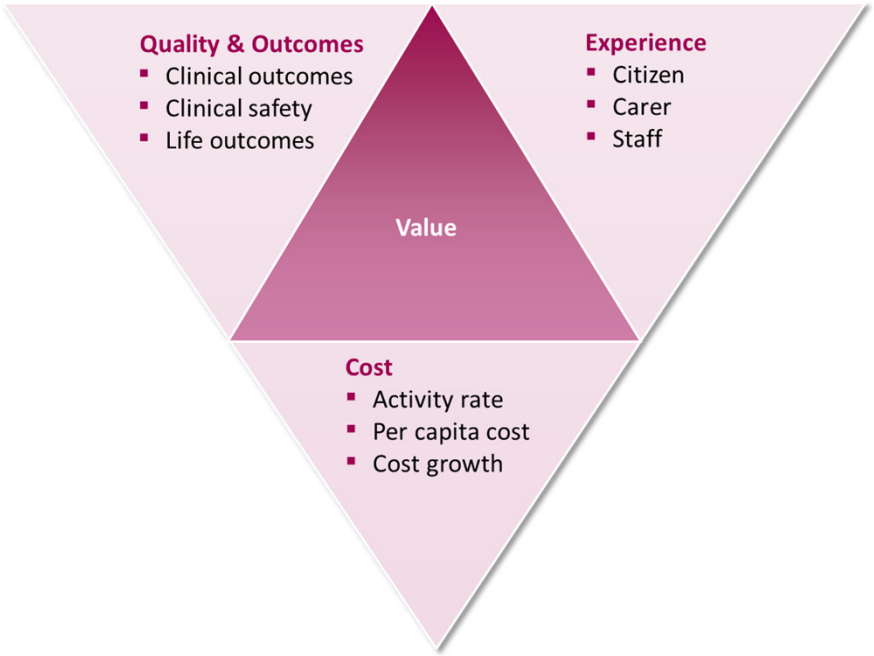
Appendix 1

Better Care Fund Lambeth - September 2014

Case for Change - Background documentation from SLIC integration business case research

We are all working together to increase the value of care we provide for the people of Lambeth and Southwark

Objectives of high value care



Issues in our current system

Quality

- The care people experience could and should be improved
- Commissioners are now looking to providers to focus on co-producing outcomes with patients through services that feel very different with an emphasis on being preventative, holistic and empowering

Cost

- If we carry on without change they system will go broke
- By working together to deliver preventative and coordinated care we can significantly reduce the gap
- But this will requires a fundamental shift in the way we work both clinically and operationally, underpinned by a new way of contracting with commissioners

The following slides provide more detail of the case for change within Southwark and Lambeth

Quality: commissioners are looking to us to work together differently to improve people's health and care outcomes

The care people experience could and should be improved

- In Lambeth and Southwark we have world-leading health and care institutions, yet our overall health outcomes are worse than average
- When asked, people describe a desire to have more control over their care, particularly with respect to those who live with long term conditions
- Evidence from local, national and international practice shows that different models of care can be used to help reduce people's need for unplanned care, reduce time spent in hospital and care home settings, to increase people's sense of empowerment, and to improve their overall health outcomes
    - Local examples include pioneering work within the Diabetes Modernisation Initiative, The Lambeth Living Well Collaborative and the Older People's Programme

In response, commissioners are now looking to providers to:

- focus on improving the outcomes we co-produce with citizens, rather than the inputs we use or outputs we deliver, with an emphasis on reducing unplanned admissions (e.g. through the Better Care Fund)
- develop services which:
    - Empower and activate people and communities, enabling people to be in control of their health and wellbeing
    - Offer holistic and co-ordinated care and support
    - Are equitable, proactive, preventative and focused on better outcomes

Cost: we need to ensure that the total costs of the system remain affordable – there is one system one budget!

If we carry on without change they system will go broke

- We estimate that in the 'do nothing scenario', health and social care spend in Southwark and Lambeth will increase by ~35%
- When compared against the funding allocations, the financial gap for social and health care in Southwark and Lambeth is projected to be ~£339m by 2018/19

By working together to deliver preventative and coordinated care we can significantly reduce the gap:

- Modelling work on our local data suggests that, through better care integration, the local system could reduce this gap by £163m, but this would require investment of £39m in new services (net saving £124m). This is the biggest opportunity we have for addressing the funding gap
- Taking this into account, integrated care could decrease the forecast social and health care spend across Southwark and Lambeth by ~11%

But this will requires a fundamental shift in the way we work both clinically and operationally, underpinned by a new way of contracting with commissioners

- The savings and investments associated with integrated care would change the balance of spend in health and social care
    - For example funding into acute trusts would decrease by an estimated £19m, and funding into primary care would need to increase by £46m

