps; ▪ Use of existing and emerging evidence in decision making and service delivery including regular change reviews, updates and additions to the evidence base, and the creation of a mechanism for fast adoption of these findings into care

	delivery. This requires real time data collection and measurement, identifying best practice, and prototyping of emerging models. Ensure that education and training reflect the latest evidence available; ▪ Designed to promote wellbeing services which tackle the root causes of poor physical and mental health; ▪ Working with local people to tailor services to local needs, focusing on care closer to home, building on the initiatives already in place to support people with long terms conditions and rapid response services (avoiding unnecessary hospital admissions) and supporting people to move out of hospital as soon as appropriate; ▪ Able to respond to our growing population e.g. Barking and Dagenham will require an additional locality, in the future, to provide for the Barking Riverside development ▪ Self-management enabled by: - Evidence based information and support for both professionals and individuals to guide shared decision making; - Personalised care planning; allowing people to identify their own needs and priorities through a process of information sharing, shared decision making, goal setting and action planning; - Holistic care plans, covering the full range and social care needs; - Education programmes will be designed to help people develop self-management skills. Participation will be encouraged for younger people, those who lack confidence and those who are finding it hard to cope.
Impact:	The model should create a shift in resource away from acute services toward services in the community that proactively on the wider determinants of health

5.3 What would the new locality model give us?

It works at all of the levels we are aiming to influence:

- At whole population level it aims to bend the curve of future health care demand by addressing wider determinants of health and building social capital by mobilising citizens, local employers and the voluntary and community sector
- For people with self-limiting conditions it builds and forms part of a more coherent and effective network of urgent care
- For people with care needs, it provides a broader range of services in the community that are more joined up between GP, social care and community service providers and the acute trust
- For a small number of very dependant people it provides wrap around extensive care services

Similar models are being trialled in some of the Vanguards (referred to as multi-speciality providers) in other parts of the country and as such BHR should be able to learn from these and negotiate a single contractual whole population budget for each locality. However in the case of BHR we would need to push the model much further by negotiating place based contracts that shift money over time from acute budgets to the locality providers. Only by doing this can we fully provide the incentives that the system needs to shift funding upstream towards prevention and better localised care. This would become the most important first element to negotiate for devolution in BHR. The locality model can be initially a virtual budget where provider contracts are bound together moving in the future to a fully integrated single budget. It is likely that in BHR we would progress through this in stages. This model would not affect existing GP core contracts and income and would not force GPs to become employed by or merge with other organisations.

5.4 Why go for a localities plan rather than a 'big bang' ACO approach?

- Moving quickly with partners who are willing and able to commit has a lot to commend it
- It goes with the grain of NHS possibilities for radically new contracting models and therefore is more likely to be negotiable, though we would want to push the boundaries on this
- It should be recognised that complex governance and regulation surround the acute trust and it being tied into productivity arrangements and delivery through the STP make the negotiation of completely integrated ACO highly complex at this time
- The acute trust operating costs make up the biggest share of the current operating deficit in BHR; unless other partners are prepared to offer a risk share and guarantees of bridging the gap, it is unlikely that the NHS centrally or the Secretary of State would grant freedoms and flexibilities for a model including the trust
- Consequently, there are understandable question marks about whether all organisations are in a place to be prepared to put their "heart and soul" into a fully integrated ACO as the only solution at this time. Without this, the NHS or Secretary of state are unlikely to agree a plan as they are seeking to move forward to new models of care through partnership and agreement, not legislation
- The new governance arrangements, would give all partners much more transparency than before in the delivery of transformation plans and 'business as usual' at the acute trust even though they might not initially be part of a new organisation

For all of the reasons set out above the new locality model is recommended.

5.5 Proposed approach

The following timeline is proposed to ensure that the system begins to see implementation between now and March 2020 and real differences for local people over the next 3 years.

2017/18	▪ Integrated Care Partnership Board to agree framework for ACS testing ▪ Preparation for ACS testing
2018/19	▪ Test year
2019/20	▪ Go live if test successful

Two pictorials of the new model are shown below.

