Sandwell Integrated Care Alliance Response Plan

2019

Version 1		15th July 2019	Lisa Maxfield
Version 2	Changes after consultation with Dottie Tipton, Jenna Phillips, Sharon Liggins	17th July 2019	Lisa Maxfield
Version 3	Changes HLAG 26/7	2 August 2019	Dottie Tipton/Dave Baker
Version 4	Prior to 9/8 workshop	5 August 2019	Dave Baker
Version 5	Following Workshop 09/08/19	15th August 2019	Dottie Tipton
Version 5 DB	Following Workshop on 9/8/19	21 August	Dave Baker

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1. The Alliance

1.1. Who are the Alliance ;

The Sandwell Integrated Care Alliance is a partnership between the CCG, mental health, primary, community, secondary care, the local authority and the third sector. The partnership aims to refocus care towards more preventative, primary and community models of care, supported by greater personalisation and self-determination. Changing the movement of resources such as funding and people to shift between health and social care, mental and physical care to where it is best utilised. Initially there should be a greater focus on children, particularly the first thousand days of life, frailty, and the end of life. The Alliance has been meeting since spring 2018.

1.2. Purpose;

"To work together as one team so that together we can improve the Health and Wellbeing of the people in Sandwell "

1.3. Vision;

In the future Health and Care system for Sandwell all provider organisations will work together to ensure that everyone starts well and stays well for as long as possible enabling them to build their skills and achieve their aspirations.

When required, an intervention will be timely and holistic, covering physical health, mental health and social care so that individuals are returned to the best possible health and social status as quickly as possible;

For those people with long term illness our health and social care system will help them to minimise the impact on their daily lives by developing their skills and those of their carers. Our system will be amongst the best in the UK for delivering outcomes during the first 1000 days of life and satisfaction through later life. It will: increase healthy life expectancy; have great maternity outcomes; a focus on children; and dramatically improved outcomes around public health, respiratory disease and cardiovascular disease.

Delivery of this vision will be underpinned by:

- A primary care led, localised approach;
- A single team ethos;
- An enhanced focus on Mental Health and the wider determinants of health;
- Effective communication;
- A happy, sustainable and resilient workforce;
- Clear and efficient processes;
- The use of technology to understand, engage, support and provide care;
- An estate that is welcoming, modern, innovative and optimised;
- The ability to constantly re-invest in the future;

1.4. Alliance Charter;

- **P**opulation focussed – The Health and Wellbeing of our population(s) is at the heart of everything we do;
- **A**spirational – We will aspire to be the best that we can be and to help our population to be the best that they can be;
- **C**aring – We will listen to and care about:
    - our population - helping them to care for themselves and for each other;
    - our people - understanding one another's context and encouraging innovation;
- **T**eamwork – We will work in partnership across all organisations to offer a holistic, seamless and integrated service;

1.5. Strategic Aims;

- To focus on the wider determinants of health and wellbeing including housing, employment, education and community safety.
- To achieve safe and sustainable acute services by 2022.
- To treat the whole person by integrating physical and mental health approaches.
- To bring together health and social care commissioning.
- To develop transformation, and reduce transactional, processes within the health and care system through a strategic approach to the commissioning and delivery of care; characterised by a focus on outcomes and experience, long term agreements and a move away from the annual contracting and PBR mechanisms in health.
- To support the integration of care through the use of common information and data systems and processes.
- To support individuals and their carers to live independently and to take responsibility of their own care through the personalisation of health and care wherever possible.

1.6. Foundation Blocks;

The intention we share is that the future will be different to the present, and our shared vision by 2030 is that outcomes locally for patients are significantly better than they are today. Redesigning who does what and how we do that facilitates but does not guarantee better outcomes. What we are trying to create is multi year innovation to achieve better outcomes and to do that we want to:

- Alter the prevailing commissioning approach
- Develop long term provider partnerships and cooperation

The overall intent is to move to an integrated care system focused on delivering jointly agreed population health and wellbeing **outcomes** through a **long term agreement**. This agreement would be based on **capitated funding** rather than more tradition transactional methods of payment.

