Note: Information contained in this paper has already been made available in the public domain in a variety of papers, arenas and discussions; material has been drawn together here into one paper for ease of reference.

Developing the Evidence Base Further for ESBT Accountable Care (November 2016)

1. Summary

1.1 This paper recaps why the features of Accountable Care will help us to fully deliver our triple aims of improving population health and wellbeing, enhancing care, quality and experience and restoring and maintaining financial balance, including addressing the system wide predicted funding gap of £169 million by 2020/21[1]. It also summarises the outcomes of local discussions during 2016, building on our initial research in Autumn 2015[2], and presents ideas for a test-bed year in 2017/18 to test and develop aspects of Accountable Care models further, and support further decisions on the most appropriate organisational arrangements for an ESBT Accountable Care Model. It can be read alongside the companion document 'The Case for Change in East Sussex (Accountable Care)' which draws together and summarises information about the changes in the nature of demand for health and social care, requiring a fundamental transformation in the way we arrange, pay for and deliver care.

2. Geography and services in the ESBT area

2.1 As of September 2016, the ESBT Programme partners are Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups (CCGs), East Sussex County Council, East Sussex Healthcare NHS Trust and Sussex Partnership NHS Foundation Trust. The ESBT footprint, and therefore this report, covers acute hospital, primary care, community, mental health, social care and specialist services provided in the Eastbourne Hailsham Seaford CCG and Hastings and Rother CCG areas.

3. Key points

3.1 Our ESBT whole system programme has provided a firm foundation for designing and implementing whole system care pathways and the integration of health and social care in commissioning and delivery. As good as this service transformation is however, it needs to be delivered by affordable and sustainable providers in East Sussex, in primary, community, mental health and social care as well as hospital-based acute secondary care, as all areas locally are challenged. In order to fully deliver our ESBT vision and realise the benefits of integration and service transformation we need to also transform the architecture of our local system in two ways:

- Integrating strategic planning and commissioning
- Integrating service delivery – establishing a sustainable provider landscape.

[1] 2016/17 figures, draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)
[2] 'Moving to Accountable care in East Sussex' (East Sussex Better Together, 2015)

4 Integrated strategic planning and commissioning

4.1 To ensure that we make fully integrated decisions about the collective use of the available £846 million[3] health and social care funding to deliver the best possible outcomes and return on in investment, there will be a single strategic planning and commissioning process across the Council and the CCGs for investment in health and social care services in 2017/18. This is a significant step forward in planning collectively for our shared resources and reflects the need to make unified decisions about priorities to get best value. It will also be critical to making coherent decisions for the future and to testing aspects of an Accountable Care model in 2017/18. The following key elements will support integrated strategic planning and commissioning:

- An integrated and aligned budget covering collective health and social care investment
- An integrated Strategic Investment Plan to prioritise investment
- A unified Outcomes Framework and performance management process

5. Integrated service delivery – establishing a sustainable provider landscape

5.1 The key focus for the first phase of the ESBT 150 week programme was redesigning the pathways and services that make up our new care model. To enable us to deliver our ESBT vision of long-term sustainability, we now need to focus on our local provider landscape and put in place the right provider infrastructure to deliver outcomes on a whole system and whole person basis. This needs to happen at a scale required to deliver our triple aims of improved population health and wellbeing, enhanced care, quality and experience, and restoring and maintaining financial balance[4].

5.2 In the Autumn of 2015[5] we undertook research into international examples of good practice to establish the characteristics of health and care systems who are successfully meeting the 'triple aims' of health and care systems globally – improved quality, improved population health and reduced costs per capita. That research pointed to provider models known as 'Accountable Care' as being particularly effective at bringing improvements to the quality of care and health outcomes, as well as slowing down the rate of increase in health and care spending. Both Multi-specialty Community Providers (MCP) and Primary and Acute Care Systems (PACS)[6] are forms of Accountable Care. In ESBT we believe that Accountable Care is the most likely model of care to resolve our issues of provider sustainability across primary, acute, community, mental health and social care, and our choice of model needs to reflect the corresponding breadth of integration.

5.3 This work was entirely consistent with the NHS Five Year Forward View, published in October 2014[7], which strongly encouraged local areas to be innovative in thinking about new models of care outlining some parameters, for example Multi-speciality Community Providers (MCPs) and Primary and Acute Care Systems (PACS) which were helpful in guiding our initial thinking. In the context of the Five Year Forward View and the Sussex and East Surrey Sustainable Transformation Plan, it is recognised that some elements of the transformation to new models of care are also likely to require dialogue with Government departments and the NHS about changes to policy or statutory guidance.

[3] 2016/17 figures, draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)
[4] Institute for Healthcare Improvement – Triple Aim for Populations
[5] 'Moving to Accountable care in East Sussex' (East Sussex Better Together, 2015)
[6] NHS Five year Forward View (October 2014) www.england.nhs.uk/ourwork/futurenhs/
[7] NHS Five Year Forward (October 2014) www.england.nhs.uk/ourwork/futurenhs/

Why 'Accountable Care' – a working definition

Accountable Care is a term used to describe a range of health and care delivery systems that have similar features to support delivery. The definition we have adopted locally is:

*A **system** in which a **provider or a group of providers** is 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*

6. Common features of successful Accountable Care systems

6.1 The Kings Fund[8] has identified that although there are several organisational approaches to Accountable Care models, all successful models share the following common features that transform the delivery of discrete care services into a whole care system that is empowered to proactively manage overall population health and prevention, as well as providing care services, through stronger networks of delivery and accountability:

- Single leadership teams working to aligned objectives.
- Single capitated budget aligned to delivery of specific outcomes – as an alternative payment mechanism to activity based payments, payment by results and block contracting.
- Longer contract lengths for example 5 – 7 and 10 – 15 years.
- A focus on whole population health that translates into 'make or buy' programmes of care and disease management, prevention and wellness.
- Use of shared electronic health records that have the ability to exchange information across providers and teams, and be aggregated to ensure real-time collective business intelligence.
- Greater attention to actively involving, engaging and supporting patients, clients and their families in the setting of outcomes and the management of care.
- Shared risk approach to both delivery and commissioning of services.
- All parties working to a common set of financial and quality measures.