Figure 6: emerging BHR locality model

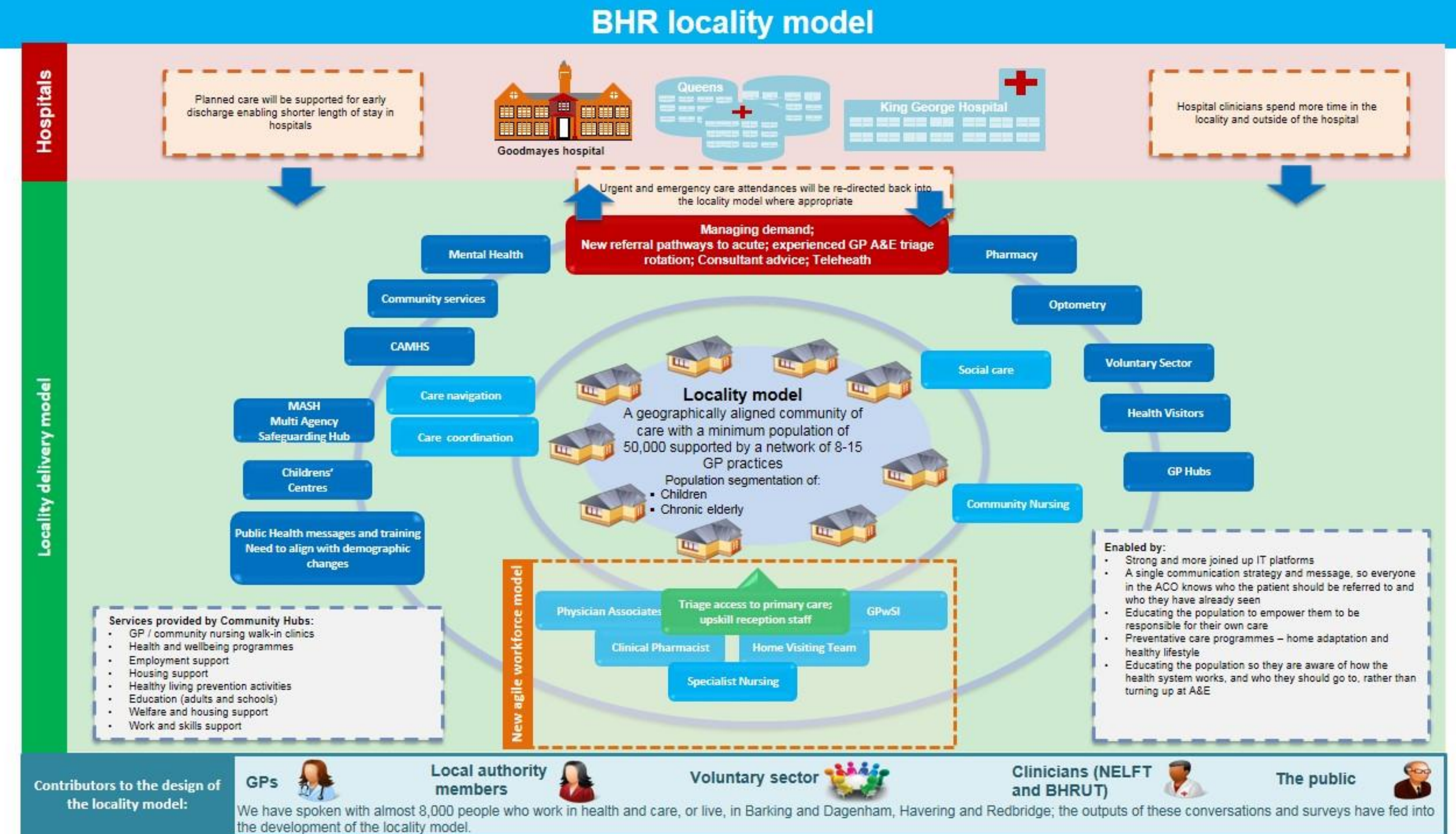