The aim is to support transformational change through the clear articulation of improvement trajectories for key health and wellbeing outcomes and to stimulate a partnership response to delivery by providing long term funding commitments, flexibility in the way in which these funds are used and the ability to refocus and re-allocate resources within an overall integrated system framework. Crucial to this process will be the development of a detailed understanding of **risk** and a clear framework for it management with the overall system.

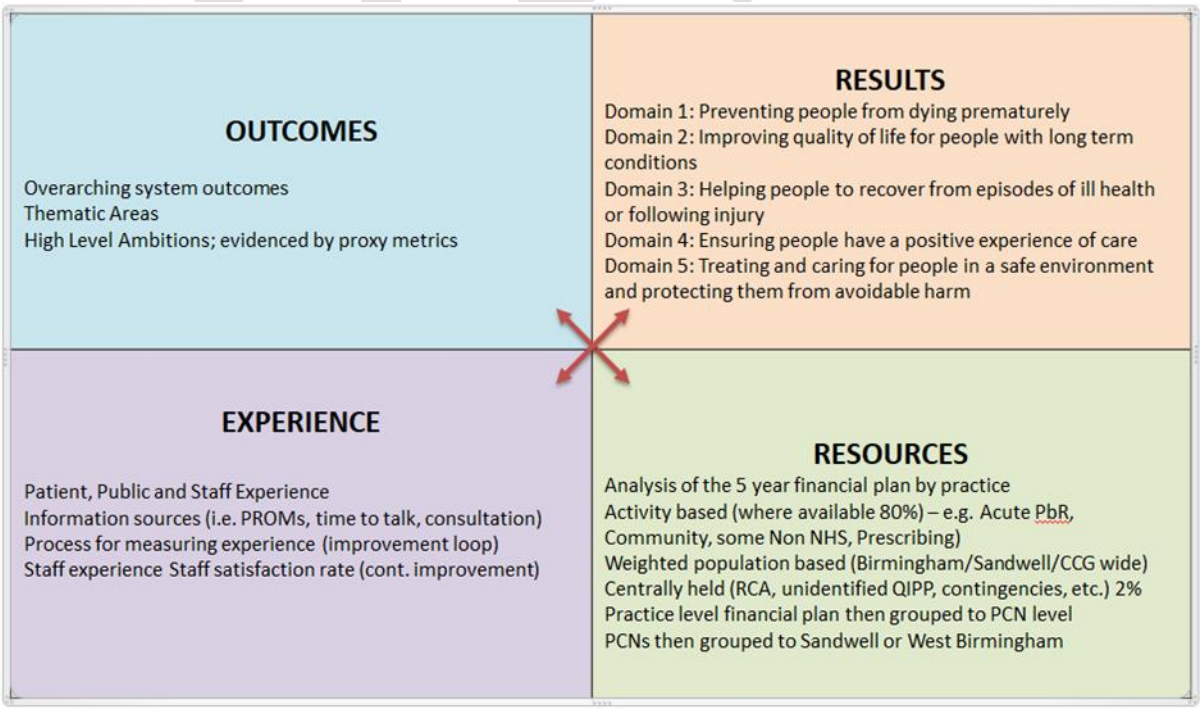
1.6.1 The Outcomes Framework

Our focus is on delivering together the priorities set from the Sandwell Outcomes Framework which have been agreed by Sandwell and West Birmingham Clinical Commissioning Group and Sandwell Metropolitan Borough Council with ratification by the Sandwell Health and Well Being Board.

The draft Outcomes Framework has been developed to cover a five year period from April 2020 to March 2025.

The outcomes framework will form one whole quadrant of a balanced score care for the Care Alliance. The other three quadrants of the balanced score card will be made up of;