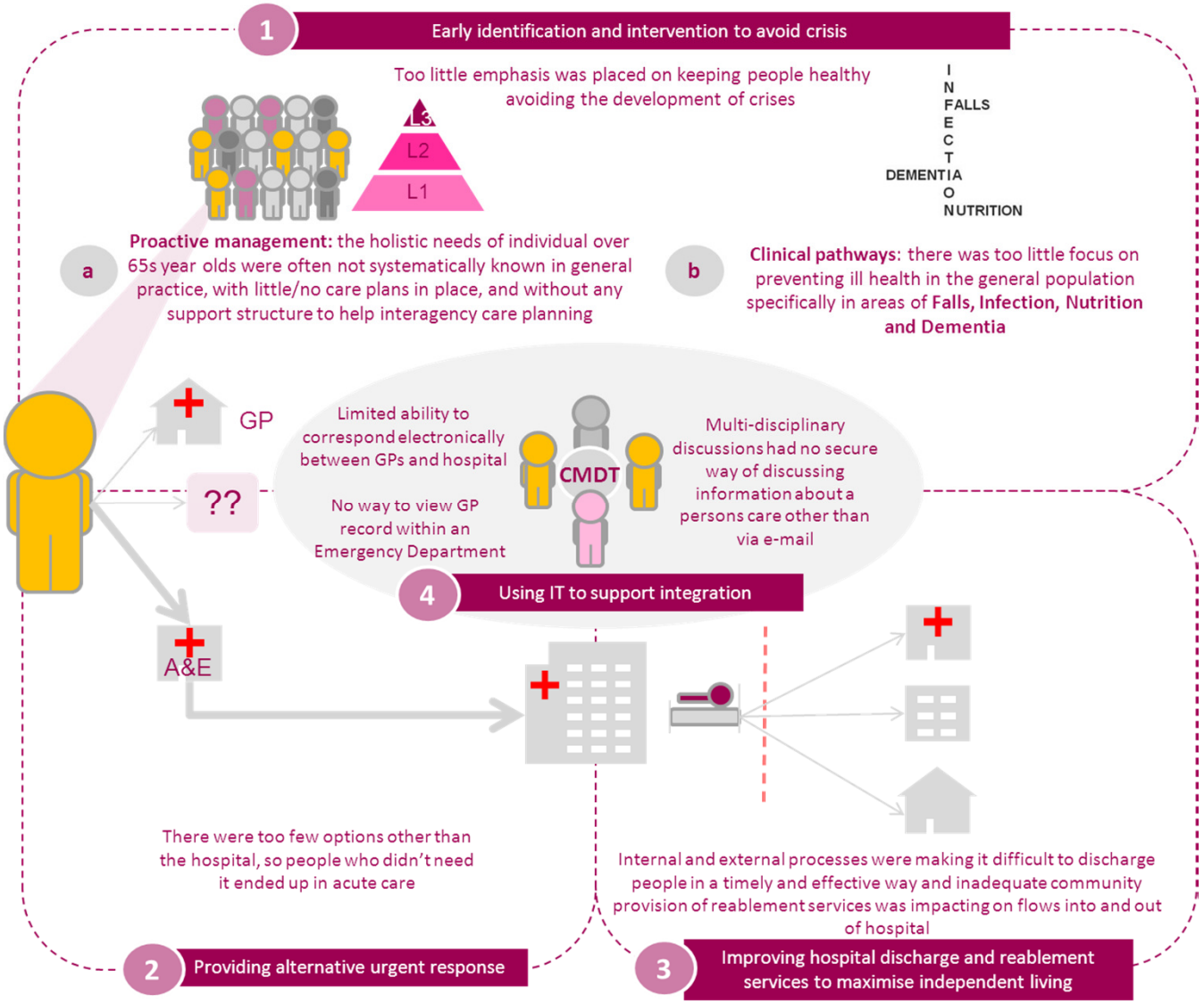
For our population of 600,000 people we have world-class medical institutions but worse than average outcomes and deprivation

Domain	Indicator	Southwark	Lambeth
Our communities	1 Deprivation		
	2 Proportion of children in poverty		
	3 Statutory homelessness		
	4 GCSE achieved (5A*-C inc. Eng & Maths)		
	5 Violent crime		
	6 Long term unemployment		
Children's and young people's health	7 Smoking in pregnancy ‡		
	8 Starting breast feeding ‡		
	9 Obese Children (Year 6) ‡		
	10 Alcohol-specific hospital stays (under 18)		
	11 Teenage pregnancy (under 18) ‡		
Adults' health and lifestyle	12 Adults smoking		
	13 Increasing and higher risk drinking		
	14 Healthy eating adults		
	15 Physically active adults		
	16 Obese adults ‡		
Disease and poor health	17 Incidence of malignant melanoma		
	18 Hospital stays for self-harm		
	19 Hospital stays for alcohol related harm ‡		
	20 Drug misuse		
	21 People diagnosed with diabetes		
	22 New cases of tuberculosis		
	23 Acute sexually transmitted infections		
	24 Hip fracture in 65s and over		
Life expectancy and causes of death	25 Excess winter deaths ‡		
	26 Life expectancy – male		
	27 Life expectancy – female		
	28 Infant deaths		
	29 Smoking related deaths		
	30 Early deaths: heart disease and stroke		
	31 Early deaths: cancer		
	32 Road injuries and deaths		

Source: Health Profiles 2013

Quality

There is good local practical and theoretical evidence to show that new models of integrated care can improve outcomes for people



Anticipated benefits

By 2015/16:

Bed Reduction
(through reduced admissions & LOS)