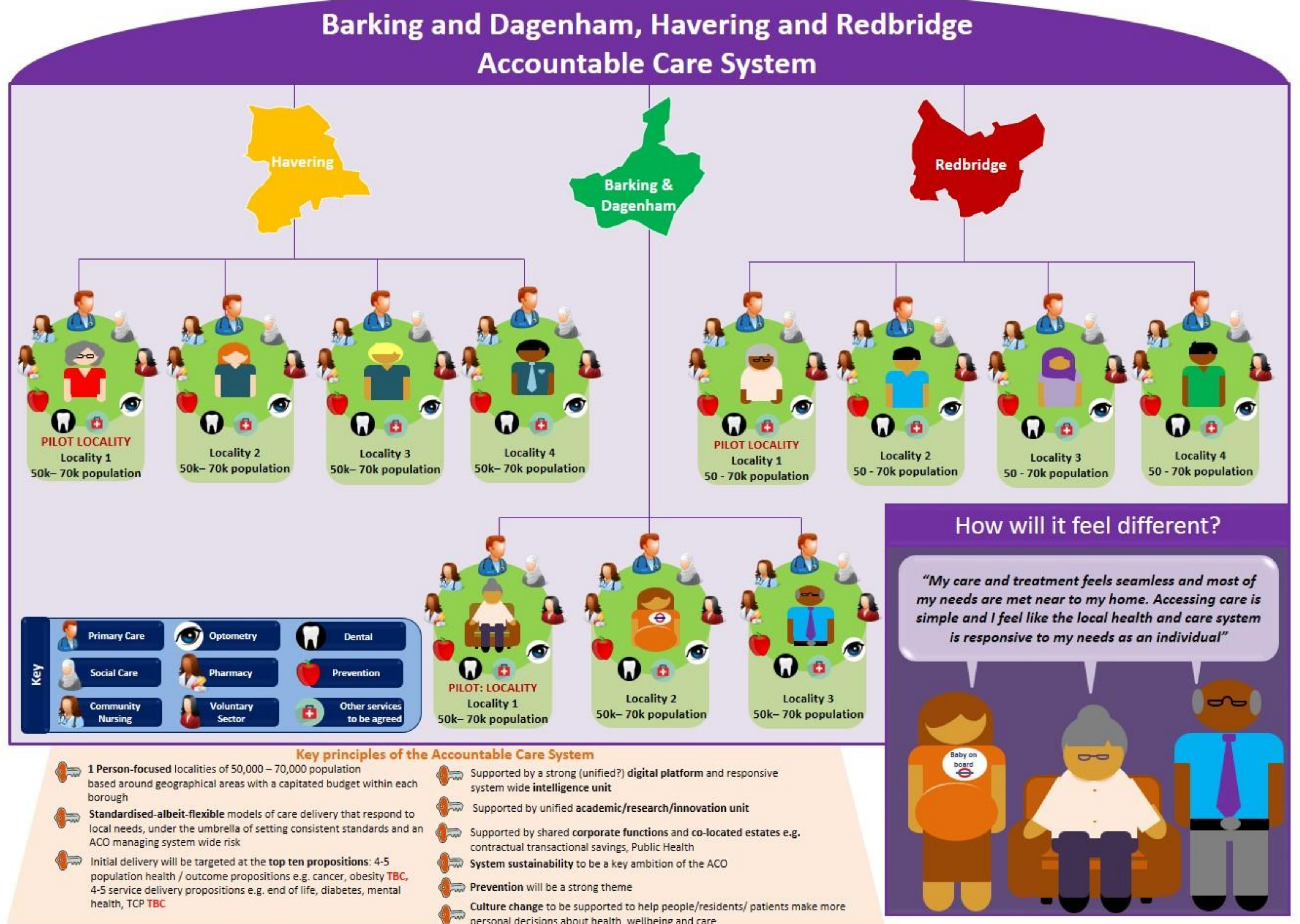