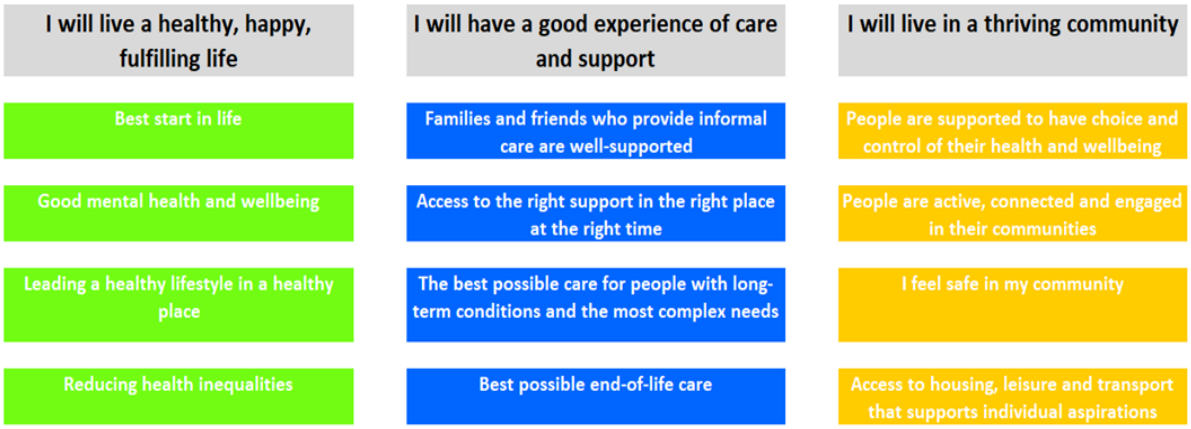
- statutory and constitutional standards
- patient and staff experience measures
- the financial framework



There are three thematic areas within this revised framework, namely;

- *I will live a healthy, happy, fulfilling life*
- *I will have a good experience of care and support*
- *I will live in a thriving community*

Contained within each of these three thematic areas are 4 high level ambitions selected to shape healthy, happy lives with the best possible services, whilst living in a thriving community. These are;



1.6.2 Risk

The QIPP challenge across Sandwell and West Birmingham will rise to £144 million by 2022/23. Gaps can be closed by increasing productivity or reducing demand.

As we working together to deliver our vision and the associated outcomes, another part of our integrated plan is to

- create a Hybrid Risk Sharing approach as providers are in different states of maturity in their approach to Risk sharing;
- plan to develop a more detailed understanding of risk by sub geography;

Recognising that partners have different levels of alignment, maturity, trust and risk appetite, we have set out a fourfold approach to partnering:

- As a risk bearing partner that takes co-responsibility for the capitated budget and the delivery of the outcomes required to sustain the system;
- As an innovation partner committed to responding to reasonable requests to work differently to meet the outcomes that the alliances requires;
- As a transaction partner promising to deliver extant services and develop the delivery model to fit with the changes made by others;
- On a bespoke basis defined in an agreed MOU with the risk bearing partners

Partners are currently confirming their preferred risk positions, alongside an understanding of how different partners will then contribute to the Shared Governance at place level

1.6.3 Capitated Budgets and Long Term Agreement

There is a task and finish group working on the implementation of a Capitated Budget model from 1 April 2020. This will help to shift the focus towards the outcomes and user experience rather than activity and contact counting.

This group will also agree the parameters of a long term agreement, based around the capitated budget model, to incentivise innovation and experimentation, rather than simply to plan buy and do. This model will also help the alliance to maintain its promises to invest a given amount in the third sector and to go beyond mandate levels of spend on mental health provision.

This work will be completed by X in time for launch on Y.

2. Delivery

2.1 Context

Delivery within the Integrated Care Alliance can be categorised into three parts: 1) Delivering Improved Outcomes in areas that have been locally agreed; 2) Delivering new capabilities that will assist in the success operating of the alliance; 3) Delivering required performance levels in the line with the Long Term Plan.

At the heart of our success will be our ability to execute the right change effectively so focus will be paramount. Research across industries evidences that:

- if any one team focuses on more than 2-3 objectives that there is a law of diminishing returns in terms of success;
- there will always be more good ideas than there is capacity to execute;
- that one in seven staff could name one of their organisation's most important objectives;

With this in mind our execution strategy is based on:

- a relentless focus on two/three prioritised outcomes, each defined by three specific objectives;
- the development of new capabilities driven by the focus on the prioritised outcomes but with an eye to future needs. We anticipate that this will involve developments in areas such: Information sharing/ Population Health and Workforce Integration but their scope will be defined by the needs of the teams driving the outcome improvements;
- the delivery of required performance levels through existing "Business as Usual" arrangements but supported by growing relationships. On this basis these areas are outside the scope of this response plan.