- 23,500 bed days saved
- Equates to 32 beds for each acute

Social Care Reduction

- 20% reduction in residential packages
- Equates to 133 less packages of care

Improved patient experience

……Working together for healthier and happier lives

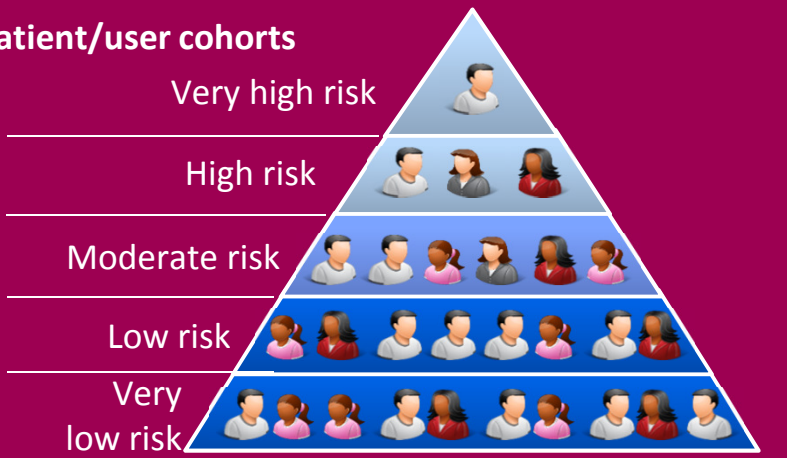
Quality

And global research shows successful integrated care systems require three core building blocks

Success in integrated care

Address specific needs based on risk …

Patient/user cohorts



… by working in a multi-disciplinary system

1. Patient registry
2. Risk stratification
3. Care packages
4. Care plans
5. Care delivery
6. Case conference
7. Performance review

… supported by key enablers


Aligned incentives and reimbursement models


Accountability and joint decision-making

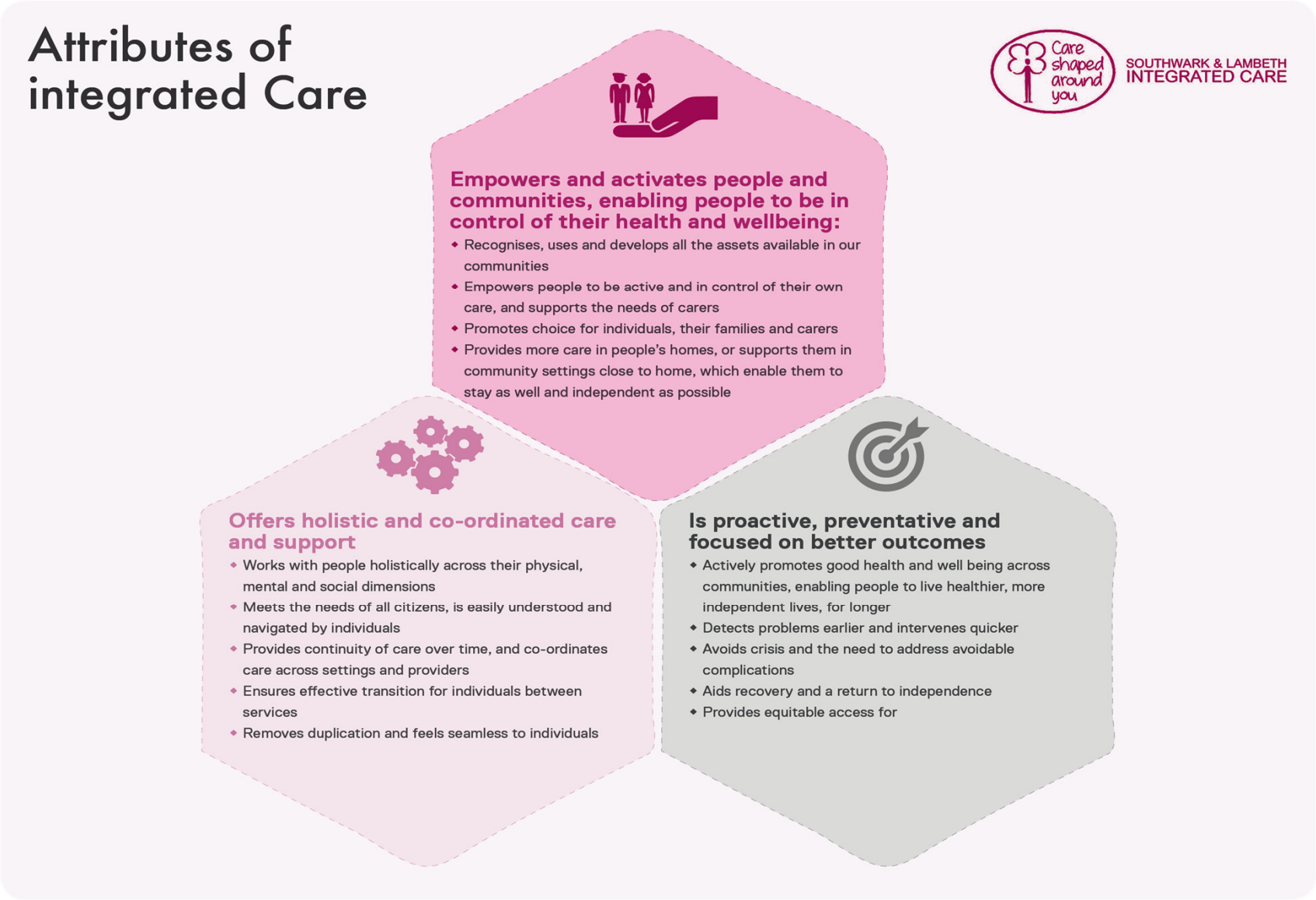

Information transparency and decision support


Clinical leadership and team working


Patient engagement

Quality

New services should feel different: people should experience services that are empowering, holistic and preventative



