Meeting:	Adult Social Care, Health and Wellbeing Sub-committee
Date:	6 October 2016
Title:	Accountable Care Organisation & North Tyneside CCG Financial Position Update

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Wards affected:	All	

1. Purpose:

This paper has been prepared by North Tyneside CCG to provide an update to members of the Adult Social Care Health and Well Being Sub-Committee on**:**

a) the development of a North Tyneside Accountable Care Organisation (ACO)
b) financial outlook and implications for services

2. Recommendation:

The Sub-Committee is recommended to:-

- Note the update in relation to the and Accountable Care Organisation and CCG financial outlook.

3. Policy Framework

This item relates to all of the objectives of the Joint Health and Wellbeing Strategy 2013-18.

- To continually seek and develop new opportunities to improve the health and wellbeing of the population
- To shift investment to focus on evidence based prevention and early intervention where possible
- To integrate services where there is an opportunity for better outcomes for the public and better use of public money
- To focus on outcomes for the population in terms of measurable improvements in health and well being

It will contribute to the following joint priorities:

- Improving the Health and Wellbeing of families

- Improving the Mental Health and Emotional Wellbeing
- Addressing Premature Mortality to Reduce the Life Expectancy Gap
- Improving Life Expectancy
- Reducing avoidable Hospital and Care Home Admissions

4. Information:

4.1 Accountable Care Organisation

During 2015, NHS North Tyneside Clinical Commissioning Group reviewed the possible options to identify the best way to commission affordable, sustainable and quality healthcare that would meet future needs for patients in the borough. In November 2015, it was concluded that an Accountable Care Organisation (ACO) was the best option, with the aim of achieving full ACO operation from April 2017.

In order to achieve this, key partners entered into a 'Memorandum of Understanding' and committed themselves to undertaking a substantial amount of work to achieve and reach an agreement on the proposed model and future ways of working.

The decision on whether or not to 'go live' would be made by both the CCG and ACO partner organisations by the end of September.

In addition to the ACO work, the CCG is now required to implement the legal directions from NHS England which are to stabilise the financial and management position of the CCG so that its commissioning capacity can be strengthened in North Tyneside.

Despite significant progress and meeting the programme milestones, the CCG and its ACO partners have concluded that the work on the ACO model will pause. It has become apparent that the ambition of establishing a full ACO operation from April 2017 is not realistic. However, all ACO partner organisations remain committed to place based commissioning which will integrate mental health, physical health and social care services. The ACO model will be given further consideration by January 2017.

4.2 Financial Outlook & Service Impact

In 2015/16 North Tyneside CCG recorded a deficit of £19.3m. NHS England rules required this deficit to be repaid by top-slicing £19.3m from the CCG's 2016/17 financial allocation and a financial control target of £19.3m deficit was set for this year. This means the CCG effectively has to deliver an in-year break-even position in 2016/17.

This control target has been reinforced by the imposition of legal directions which oblige the CCG to take whatever actions are necessary to secure this outturn.

In order to achieve this level of financial recovery, the CCG has identified a £20.3m savings programme – also known as the Quality, Innovation, Prevention and Productivity (QIPP) programme.

Savings have been identified in the following areas:

Service	Savings Plan (£000s)	Description
Intermediate Care	1,020	Reduction of intermediate care investment with Northumbria Healthcare Trust. Recurrent FYE saving of £1,020k agreed in principle, achieved by reduction in number and staffing intensity of bed capacity at NTGH.
Continuing Health Care	800	Management of budget transferred to Local Authority with gain share agreement to reduce cost of continuing care packages through tighter application of criteria
End of Life Care	417	Two schemes: i) RAPID a dedicated team to provide support to end of life patients in their own homes ii) Advanced Macmillan nursing support for patients in care homes Both schemes were established and delivered in 2015/16. Savings target in 2016/17 is the residual part-year effect. Savings to be achieved by avoided hospital admissions
Proactive Management of Complex Patients	75	Two schemes: i) Case management of patients identified at risk of hospital admission using risk stratification tool ii) GP support for patients in care homes Both schemes were established and delivered in 2015/16. Savings target in 2016/17 is the residual part-year effect. **Schemes delivering in Northumbria. At risk of not delivering in Newcastle**
Better Care Fund	1,083	Saving part-achieved in approved 2016/17 Better Care Fund agreement, including saving attributable to closure of Cedars (Intermediate Care Home).
New Models of Care Pilot	345	Bespoke service for patients with long-term conditions / high risk of hospital admission. Pilot commenced in Whitley Bay and rolling-out to North Shields.
Learning Disability Contracting	400	Reprovision of service at Rose Lodge. Saving secured through block contract reduction.
Mental Health Contracting	300	Removal of unused contingency for out of area placements and closure of Belsay ward.

Joint Commissioning	1,014	Two schemes: i) S117 funded patients – revision of criteria for assessment of NHS liability. ii) S256 agreement with Local Authority – reduced value of S256 agreement with Local Authority.
Medicines Management	835	Improved efficiency in primary care prescribing.
System-wide prescribing savings	417	Savings identified as potential opportunities for Right Care efficiencies.
Primary Care Demand Management	2,231	Variety of schemes initiated and delivered in 2015/16, including: i) Referral Management System ii) Value Based Commissioning (IFR) iii) Reduction of primary care variation iv) Practice Activity scheme Extension of RMS in 2016/17 to include new specialties.
Respiratory Care	200	Scheme initiated and delivered in 2015/16. Project to improve management of COPD.
System-wide pathway redesign	904	Notional allocation of Right Care savings in 2016/17 attributed to Newcastle Hospitals contract.
Acute hospital contracting	2,315	Three key schemes: i) Guaranteed saving intended against A&E block contract agreed for Minor Injuris Unit at NTGH. ii) Impact of emergency admissions reductions as part of changes to system / opening of NSECH iii) Block contract reductions agreed with Northumbria Healthcare NHS FT
Community services contracting	1,560	Block contract reductions agreed with Northumbria Healthcare NHS FT
Other budget adjustments	6,390	Number of changes to budget planning assumptions.
Total	**20,306**	

4.3 Service Implications

The CCG estimates that approximately 80% of its QIPP is on track to deliver. Combined with other mitigations, the CCG is still forecasting achievement of its overall financial control target. Savings fall broadly in to three categories:

i) Avoidance of unnecessary hospital care. The savings associated with most schemes are achieved by delivering care in more cost effective settings or avoiding the need for hospitals care altogether (eg. end of life care, proactive management of complex patients, New Models of Care, primary care demand management).
ii) The second category of savings are service efficiencies and cost reductions. Examples include Learning Disability / Mental Health / Community Services, joint commissioning contracting where specific areas of cost reduction have been identified. Medicines management and prescribing, continuing health care, respiratory care and system-wide pathway redesign are other examples of care being delivered more cost effectively.
iii) The third category are transactional or administrative costs and adjustments to budgets where excess provision has been identified.

Collaboration with our key providers and commissioning partners has successfully identified ways of delivering care more cost effectively. Key service changes include:

i) Adjustments to intermediate care services, including the decommissioning of the Cedars Care Home and a reduction in the investment in hospital beds in favour of a growth in investment in community and home-based intermediate care services.
ii) Changes to community nursing to consolidate teams in support of GP Practice localities and dovetailing with the New Models of Care arrangements.
iii) Decommissioning of ineffective elderly assessment services and consolidation around other access points to support older people.