This can be captured using the time/desire matrix:

	Now	**Later**
Want to Do	Local Priorities	Next wave of local priorities
Must Do	Underperforming National Targets	Further improve National Targets

2.2 Local Priority Outcomes/Objectives

From within the Outcomes Framework the three priorities identified by the CCG and SMBC are:

- Best Start in Life;
- Living a Healthy Lifestyle in a Healthy Place;
- Best Possible End of Life Care;

There is strong evidence suggesting that improving the development of children so that they are ready for school (able to interact well with others, feel confident, feel safe,

having good speech and language) significantly improves their physical and mental health in later life.

Living a Healthy Lifestyle in a Healthy place accelerates the agenda around personal behaviours and environmental factors. By its very nature this outcome cuts across Best Start in Life and Best Possible End of Life Care as well as supporting the population imbetween.

Ensuring people have a best possible end of life care aims to improve end of life planning in order to improve experience and deliver system efficiencies releasing them to be invested elsewhere.

This response plan initially focuses on the first two these local priorities (prototype areas). Each is represented by a single statement and between three and eight objectives:

1) **To give children the best possible start in life to increase lifelong health**;
    a. Objective 1 – To reduce the percentage of Mothers who are deemed smokers at the time of delivery from 9.8% to 3.3% by 31 March 2025;
    b. Objective 2 – To reduce the percentage of babies born with a birth weight under 2500g from 3.7% to 3.1% by 31 March 2025;
    c. Objective 3 - To increase the percentage of children achieving a "good" level of development (school readiness) from 66.4% to 91.4% by 31 March 2025.
2) **To continue to increase the quality of end of life care available in Sandwell**;
    a. Objective 1 - To increase the percentage of deaths that occur at home from 25.5% to 31.2% by 31 March 2025;
    b. Objective 2 – To increase the percentage of deaths that occur in care homes from 16.9% to 20.3% by 31 March 2025;
    c. Objective 3 – To reduce the number of people that have three or more hospital admissions in their last three months of life from X to Y by Z (awaiting data, target and trajectory).
3) Leading a Healthy Lifestyle in a Healthy Place
    a. Objective 1 – to reduce the percentage of adults (aged 18+) classified as overweight or obese from 71% to 61.2% by 31 March 2025;
    b. Objective 2 – to reduce the percentage of physically inactive adults from 29.6% to 25.492% by 31 March 2015;
    c. Objective 3 – to reduce admission episodes for alcohol specific conditions from 670.3 to 527.75 by 31 March 2025;
    d. Objective 4 - To reduce diabetes QOF prevalence from X to Y by Z;
    e. Objective 5 - To reduce social isolation from X to Y by X;
    f. Objective 6 - To reduce air pollution (fine particulate manner) from 11.2micrograms per cubic metre to 9.1 by 31 March 2025;
    g. Objective 7 - …desire to have a social prescribing metric but is this an input rather than an outcome?

These outcomes and objectives have been agreed between the SWB CGG and the SMBC. It is our plan that in the early stages of the alliance everything that we do will be focussed on achieving these objectives.

2.3 Our fit with the Black Country Sustainability and Transformation Partnership/Integrated Care System

The Black Country STP/ICS is an important development to support all five of the places/Integrated Care Partnerships/Alliances that are contained within it. Our approach to the response plan, through a relentless focus around local priority outcomes, is coupled with our Business as Usual approach to resolving National Targets across the STP/ICS. This provides us with an approach that is both bottom up and top down.