Cost

We estimate that in the 'do nothing scenario', health and social care spend in Southwark and Lambeth will increase by ~35%

Care setting	Spend 13/14, in £m			Projected spend 18/19 'do nothing scenario', in £m			Change, in %		
	Southwark	Lambeth	Sum	Southwark	Lambeth	Sum	Southwark	Lambeth	Sum
Acute	201	230	431	297	325	622	48%	41%	44%
CHS	30	45	75	38	42	80	29%	-7%	7%
MH	58	66	124	78	95	173	35%[3]	44%[3]	39%
Primary[1]	57	68	125	72	84	156	26%	23%	25%
Prescribing	32	36	67	42	44	87	34%	25%	29%
CC	6	11	18	10	12	22	67%	1%	25%
SC	112	92	204	144	112	255	28%	22%	25%
Other[2]	21	28	48	35	48	83	70%[3]	73%[3]	72%
Total	**517**	**575**	**1,092**	**717**	**761**	**1,478**	**39%**	**32%**	**35%**

For Lambeth **£10.3m** transferred from CHS into BCF

Note: numbers may not add up due to rounding. Specialist care excluded. BCF involves allocation transfers from Acute, CHS and CC into Other (set up of reserves)
1 Includes dentistry and eye health
2 Incl. free nursing care, contract reserves (e.g., BCF), reablement, corporate budgets and other budget items
3 Non-demographic growth of MH stimulated by high outturn
4 Change driven by increased reserves set up for BCF
SOURCE: Southwark (v. 28.2.2014) and Lambeth (v. 10.3.2014) CCG plans; LA budgets as latest available; Team analysis

Cost

The financial gap for social and health care in Southwark and Lambeth is projected to be ~£339m by 2018/19

Million £

Council	Object	13/14	14/15	15/16	16/17	17/18	18/19
Southwark	CCG[1]	0	20	43	67	88	109
	Social care	0	11	28	39	50	62
	Total Southwark[2]	**0**	**31**	**71**	**106**	**138**	**171**
Lambeth	CCG[1]	0	25	53	79	102	124
	Social care	0	9	17	28	36	44
	Total Lambeth[2]	**0**	**34**	**70**	**107**	**138**	**168**
Total financial gap		**0**	**65**	**141**	**213**	**276**	**339**

The methodology used to calculate the financial gap is different to how CCGs report the gap in their strategic plans. We define it here to include the total gross QIPP requirement subtracting all investment costs, and adding back any projected savings. The rationale is that the gap as presented here reflects the total challenge under status quo conditions. The bridge between CCG QIPP and the CCG financial challenge as reported here, is set out in the appendix

1 CCG forecasted financial gap, including running cost allowance, and excluding BCF
2 Does not include the Public health budgets held jointly by CCG and Local Authorities
Note: Numbers may not add up due to rounding; numbers as presented in last ICG meeting

SOURCE: Southwark (v. 28.2.2014) and Lambeth (v. 10.3.2014) CCG plans; LA budgets; Team analysis

