1 Development Seminar Objectives

East Sussex health and care system has embarked on a transformational 150 week programme, East Sussex Better Together, to make sure that the delivery of care is fit for the future needs of the population and can be delivered within the available financial envelope at the appropriate quality. As part of this programme research has taken place to better understand Accountable Care models.

The objectives of the ‘Exploring Accountable Care’ development seminar series are to:

- Create a shared platform of understanding of key aspects of Accountable Care through discussion and sharing of international and national examples
- Support the development of the principles and characteristics of local Accountable Care for East Sussex through engaging with a range of health and social care system leaders from across commissioning and provider organisations.

This development series is composed of 4 seminar sessions:

1. Payment reform and incentivisation – outcomes based capitation funding
2. Procurement and contractual options – decision making process, governance and timescale
3. Governance and management of risk – ongoing public sector accountability
4. Long term financial model – implications across the system

Seminar 1 was held on 24 March 2016. A list of attendees is contained in appendix 1. The seminar focussed on ‘Payment Reform and Incentivisation’, and the objectives were to:

- Build an understanding of the topic and explore options
- Debate the opportunities and challenges of different Accountable Care models
- Consider the potential implications for East Sussex

2 Overview of Payment Reform and Incentivisation Seminar Discussion

During the seminar key concepts around payment reform and incentivisation were shared with participants. A summary of the points covered during the seminar is below.

There is not a single definition for an Accountable Care System (ACS), however the definition below, which is being used in East Sussex captures the key elements.

“A system in which a group of providers [or a provider] are held jointly accountable for achieving a set of outcomes for a prospectively defined population over a period of time and for an agreed cost under a contractual arrangement with a commissioner”.

International case studies were shared and explored (appendix 2); international best practice shows that successful ACSs have similar characteristics that include:

- A network of organisations involved in managing and delivering the health and care for a population. Often within a single contract/agreement.
- The ability to manage and co-ordinate the care of individuals along the care continuum through care management
- Strong and effective primary care
- A care model that focuses on integration and collaboration resulting in more multi-disciplinary working, differentiated offer and management of defined population groups as well as alternative settings based on the health and care needs of the individual
- Key enablers in place such as integrated IT solutions to support collaboration and sharing of information, innovation and learning across the system, alternative payment and contracting models and a shared and flexible workforce focused on outcomes and value

ACSs are supported by a reformed system incorporating alternative payment mechanisms because commissioning integrated services – either on a pathway or population basis – requires different ways of paying for them. Value-based healthcare models typically use payments that reflect the value of the solution or placing some of the payment on outcomes.

Capitation brings together multiple contracts and payments. Capitation allows commissioners to reimburse providers for making available specified services and possibly delivering specified outcomes for a defined target population, drawing on services that cross different organisational boundaries to meet individual patient needs. Key risks to mitigate with capitation include:

- The provider could become financially unstable if they cannot manage the risk (such as demand risk) they take on
- Commissioners could pay twice for the same service, or pay more for the same service
- Providers other than the lead provider could find it difficult to challenge the dominant player in the collaborative
- Reducing the equality of care provided if access to services is dependent on where a patient lives (for example, if an acute trust treats patients from a number of clinical commissioning groups, but only has a capitated contract with one or a few of these CCGs)
- Reducing access to care as providers have an incentive to withhold or delay more expensive care
- Improved coordination and better visibility of the care pathway may lead to the identification of previously unmet additional needs

Monitor has identified a number of design choices when designing and developing a capitated payment approach. These choices include; identify the patient cohort, define services to be covered by capitation / services in scope, select method for determining the price, plan financial risk mitigation mechanisms, define provider-to-provider payments, define gain/loss sharing arrangements and define quality and outcome incentives.
During seminar 1 table discussions centred on principles related to identifying the patient cohort / population groups and defining services to be covered by capitation / services in scope.

Understanding the population is the starting point in identifying the cohort in scope. Other important factors in defining the cohort include; sufficient size in order to mitigate any overspend risk (Monitor suggest a minimum population of 30,000) and a population with similar needs that can be clearly defined. Geography can be a determining criteria as well as condition or age.