Figure 7: BHR Accountable Care System



5.6 New joint strategic commissioning arrangements

A fundamental change in commissioning is required to support the transformation in service delivery. The commissioning model needs to be more integrated and strategic, based on long term contracts tied to the delivery of population health outcomes across BHR.

To address this a BHR Joint Commissioning Board is recommended to:

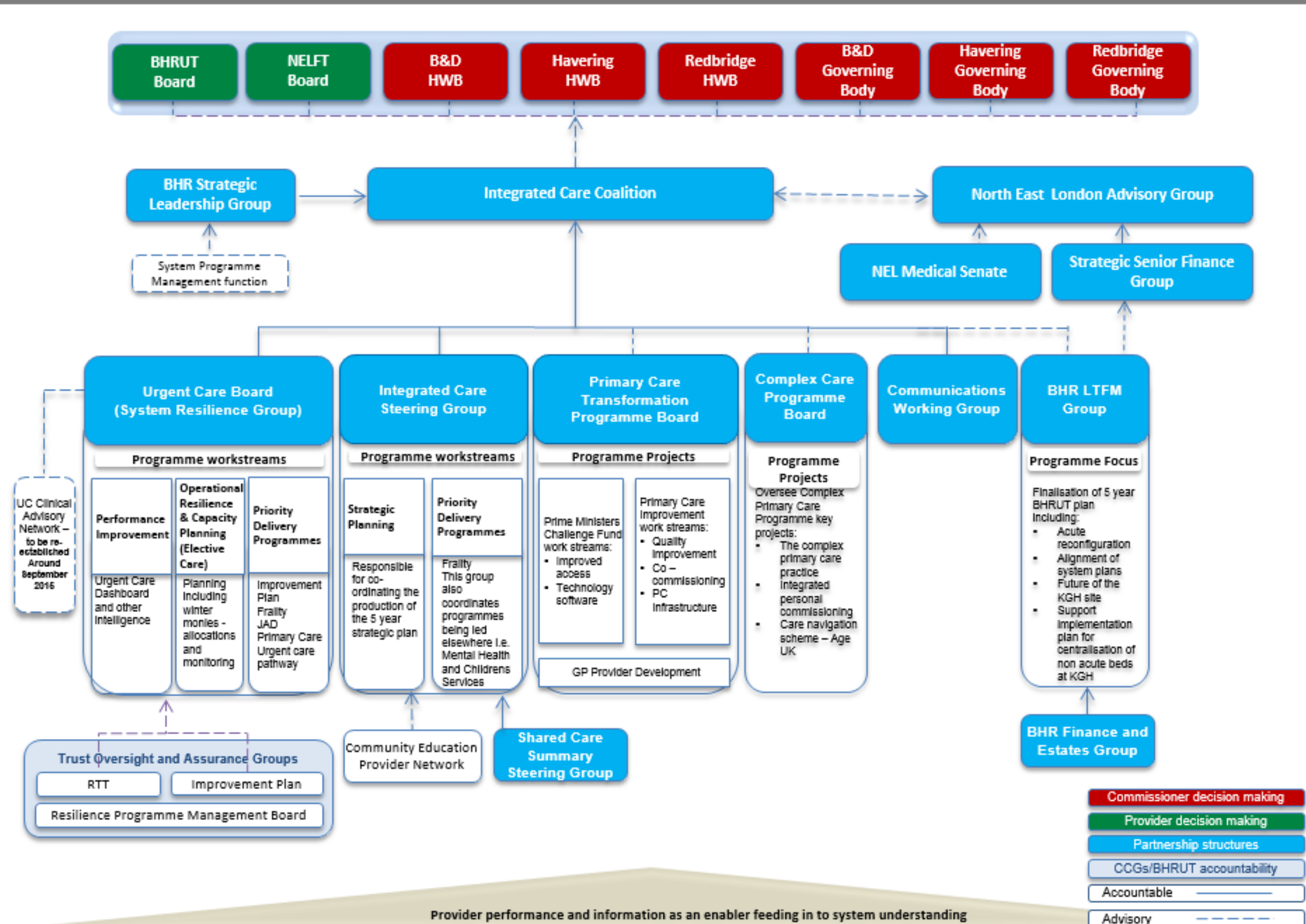
- Bring local authorities and CCGs together to strategically commission services to deliver the vision set out in the paper
- Develop strategies that enable the shift in emphasis of commissioning towards services that prevent harmful behaviours or conditions in the first place. This will require working with public health colleagues to develop and implement comprehensive behavioural change strategies to be embedded in care
- Work with localities to develop the new service model
- Develop contracts that incentivise improvement in population outcomes
- Encourage links with the third sector who are already committed to developing innovative prevention activities

A priority is the establishment of strong system governance to support the transformation required, exploring the opportunities that devolution can provide.

5.7 Our approach; programme governance

The current BHR governance arrangements include strong partnership structures which were the basis of the successful initiatives described in this SOC. An illustration of the current governance structure is illustrated below:

Figure 8: BHR 'as is' Integrated Care Coalition Governance Structure



Each group has a clear set of responsibilities as set out below:

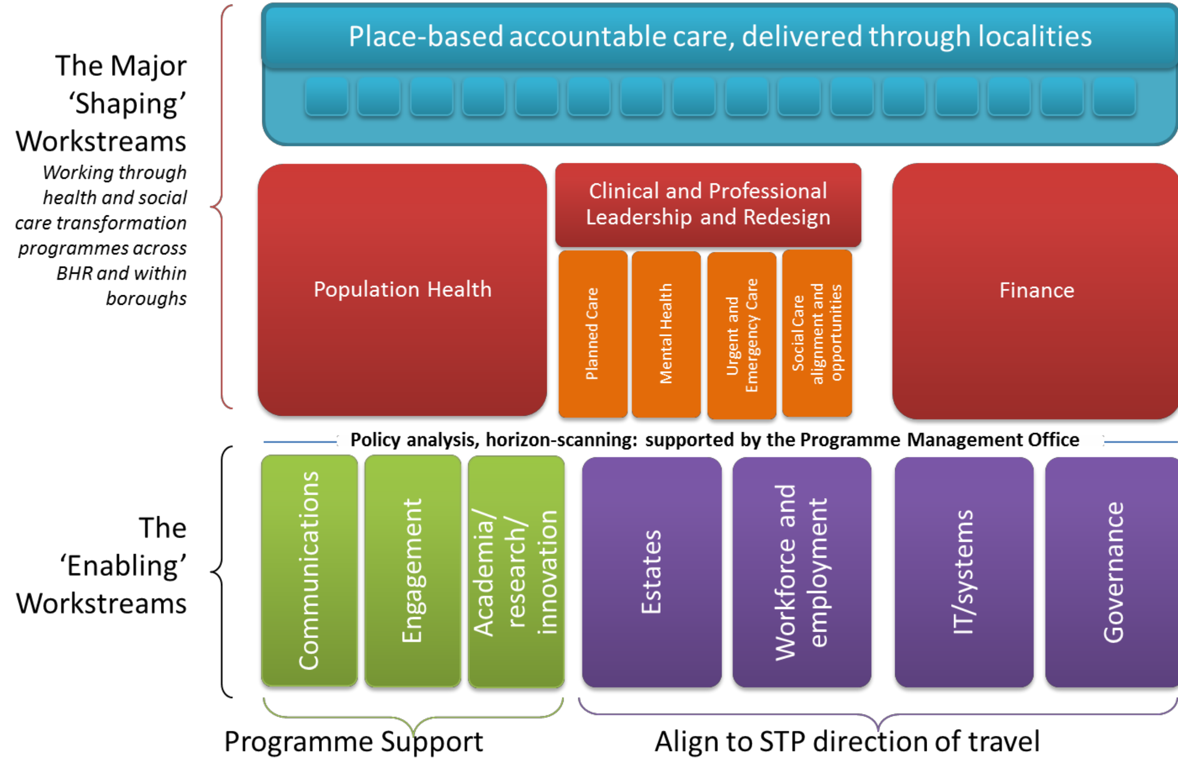
- **Democratic and clinical oversight group;** this brings together system leaders (including council leaders) and members of the public to shape and review all input into the development of the ACS business case

- **Clinical leadership and strategic planning group;** this group provides clinical leadership and strategic planning. They have regular input to the development of the BHR locality delivery model

- **Executive group;** this includes Chief Execs and DOFs of organisations in the BHR health and wellbeing system. They provide executive oversight of the programme and are responsible for taking the critical decision about the development of the ACS; and

- **Programme management team;** responsible for the day-to-day creation and Development of the all inputs to the ACS programme. The programme is organised in the following way.

Figure 9: BHR Programme management team



To consolidate the strong BHR partnership, including democratic and clinical leadership, further changes are recommended to the governance structure.

It is proposed that the role of the Democratic and Clinical Oversight Group (DCOG) as a leadership group for the ACO programme is built upon to create a leadership group (Integrated Care Partnership) to drive forward the transformation programme set out in this strategic outline case.