The ICG has developed a population segmentation for Southwark and Lambeth

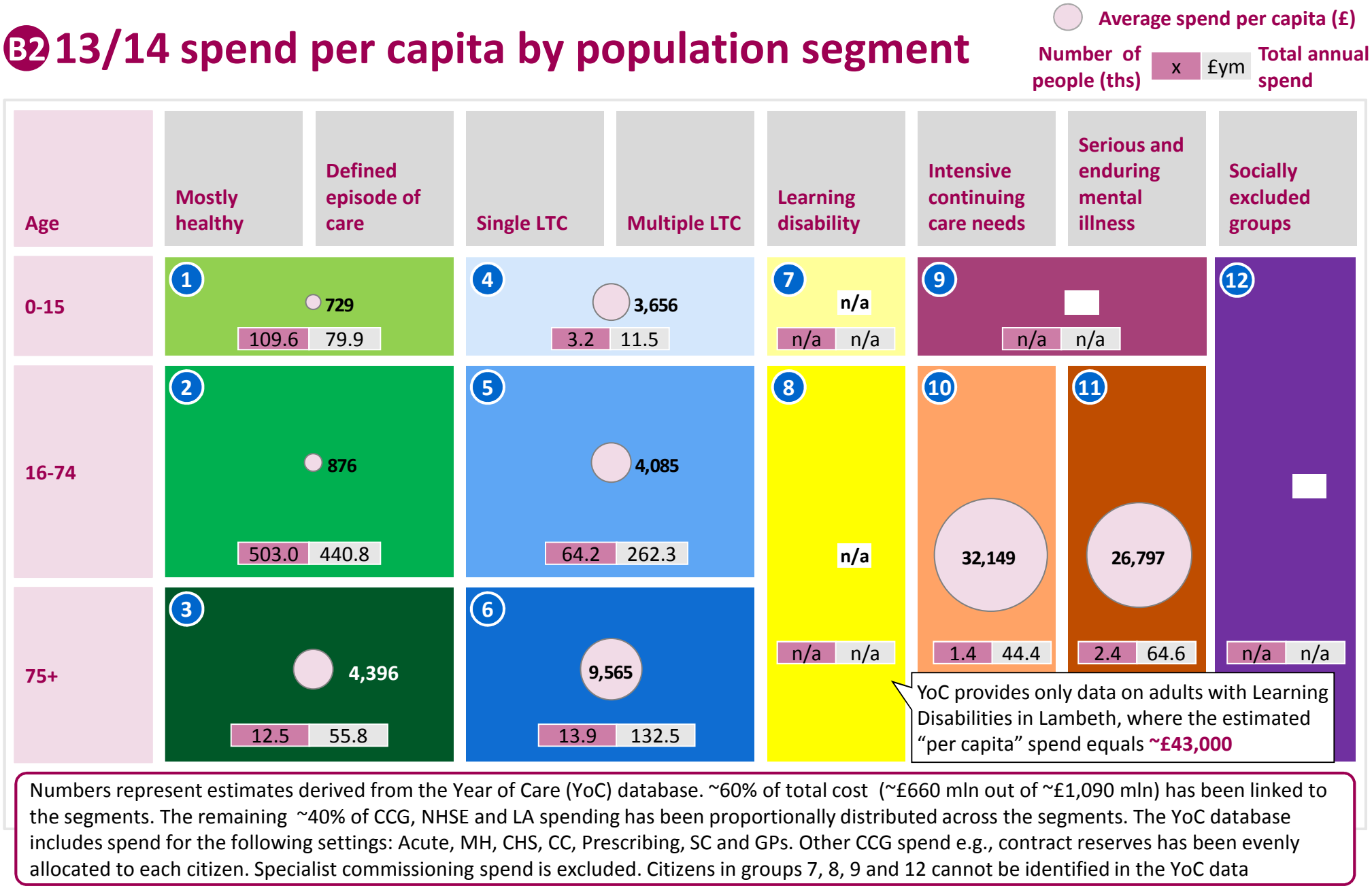
PRELIMINARY

Age	Mostly healthy	Defined episode of care	Single LTC	Multiple LTC	Learning disability	Intensive continuing care needs	Serious and enduring mental illness	Socially excluded groups
0-15	1 Mostly healthy children		4 Children with one or more LTCs		7 Children with LDs	Children with intensive continuing care needs[1]		11 Homeless people, alcohol and drug dependencies
16-74	2 Mostly healthy adults		5 Adults with one or more long term conditions		8 Adults and elderly people with learning disabilities	9 Adults and elderly people with intensive continuing care needs	10 Adults and elderly people with SEMI	
75+	3 Mostly healthy elderly people		6 Elderly people with one or more long term conditions					

In addition there will be several **cross-cutting themes** that should be used to prioritise the particular approach within each grouping, e.g. frailty, deprivation, behaviour, social involvement, utilisation risk, presence of a carer, a person's own caring responsibilities

1 Small numbers of citizens in this category; ICG to confirm how to approach this group

B2 13/14 spend per capita by population segment



Numbers represent estimates derived from the Year of Care (YoC) database. ~60% of total cost (~£660 mln out of ~£1,090 mln) has been linked to the segments. The remaining ~40% of CCG, NHSE and LA spending has been proportionally distributed across the segments. The YoC database includes spend for the following settings: Acute, MH, CHS, CC, Prescribing, SC and GPs. Other CCG spend e.g., contract reserves has been evenly allocated to each citizen. Specialist commissioning spend is excluded. Citizens in groups 7, 8, 9 and 12 cannot be identified in the YoC data

SOURCE: NWL Whole Systems work; SLIC Sponsor Board discussion July 2013; ICG discussions January-March, 2014

Cost

National and international case studies of integrated care identify a 15-25% savings potential

Group[1]	Relevant cases	Investment range	Impact range	Net savings[2] (%)
1 Mostly healthy children	▪ Colorado Children's Healthcare Access Program (CCHAP)	▪ ~25-35% increase of GP costs (preventive care)	▪ ~15-25% decrease of A&E spend ▪ ~20-25% decrease for non-elective inpatients spend	10-15
2 Mostly healthy adults	▪ Geisinger Health System ▪ Valencia's IC	▪ n/a	▪ 20% reduction in hospital admissions ▪ 7% savings in medical costs ▪ 76% increase in hospital productivity	10-20
3 Mostly healthy elderly	▪ NHS Torbay	▪ n/a	▪ Non-elective inpatient bed use in for 65+ patients reduced by 29% with LOS 19% lower	10-20
4 Children with LTCs	▪ Colorado Children's Healthcare Access Program (CCHAP)	▪ ~25-35% increase of GP costs (preventive care)	▪ ~5% decrease of A&E department utilisation ▪ ~25-35% decrease for non-elective inpatients spend	15-25
5 Adults with LTCs	▪ NHS Tower Hamlets	▪ Increase of GP spend by 40-50%	▪ 12-14% decrease of non-elective admissions spend	10-15
6 Elderly with LTCs	▪ ChenMed	▪ n/a	▪ 38% lower hospitalization rate ▪ 17% lower readmissions rates compared to national averages for patient group	20-30
10 Intensive continuing care needs	▪ n/a	▪ n/a	▪ n/a	n/a
11 SEMI	▪ NY Care Coordination Program ▪ Maricopa/Magellan	▪ n/a	▪ 29% reduction of annual per capita mental health costs	25-30
			Total	15-25