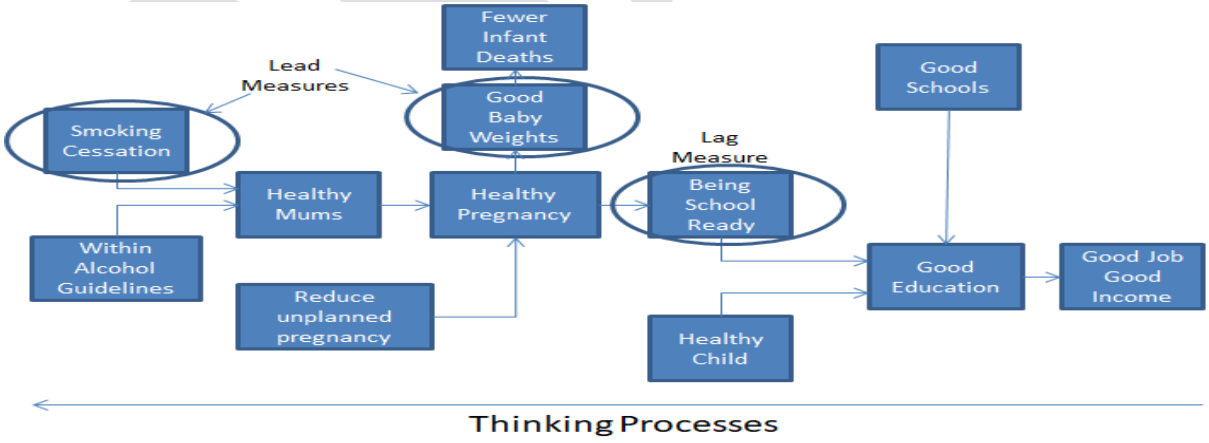
2.4 Governance

To be inserted based on the outputs of the Governance task and finish group.

The rest of this document is about delivery plans a timelines against the two local priorities to improve the outcomes. This will be the focus of the workshops. The intention is that the detail of this work will make up ~half of the response plan.

3. Action Plans – What (form the basis of the workshops)

Arising from the workshops is an alignment around understanding how to move the outcome. This aligns to the SMBC approach and the development of network dependency diagrams in understanding how the improvement of processes and their measures ultimately impact the outcome. This is consistent with the Outcomes Framework and is captured as an example below:



Whilst the clarity around what our outcomes are show that we know our goals, the clarity as to the what moves our outcomes shows that we know how to improve our goals. Our objectives and trajectories mean that we can keep score and our Governance framework will set out how we will create accountability for delivering change.

Initial actions arising relating to improving the Best Start in Life Outcome were as follows:

Outcome	Objective	Proposed Actions
Best Start in Life	Smoking at Time of Delivery Low Birth Weight School Readiness	1. Data Analytics - who are the mothers that are having low birth weight babies- what can we learn from their characteristics; age, location, background, employment, previous births, neighbourhoods, culture, interactions with services, food poverty, social services, police, hospital, mental health services, schools. Action 1 – agree the specific data set required; Action 2 – agree with what resource and from where this data set will be established including IG; Action3 - agree a date by which this analytics will be presented back to the Group.. 2. Baseline - what are we currently doing to change the metrics in school readiness and where are we spending the money, map both statutory and voluntary services. Action 1 – agree who will do the baseline work and by when it will be presented back (with costs). **3.** Logic Maps - create logic maps for priority areas include metrics **(broader than just best start in life)** Action – agree who, how and by when? 4. Clarify how the underlying metrics for school readiness are calculated Agree who, how and by when? 5. Understand the evidence base for how best to stop smoking and achieving low birth weight Action – agree who, how and by when? 6. Create a process for dealing with actions 7. Agree resourcing for the alliance from partners
Best Possible End of Life Care	% of deaths that occur at home % of deaths that occur in care homes Number of people that have three or more "emergency" admissions in their last three months of life	

Thought Stimulant Questions (not prescriptive or exhaustive)

1. How do we identify who to focus on? **Population Health** – what can we use now, what can we develop to further improve this and what is this dependent upon e.g. data sharing?
2. Where and what should we do to improve the wider determinants?
3. What actions can we take to **prevent** illness or exacerbation?
4. How can **research and genomics** add value?
5. How do we improve **access** (time and ease)?
6. What **out of hospital** services do we have/need and how accessible should they be 24/7?
7. What role can **personalised care** play to enhance self control?
8. What are the most important **pathways/processes** and how can we improve them?
9. How can we harness **MECC** to make better, more holistic decisions?
10. How can **digita**l help?
11. Where should we invest/divest **money**?
12. X
13. X
14. X
15. X
16. X
17. X
18.

4. Timelines – When?