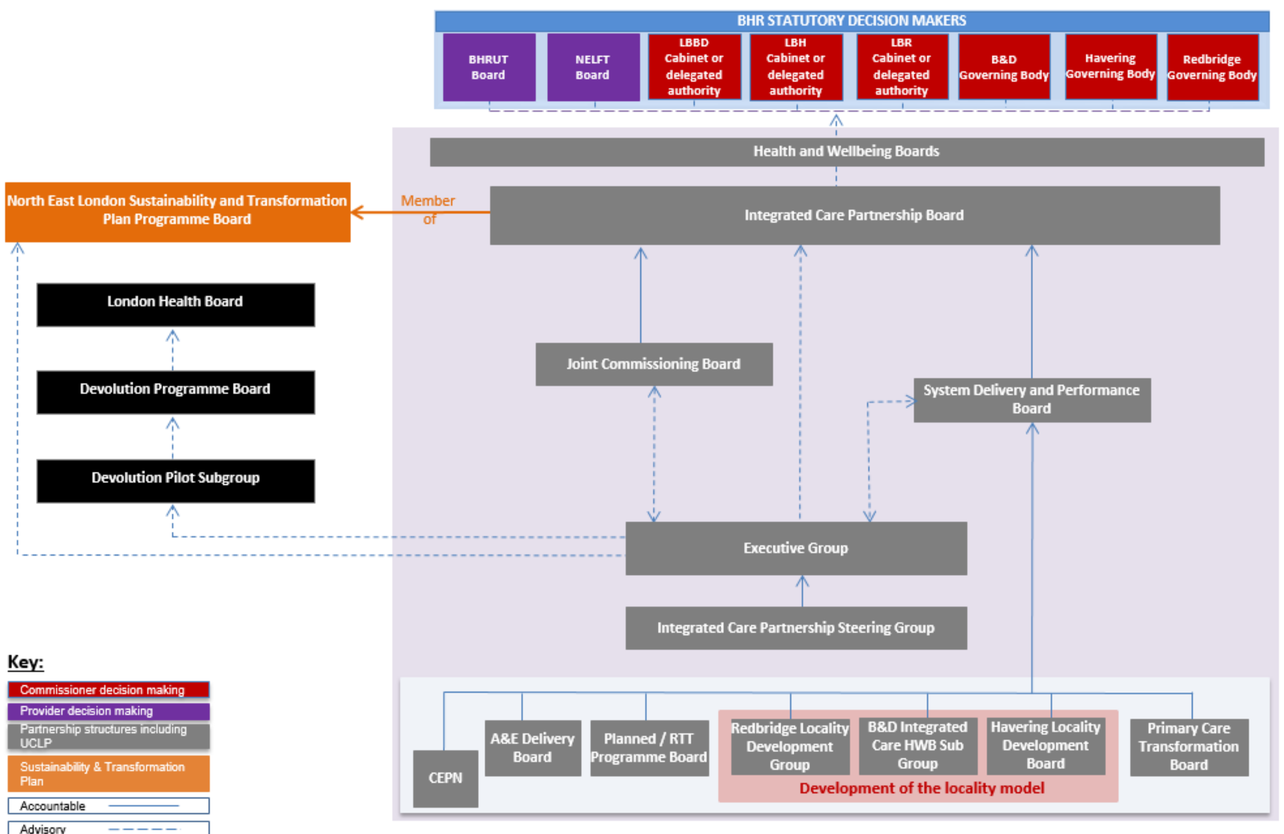
The Integrated Care Partnership would be supported by a Joint Commissioning Board (comprised of local authorities and CCGs) and a provider System Delivery and Performance Board.

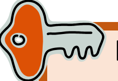
Our roadmap in section 7 sets out the development programme to further test and refine the governance model for BHR. We understand that robust governance will need to be in place before any additional powers can be granted. We also recognise the need to seek legal advice as we develop out model.

The following proposed governance structure will build upon this successful partnership working, designed learning from our experience and knowledge of the challenges that need to be addressed in mind, as well as ensuring that the structure supports the wider STP programme.

Figure 10: Proposed BHR Accountable Care Partnership structure

***Proposed:* BHR Integrated Care Partnership Structure**





In summary our analysis shows a new delivery model and commissioning arrangement could result in better outcomes for our residents, at the same time as saving £45 million over the next five years.

6.0 Our devolution ambitions

If we are to achieve the scale of system-wide reform envisioned in this business case, a fundamental shift in the way we work, to commission and provide services will be required. As we have developed our plans for a more integrated system of care, it has become clear that much can already be achieved with existing powers. BHR is committed to achieving this. But we are also clear that as our transformation journey progresses; our aspiration is to take greater control of our system and the enablers of transformation. We will use the next phase of our programme to develop joint commissioning arrangements and the new service model to further test specific proposals through case studies to substantiate robust business cases. We also seek to continue co-developing the details of our proposals with national partners, particularly around regulatory and payment opportunities.

6.1 Commissioning levers, financial flows and new payment models

Our contracting and commissioning structures are fragmented and do not enable or support integrated working. Currently most of the resource in the system is weighted toward treating people when they become unwell, with significantly lower investment in preventing people from becoming unwell in the first place. Similarly, contracts for services are based on activity rather than outcomes, creating artificial and perverse incentives which pay for services based on the number of people that they treat, as opposed to the experience and outcomes of those that receive them. By changing the way in which we commission and contract for services, and pooling the resources and expertise of commissioners and local authorities, we would be able to utilise greater budgetary flexibility to enable financial incentivisation and prioritisation that more accurately responds to local needs.

Our offer:

- We will extend our CCG joint commissioning function to include local authorities to form a single strategic commissioning body for the whole of BHR from September 2017.
- We will explore options to develop capitated outcome-based budgeting during FY17/18 to ensure the system is commercially incentivised to deliver the desired outcomes.
- We will use new budget-pooling opportunities to more appropriately allocate funding to primary and community care and incentivise early intervention and rapid discharge.
- We will lead the way towards more formal integrated joint working and delivery of specific health and wellbeing outcomes for our population.