During the table discussions the groups considered criteria to help determine the population cohort for East Sussex. Criteria felt to be important by participants included:

- Ability to achieve economies of scale
- Level of overall resource consumption (i.e. there must be a significant proportion of use of resources to make the transformation meaningful)
- Opportunity to innovate beyond the current delivery model

There was acknowledgement from participants that any cohorts other than whole population would overlap and could be difficult to manage. There was also recognition that a whole population cohort was a big step and would need to be properly worked through.

In terms of scope of services it is important to establish a set of principles for determining the services in scope. Other factors to consider when defining scope include;

- A capitated budget should cover a sufficient range of services to incentivise integrated care and prevention
- Inclusion/exclusion may be influenced by population cohort, size and level of risk
- Some sub-services may be included/excluded
- The greater the number of exclusions the potential for increased fragmentation and costs
- Some services may be phased in over time

The table groups discussed design principles for determining the scope of services. There was a general preference for broader international models which had greatest scope such as the Jönköping County Council (Sweden) model. There was also an appetite to explore the option of including other public services (e.g. education, policing, housing) are limited in those models and could be attractive in east Sussex. There was an emphasis on the need to include primary prevention and Public Health in any scope being considered. As the discussions progressed the table groups came to the conclusion that it would be easier to start from assumption of all services were in scope and then identify any exceptions. For example, some specialised services could be difficult to include due to insufficient scale.

In the table groups some of the benefits that an ACS could bring for the workforce were also highlighted, including;

- Non-financial incentives (as in Canterbury, NZ case study) could change the experience of working in health and social care which could improve recruitment and retention
- Staff would be enabled to deliver and change, which could also lead to improvements in recruitment and retentions
- A more flexible workforce
3 Conclusions

In summary, during the seminar international examples of Accountable Care, examples of current payment mechanisms and options for scope of services and population were discussed.

Key principles and characteristics were identified during the seminar as important for a successful accountable care model in East Sussex, to be seen as working assumptions to be tested when developing the detail in the full business case. This included:

- A starting assumption that all services are in scope and those that are ruled out are by exception, for example where feasibility may be an issue. It was acknowledged that ‘whole person’ care needs to be supported by a whole system and therefore population approach, rather than segmenting the population by conditions or age.
- The contract should be sufficiently large to achieve the economies of scale needed to tackle a £135 million funding gap, as well as avoiding the pathway fragmentation that undermines integration and adding in transaction costs through operating parallel care models and pathways.
- A strong emphasis on public health and primary prevention in order to ensure the population health is a part of the model of care
- The model will be based on delivering outcomes that are important to local people – and this would cover both health outcomes as well as experiential outcomes.

Appendix 1 – List of participants in seminar 1

Appendix 2 - International Case Studies
## Appendix 1

1. Amanda Philpott  
   Chief Officer, EHS & H&R CCG  
2. Andrew Slater  
   Director of Clinical Information and Strategy, ESHT  
3. Cynthia Lyons  
   Acting Director of Public Health, ESCC  
4. David Till  
   Consultant, ESHT  
5. David Warden  
   GP & Governing Body Chair, H&R CCG  
6. Ian Gutsell  
   Head of Strategic Finance, ESCC  
7. Jessica Britton  
   Chief Operating Officer, EHS & H&R CCG  
8. Joerg Bruuns  
   GP and Governing Body Member, EHS CCG  
9. John O’Sullivan  
   Chief Finance Officer, EHS & H&R CCG  
10. Julius Parker  
    Chief Executive (Kingston & Richmond), LMC  
11. Marion Kelly  
    Chief Finance Office, ESCC  
12. Martin Hayles  
    Assistant Director (Strategy, Commissioning and Supply Management) Adult Social Care and Health, ESCC  
13. Paula Gorvett  
    Programme Director, ESBT  
14. Richard Eyre  
    Strategic Partnerships and Business Development Manager, Healthwatch East Sussex  
15. Barbara Vincent  
    Sussex Partnership NHS Foundation Trust  
16. Vicky Smith  
    Accountable Care Strategic Development Manager, ESBT  
17. Andrew Marshall  
    Consultant, ESHT  
18. Karen Hoskin  
    Sussex Partnership NHS Foundation Trust  
19. Dan Moore  
    PricewaterhouseCoopers  
20. Claus Crede  
    PricewaterhouseCoopers  
    PricewaterhouseCoopers  
22. Alison Cross  
    PricewaterhouseCoopers