Each of the studied business cases and clinical papers **records actual savings** that have been observed during an adequate time span (i.e. mostly within 5 years)

1 Excludes groups 7, 8, 9 and 12, where no cost data is currently available

2 As part of total acute spend in segment; where no information on investment, savings reduced by 5-10%p

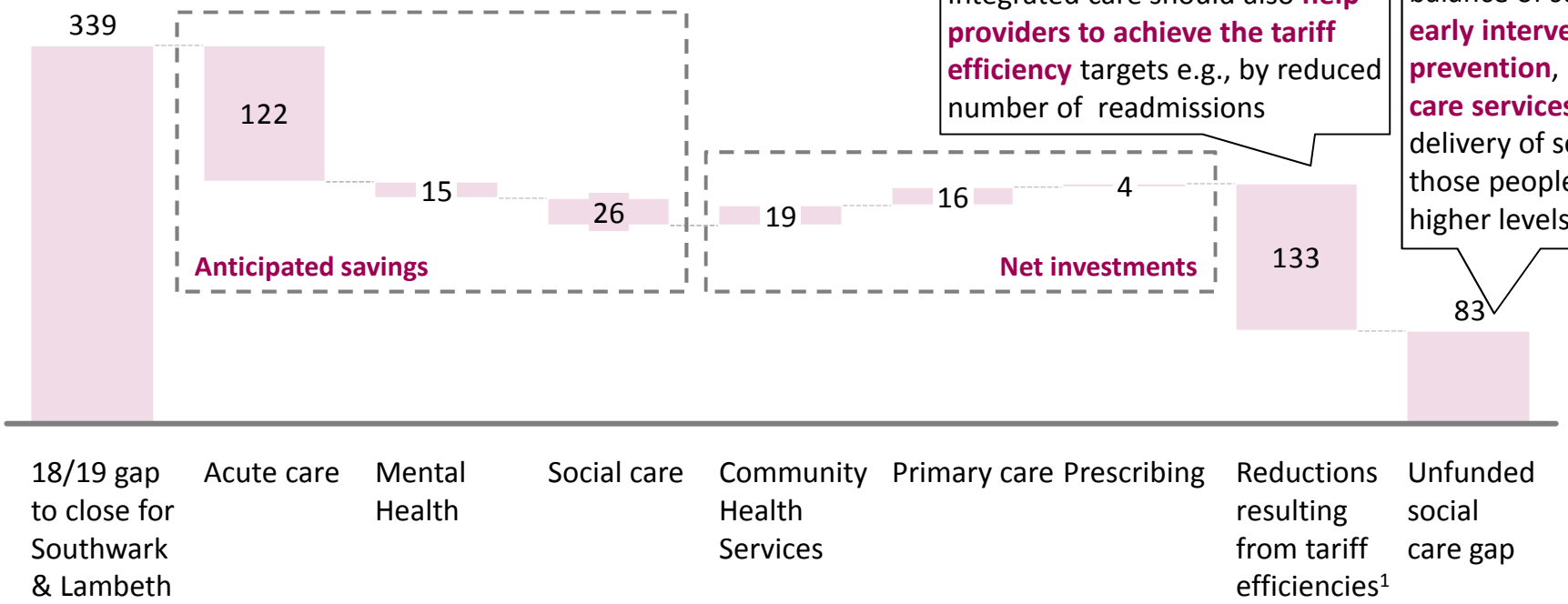
SOURCE: Expert interviews; Press search

Cost

Our modelling shows that investments of £39m are needed to release potential savings of £124m

Million £

'Financial Challenge' for Southwark and Lambeth CCG and SC closed through net impact of integrated care, tariff efficiency and further savings in Social Care



Integrated care should also **help providers to achieve the tariff efficiency** targets e.g., by reduced number of readmissions

Local authorities will adopt a number of approaches with the aim of prioritising spending to achieve a balance of support for **early intervention**, **prevention**, and **respite care services** and the delivery of services to those people with higher levels of need[2]