Our asks:

- Please refer to the '*Commissioning models and payment mechanisms'* section of the London Devolution Memorandum of Understanding

6.2 Regulation and governance

Regulation is currently based on a model whereby each organisation providing health and wellbeing services is subject to an individual regulatory assessment and regime to assure that it is meeting national standards. The regulatory system is complex and imposes a burden on all of our organisations. The frameworks developed by various bodies impose additional and sometimes contradictory reporting requirements; it is a struggle to drive whole system improvement through often disjointed regulatory recommendations. Within our own organisations, leadership is accountable for different parts of the system rather than the overall system challenge. Devolution provides the opportunity to govern and regulate on a whole system basis, and for a more integrated approach by regulatory bodies.

Our offer:

- As we implement the changes to our service model, starting with the aim to launch of the first wave of locality delivery models by April 2018, we commit to working with national and

London partners to co-develop new regulatory frameworks to enable and promote the implementation of ambitious new ways of integrated working.

- We will work together with national partners to develop a system model that meets choice and competition requirements; and explore whether additional regulatory flexibilities are required to help overcome disincentives for prevention and place-based care.
- In compliance with agreed core standards, we will pilot a place-based prototype to system regulation, sharing our learning with external bodies and other health systems as we go.
- By April 2018, we will consider the need for a "memorandum of understanding" between all of the core system delivery partners (commissioners, providers and local authorities). This will pave the way for a single leadership group which will take accountability for the BAU and transformation programmes.
- Through the MoU, we will develop a common set of system-wide objectives; and support locality pilots to develop a governance structure to receive accountability.

Our asks:

- Please refer to the '*Regulation and oversight'* section of the London Devolution Memorandum of Understanding

6.3 Changes to workforce

Our current system cannot cope with current demand and we have significant challenges in the recruitment and retention of suitably qualified staff. We need to develop our locality delivery model with an enhanced role for primary and community care, and a reduced reliance on acute care. We want to change culture and working practices so that our health and care workforce is united together as one team, satisfied with their ways of working and able to pursue new opportunities. This will be primarily achieved through the creation of co-located multi- disciplinary teams.

Our offer:

- We will explore new ways to develop a more transparent and consistent approach to contracting for integrated workforce teams.
- We will explore opportunities to attract, retain and develop appropriately qualified staff (e.g. through key working housing provision, creating training opportunities for local residents).
- We will develop links with training colleges to ensure the existing workforce can be up-skilled, and the new workforce is able to operate in a multi-disciplinary environment.
- We will explore new workforce models to remove the barriers to joint working and shared decision-making across organisations and professional groups.

Our asks:

- Please refer to the '*workforce and skills'* section of the London Devolution memorandum of Understanding.

6.4 Focusing on prevention – supporting personal autonomy and community resilience

We want to shape BHR in to a healthier place to live, that better supports individuals and communities to lead healthy lives. Our health and wellbeing system will provide preventative interventions that are of high quality and scaled to have an impact. We recognise that residents may need help and support to change those behaviours that negatively impact on their health (like smoking, alcohol consumption, or physical inactivity), but that their wider living environment also has a profound impact on their health and wellbeing outcomes and life chances.

Our offer:

- We commit to considering how the system will be incentivised to deliver the required step change in prevention set out in the NHS five year forward view and through social care, primary care and mental health;
- We will develop strong leadership for prevention across our service model;
- Through the fast track localities, we will join resources across primary, community and social care with public health to focus support for key population groups to improve health and wellbeing through joined up and consistent messaging and integrated and holistic support, e.g. management of housing issues that impact on mental and physical health.
- We will embed prevention in services and strategies and ensure joined-up decision making across health, social care, housing, and planning;
- We will build capacity and skills to deliver effective prevention and behaviour change strategies for individuals and communities, while working to shape the places where people live and work into healthier places;
- We will learn from, and build upon, the prevention devolution pilot in Haringey, and other areas.

Our ask:

- Please refer to the '*Prevention and Employment and health*' section in the London Devolution memorandum of Understanding.

6.5 Estates

We have made good progress in developing initial plans for a single estates strategy across BHR which will make better use of the facilities available and contribute to achieving a system wide sustainable position. In order to achieve the full potential which estates has, we need to redefine the relationship with NHS Property Services and Community Health Partnerships to ensure all local land and assets locally available are fully utilised within our ACS. Wherever possible, local estate must be put under local control to support our objectives.

Our offer:

- We will work with the London Estates Board to share knowledge and develop best practice across London; and

- We will continue to develop a comprehensive estates strategy for the system (supported by appropriate modelling); this will include mapping the social infrastructure required within our locality delivery model and developing plans for all existing assets (disposal / increased utilisation / change of purpose etc.).

