New care models & workforce considerations

Lessons from NW London

David Freeman, Director of Development
5 March 2018
What we’ll cover

• Recognising the challenge

• The context

• Our view on Integrated (accountable) Care

• The approach we are taking - working in a unified way

• Workforce considerations

• Embracing different perspectives

• Discussion points
We start with a recognition that...

....change is scary

....and local differences matter
The context

WSIC & ACP Commitment

NHS E/I policy direction (provider call to arms)

STP / ICS / SOC-ImBC / SqHF / SCT

NWL Collaboration

The NWL ICS built on Accountable Care models

2014/15

c.2021

TODAY
We take the view that integrated, accountable care is not an organisational construct...

“Integrated care should be seen as a different way of collectively thinking about planning and delivering care - based on people, not buildings or organisations, and based on outcomes, not procedures or activity.”

David Freeman, Director of Development, NWL
It is not about off-the-shelf models

“If you’ve seen one ACO, you’ve seen one ACO!”

Chris Ham, CEO, The Kings Fund

Our aim is not to drag and drop internationals model of Accountable Care into NW London.

*Our ambition is to take the best of what this way of working offers and design an integrated care system that works for our patients & residents*

This means working with patients, residents & stakeholders to explore MCPs, PACS, ICPs and any other models that will best enable us to unlock the benefits of whole system integrated care.
So we are focused on building conditions for success...

**Learning by doing**

- Build on progress
- Build in stages
- Build together

...small steps leading to big change...
Our approach combines two components

Local, bottom-up developments...

...using common principles...
# 17 common elements

- **Outcomes** incorporating an outcomes framework, population segmentation and metrics
- **Capitation** including consistent methodology, risk and gain share arrangements
- **Contracts** incorporating NHS E Integrated Support and Assurance Process, incentive models
- **Data & Informatics** incorporating use of WSIC Dashboard, data quality, information sharing
- **Culture** incorporating system change and system readiness assessment

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<td>1.</td>
<td>Outcomes based contracts &amp; putting an end to activity based payments</td>
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<td>2.</td>
<td>Core outcome measures in key population or service segments – esp patient described outcome measures / targets</td>
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<td>3.</td>
<td>Alignment on priority targets – eg 65+, frailty, children etc</td>
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<td>4.</td>
<td>Requiring providers to increasingly focus on primary &amp; secondary prevention</td>
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<td>5.</td>
<td>Pooled budgets</td>
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<td>6.</td>
<td>New payment mechanisms (based on outcomes, shared accountabilities)</td>
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<td>7.</td>
<td>New risk / gain share arrangements</td>
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<td>8.</td>
<td>Capitation methodology</td>
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<td>9.</td>
<td>Long-term contract (c.10 years)</td>
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<td>10.</td>
<td>Single contracts covering multiple providers (ie all providers that are necessary to deliver target outcomes)</td>
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| 11. | Multi-partner provision – Primary Care, Community definitely need to be in  

**11a.** MH, SC assumed ‘in’ from the start until/unless circumstances require a different approach |
| 12. | Requiring providers in existing contracts or allied arrangements to commit to becoming part of wider accountable care arrangements as and when required |
| 13. | Locking progress / transition gateways into contracts (contract updates, CVs etc) |
| 14. | Shared Data / BI capability and information flows – building on and expanding the WSIC dashboard |
| 15. | One set of back-office functions across the AC partners |
| 16. | Culture and system change – to prioritise new ways of thinking, working (ie a one system, one budget mindset) & staff development |
| 17. | Use of readiness matrix assessment / accreditation standards to support provider capacity and capability development toward AC working; driving principle to reduce unwarranted variation supports need for consistency |
We are working in a unified way

How far have we got (borough plans)?

- **4 x CCGs have advanced plans for Integrated Care developments** with shadow contracts in place or planned within the next 6-12 months (Central London, H&F, Ealing and Hillingdon).

- **1 x CCG has in place a well developed clinical model** (West London) and over the next 12 months will develop organisational and partnership form(s) to support this; rapidly advancing.

- **3 x CCGs have rapidly developing models** and have agreed plans to further develop these along AC lines with a view to shadow contracts in the next 12-18 months (Brent, Harrow and Hounslow).

How far have we got (system support plans)?

- Established a ‘virtual programme team’ of ICS Leads progressing the common elements
- Systemwide development events being planned
- Virtual / ‘digital learning lab’ - proposed web platform
- **Behaviour Insights investment secured** with the NHS E, King’s Fund – a different type of narrative & focus
- Community conversation hubs where we all come together on a quarterly basis across the system to discuss, share and learn from each other and from those outside our NWL footprint
Zooming in...on workforce

West London’s MCMW providers are bending the curve in all measures relating to unplanned care:

✓ A&E attendance
✓ Non-elective admissions
✓ Out of hours GP call-out lower in the MCMW group.

...and starting to see financial benefits:

✓ c.£2m costs avoided in mobilisation year alone (Nov 16 to Oct 17)
Zooming in...on workforce

A significant focus has been placed on a different type of workforce:

**Health & Social Care Assistants**
- Hold a variety of interdisciplinary qualifications: able to cover the ‘basic’ functions of Practice Nurse, Social Worker and District Nurse and have ‘3rd sector’ skills and knowledge
- Creating a new type of **interdisciplinary workforce – an operational challenge in trying to attract right people to apply**

**Case Managers**
- Staff with clinical/ professional qualifications
- Recruitment was again challenging:
  a) Could the right people be found who wanted to ‘break the mound’ of their professional training
  b) **Staff with social work background found it harder** as they couldn’t perform basic clinical functions.

**Interface with ‘traditional’ roles**
- **New roles have to interface effectively with more traditional roles** (eg DNss) to avoid duplication and mixed messages (confusion) to patients.
## Zooming in… on workforce

**Analysis: The areas seeing sustained falls in emergency admissions**

**By Rebecca Thomas | 20 November 2017**

<table>
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<tr>
<th>CCG</th>
<th>Per capita % change 2014-15 to 2016-17</th>
<th>Median monthly year on year growth rate in total emergency admissions, over two years</th>
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<tr>
<td>Hillingdon</td>
<td>-13.3%</td>
<td>-5%</td>
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Zooming in... on workforce

- New community geriatricians
- Staff getting to know each other across traditional boundaries...
- Planning better discharges together
- Extended rapid response services
- Rolling out 15 Care Connection Teams
- H4All providing access to support to keep older people fit and well
- Opening ‘Home-Safe’ unit for newly admitted frail older people
- Exploring how we can deliver end of life care more effectively
Common approach essential but we still need different perspectives

- bullet-free airplane
- heart = bullet hole locations on returning airplanes
Key discussion points

• How do we map workforce needs in the context of a multi-dimensional approach to integrated care?

• How much of the change is OD / further training, and how much is it about creating new professional disciplines?

• If new disciplines, how do we get the training pipeline going without further clarity on the end-state?

• We need to consider how we can overcome organisational / professional cultural barriers and resistance

• What is the impact on existing services of drawing together new professional teams (eg social workers becoming care connectors etc)?
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Thank you

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