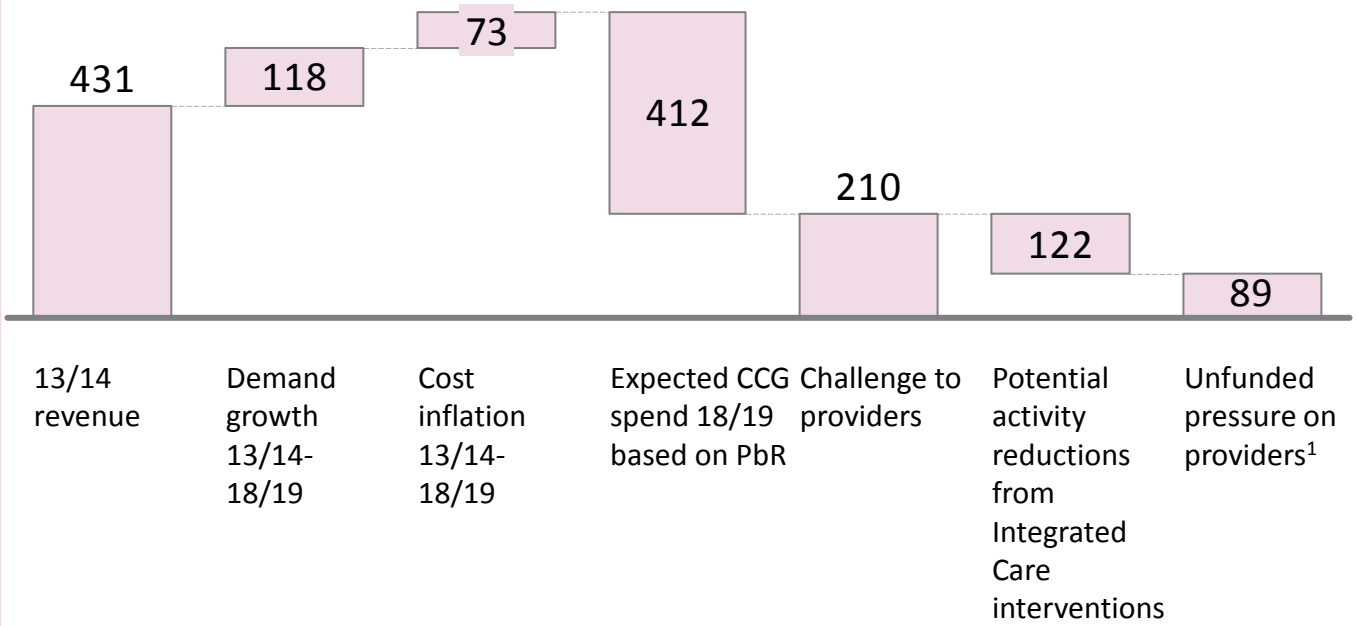
All savings and investments to be revised as plans for specific IC interventions are developed in more detail

1 National planning guidance on 4%pa tariff efficiency for acute, mental health and community services
2 More details on LA approach regarding options available for the financial gap closure can be found in the appendix
SOURCE: YoC database, Southwark and Lambeth CCG plans

Cost

Commissioners' ability to invest in new services is based upon the ability to move resources from acute trusts…(1/2)

Financial challenge bridge for acute Trusts – only includes services at GSTT and KCHT for Southwark and Lambeth CCG



- Potential activity reductions through integrated care (based on case studies and benchmarking) approximately offsets demand growth (£122m vs. £118m), so the net change in Trust activity is small
- Remaining £89m is a large financial pressure on Trusts
- This analysis represents a small part of the larger financial challenge for the acute Trusts, as Lambeth and Southwark account for less than 20% of total Trust revenue[2]

1 This is equivalent to the 4% 'tariff efficiency' real reduction in prices that is embedded in Tariffs

2 Lambeth and Southwark CCG represent 16% total income (21% clinical income for KCH, and 19% total income (25% NHS clinical income) for GSTT. The total 5 year savings requirements for the Trusts when considering their full business (equivalent to the £210m challenge here), as reported by the Trusts, are approximately £350m (KCH) and £310m (GSTT) – this is beyond the scope of the SLIC work so has not been derived or tested here. The Trusts report that "The financial challenge to the Acute providers will be greater than the national efficiency factor of 4/4.5% due to additional cost pressures in the system such as a phased reduction of training & education funding, the loss of project diamond funding, Commissioner QIPP targets, cost pressures such as pension costs, medical locum and nursing agency costs due to staff shortages and an increased nursing requirement regarding patient acuity. In order to provide adequate capacity, there is an increased cost of debt service and associated PFI cost pressures." – Head of Financial Planning, King's College Hospital May 2014

SOURCE: SLIC financial modelling, based on CCG plans (Southwark (v.28.2.2014) and Lambeth (v.10.3.2014)) and comments provided by Trusts May 2014

Cost

…(2/2) but this is very difficult; unless activity falls, or risk is shared, trusts will face the cost of care without income to fund it