7. Proposed roadmap

We have set out a bold plan for how we intend to work together as a system. The table below sets out the system roadmap for delivery.

BHR Transformation Roadmap		
By	**Key action**	**Further detail**
20th September 2016 (Completed)	**Hold locality development event to discuss new delivery model**	The Locality delivery model concept is one of a holistic and truly integrated model of care which will bring together all elements of health and care in a locality; providers will take forward development of the locality model of care.
September 2016 (Completed)	**Share outcomes of locality development event with key partners**	Ensure all key partners are briefed on the outcomes of locality development event and are appropriately engaged with the process, in advance of the DCOG. Ensure actions agreed at the event progress.
October 2016 (Completed)	**SOC updated in line with DCOG recommendations and London Devolution feedback** **Finalised SOC played into NEL STP and submitted to London Devolution team**	
July 2017 (Completed)	**BHR ACS development event**	PwC led event to take stock of the current position and agree next steps which included strengthening joint commissioning arrangements through the establishment of a BHR Joint Commissioning Board to explore opportunities around joined up commissioning between health and care, and establish a Provider Forum where NELFT, BHRUT and GP Federations can come together to discuss development of a Provider Alliance that can respond to the Commissioning Intentions from the Joint Commissioning Board and improve integrated service delivery. Across both providers and commissioners, there was agreement to establish a system wide programme leadership function that bridges commissioner/provider governance arrangements and to ensure the delivery of the ACS is aligned
August 2017 (Completed)	**Establish Joint Commissioning Board (JCB)**	Joint Commissioning Board between Health (BHR Clinical Commissioning Groups) and Care (LBBD, LBR, LBH) established to; ▪ support and promote the development of effective joint commissioning arrangements within the BHR Integrated Care Partnership ▪ create, develop, support and monitor a work programme of joint commissioning activity ▪ coordinate the development and delivery of the Better Care Fund across the BHR Integrated Care Partnership

August 2017 (Completed)	Establish Provider Forum	Providers arranged a meeting at which their commitment to work together in a more integrated way was articulated, and agreed to take forward these discussions through the System Delivery and Performance Board. Providers continue to build relationships in preparation to respond to the Joint Commissioning Intentions expected from the JCB.
Ongoing	**Work with regulators and be a part of the negotiation process through the London Devolution Programme**	▪ Devolution provides the opportunity to regulate on a whole system basis, and for a more integrated, streamlined approach by regulatory bodies. We will be part of the negotiation process to identify whether the model will require some regulatory flexibility in order to succeed.
	Ensure that learning from existing Devolution initiatives such as Greater Manchester, Northumberland and Scotland informs our programme of work	▪ We will use our existing academic relationships to identify best practice and lessons learnt from existing national and international programmes and tailor these to our programme.
November 2017	**Develop commissioning plans to test the ACS concept**	JCB developing commissioning plans around proposed areas to test the ACS concept including: - Intermediate Care - Diabetes - Childrens SEND
	ACS commissioning plans around the specific areas agreed for testing shared with providers for response	▪ BHR Providers to review ACS commissioning plans and develop proposals around how they can work together to respond and deliver these ▪ Iterative discussion between commissioners and providers to further develop the proposals
December 2017	**Seek legal advice for proposed testing/changes**	BHR Partners to seek legal advice around the deliverability of the proposals within current legal and legislative rules
Ongoing from December 2017	**Accountable Care gateway assurance process**	▪ Proposals will be subject to a robust gateway assurance process ▪ Agree final budgets and outcomes
January – March 2018	**Integrated Care Partnership Board asked to approve way forward**	▪ ICPB to review proposals and approve those to take forward for ACS testing
	Preparation for operationalisation of Accountable Care test proposals	Providers to prepare for operationalisation of the proposed service changes to test Accountable Care including programme of communications and engagement and share with Commissioners for review via the assurance process
April 2018 onwards	**Operationalisation of ACS testing proposals**	Providers to lead on operationalisation of ACS testing proposals; ongoing PDSA review and improvement of the testing areas to be embedded within this
October 2018	**Review of progress and begin to discuss next steps for 2019/20**	▪ Six month review of progress ▪ Begin discussions around preparation for next steps for the establishment of Accountable Care in BHR if the test areas are proving successful
April 2019	**Potential go live of further BHR Accountable Care developments**	▪ Go live of further ACS developments in BHR subject to decision to proceed by statutory bodies, development of proposals, assessment of provider readiness to deliver, assurance that the proposed changes are deliverable within the legal and procurement rules at the time etc.