Acute providers

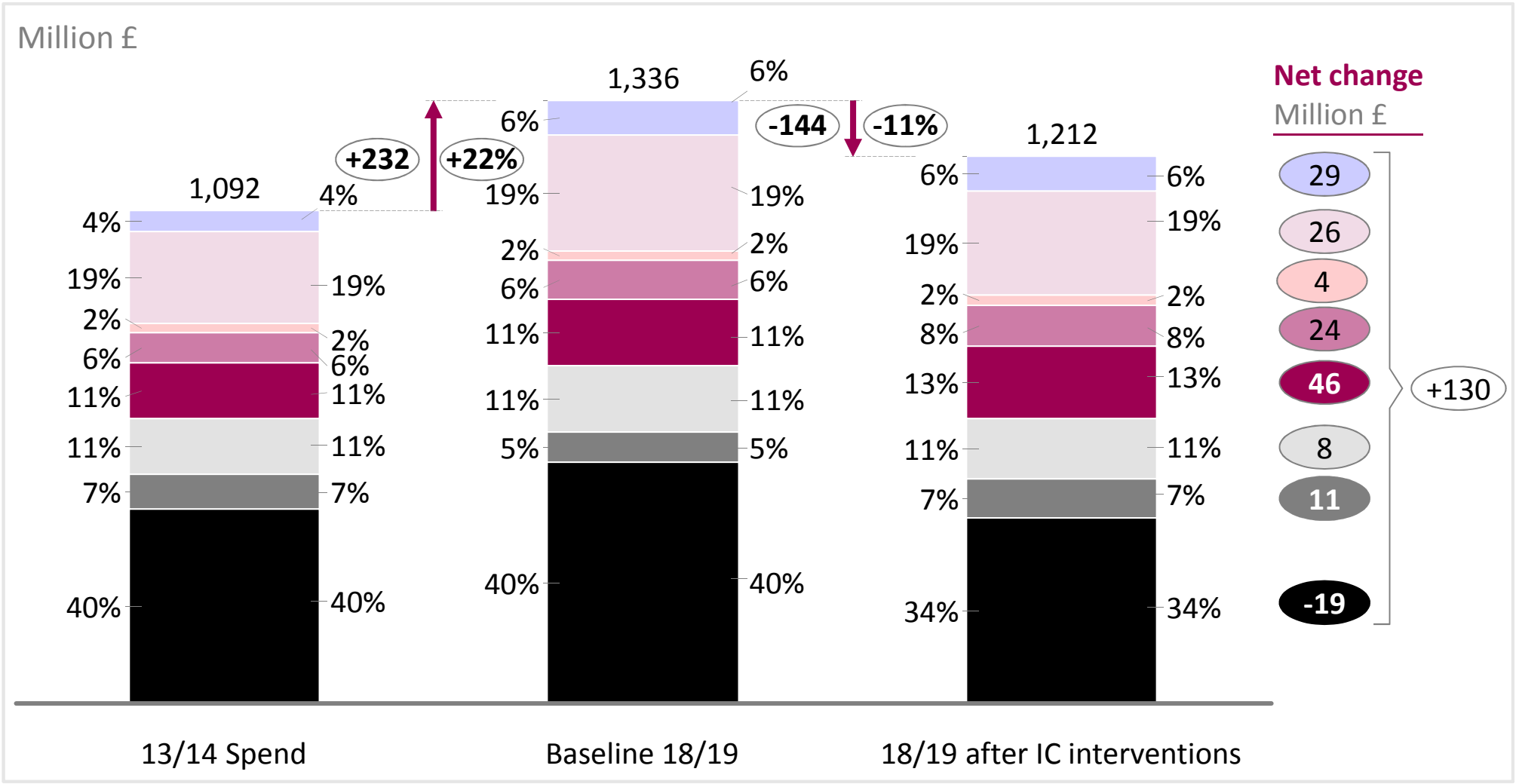
- On the current trajectory, 2018/19 would see the provision of £118m of acute activity that commissioners cannot afford given their future allocations and aspirations for spending on non-acute services
- Under this scenario, acute providers would be left with unrecoverable costs
- Halting this increase will take a heroic effort
- Cases studies and benchmarks indicate that integrated care can reduce activity by £122m offsetting this growth
- Doing this will require a significant increase in the resources in primary and community and their effectiveness
- Even with activity remaining flat, acute Trusts will need to achieve productivity savings that offset the £89m pressure from tariff efficiency

Out of hospital providers

- Out of hospital services, including community, mental health will also have to manage price reductions of 4 % below cost inflation (a total of £7m).
- However, there will be a need to invest additional resources in out of hospital services to deliver these improvements in health.

Cost

Implementing IC would change the balance of spend in health and social care away from acute hospitals



Note: Numbers may not add up due to rounding

SOURCE: YoC database; Southwark and Lambeth CCG plans, team analysis

Cost

Overall, IC could decrease the forecast social and health care spend across Southwark and Lambeth by ~11%

For each setting we assumed the maximum net saving

Setting	Service line	13/14 spend	Baseline forecast		18/19 baseline spend	Applied net saving, in %	Net changes			18/19 after IC interventions
			Activity	Price[1]			Activity	Price[1]	Total	
Acute	Total acute	£431m	£118m	-£16m	£534m	-23%[2]	-£4m	-£16m	-£19m	412
	Non-elective	£110m	£30m	-£4m	£136m	-33%	-£15m	-£4m	-£19m	90
	Elective	£132m	£36m	-£5m	£164m	-30%	-£12m	-£5m	-£17m	115
	Outpatients	£105m	£29m	-£4m	£130m	-18%	£6m	-£4m	£2m	107
	A&E	£22m	£6m	-£1m	£28m	-18%	£1m	-£1m	£0m	23
	Non-PbR	£63m	£17m	-£2m	£77m	n.a.	£17m	-£2m	£14m	77
Primary		£125m	£31m	£0m	£156m	10%	£46m	£0m	£46m	172
Community		£75m	-£5m	-£2m	£67m	25%	£14m	-£2m	£11m	86
MH		£124m	£27m	-£5m	£147m	-10%	£13m	-£5m	£8m	132
Prescribing		£67m	£12m	£7m	£87m	5%	£17m	£7m	£24m	91
CC		£18m	£2m	£2m	£22m	n.a.	£2m	£2m	£4m	22
SC		£204m	£16m	£35m	£255m	-10%	-£9m	£35m	£26m	230
Other		£48m	£28m	£1m	£77m	n.a.	£28m	£1m	£29m	77
TOTAL		£1,092m	£230m	£23m	£1,345m	11%	£107m	£23m	£130m	1,222

Note: Numbers may not add up due to rounding

1 Includes tariff efficiencies

2 Lack in Non-PbR savingsresults in total for Acute of 23% vs.27% as proven by GP variation

SOURCE: YoC database; Southwark CCG plans