6.2 Having looked at the evidence we have think that a 'PACS' type of model of Accountable Care looks the most appropriate for East Sussex. This would mean that East Sussex Healthcare NHS Trust (ESHT), as our local provider of acute hospital and community services, would be a part of a fully collaborative model with primary care, mental health and social care, enabling us to deliver the scale and impact of the benefits we are seeking to achieve for our population in the following ways:

- Integrating provision of out of hospital health, care and support to deliver prevention, wellbeing and independence and less reliance on high cost services
- Integrating acute and primary care and improving hospital based and primary care services to reduce variation, increase standards and improve productivity
- Providing parity of esteem and approach to mental and physical health
- Integrating effort on the challenges of workforce, IT, estates and quality across these services to deliver more benefit for the system as a whole.

[8] Accountable Care organisations in the US and England, testing, evaluating and learning what works, Kings Fund, March 2014

Primary and Acute Care Systems (PACS)

Although there is no rigid definition of PACS models or how they are expected to work in practice, a PACS model "will deliver an expanded version of core general practice, but will go much further (than MCPs) in joining with acute hospitals to create a single provider system" (NHS New Models of Care: Update and Initial Support, July 2015)

6.3 There is no 'off the shelf' solution however, and as a result of these discussions we asked PricewaterhouseCoopers (PwC) to facilitate four seminars to get a better technical understanding about the governance of Accountable Care models during March to April 2016. These were attended by clinical and executive leaders from across our local health and social care system alongside representatives from the Local Medical Committee and Healthwatch East Sussex. The summary reports from these workshops and the original research paper can be found on the ESBT website at ESBT Website/ Accountable Care

6.4 Having been firmly embedded as partners in the ESBT programme of service and care pathway redesign, as a result of the seminar discussions in May 2016 it was formally agreed that ESHT and Sussex Partnership Foundation NHS Trust (SPFT) would join the ESBT Programme Board to make our approach truly whole system, enabling a full alliance between commissioners and providers of health and social care.

7 ESBT, place-based models of care and the Sustainable Transformation Plan

7.1 In early 2016 in order to address significant NHS deficits NHS England (NHSE) requested the development of 44 sub-regional Sustainable Transformation Plans (STPs) across England. The plans are being developed to deliver financial sustainability with 'footprints' prescribed by NHSE, which focus on acute service configurations - ESBT is one of three local areas within the Sussex and East Surrey STP. The STPs will be developed and submitted in Autumn 2016 to NHSE for approval.

7.2 As a result of our early learning and discussions about Accountable Care in May 2016 we agreed a set of principles and characteristics to be used when appraising the design options for a local ESBT place-based model of care. These nine principles also fit within the context of the evolving Sussex and East Surrey STP and have been adopted by all the partners in our STP footprint as the template for the local place-based approaches within the STP, subject to NHSE approval of the wider STP. The table below sets out these principles and characteristics.

	Key principles and characteristics of a local Accountable Care model
1	Our evidence-driven, place-based models will firmly embed the first principle for us all of a prevention-led approach across the Sussex and East Surrey STP. The model will have a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services and allow care to be delivered increasingly out of hospital and at the lowest level of effective care.
2	All health and social care services should be in scope – primary, local acute DGH,

	community, mental health, social care and public health services for children and adults. Those that are ruled out will be by exception.
3	'Whole person' care needs to be supported by a whole population approach rather than segmenting or subdividing the population by conditions or age, and thus although delivery will normally be based around localities with populations of circa 50,000, accessing health and care should support patient choice and be consistently simple for patients regardless of where they access it.
4	The model will have a positive impact and deliver outcomes that are important to local people – both health outcomes and experiential outcomes. This includes involving local people in designing, commissioning and delivering outcomes.
5	The outcomes based contract and capitated budget will be sufficiently large to achieve the economies of scale needed to tackle each Place's total funding gap, and establish an ongoing in-year budget balance.
6	There will be a focus on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adds in transaction costs through operating parallel models. We will seek to achieve our aims through collaboration in the way that we procure new models.
7	There will be a strong culture of whole system working on the ground that actively empowers staff to be able to 'do the right thing', putting patients' and clients' needs first within a single health and social are system covering primary, community, local DGH, mental health, social care, public health services, and independent and voluntary services where appropriate.
8	Our model will align incentives in order to inspire and attract health and social care professionals and offer maximum levels of clinical and staff engagement and leadership, embed system-wide organisational development.
9	The organisational forms in each Place will require collective leadership and have governance and operational mechanisms that enable learning and development to take place in stages to share and manage risks between commissioners and providers. This will lead to delivery of full Accountable Care models, as per the ambitions of the FYFV, i.e. the fullest possible levels of integration and maximum ability to achieve the long term vision and benefit of a sustainable and affordable health and social care system

8 Why a new model of Accountable Care will help deliver sustainability in the ESBT area

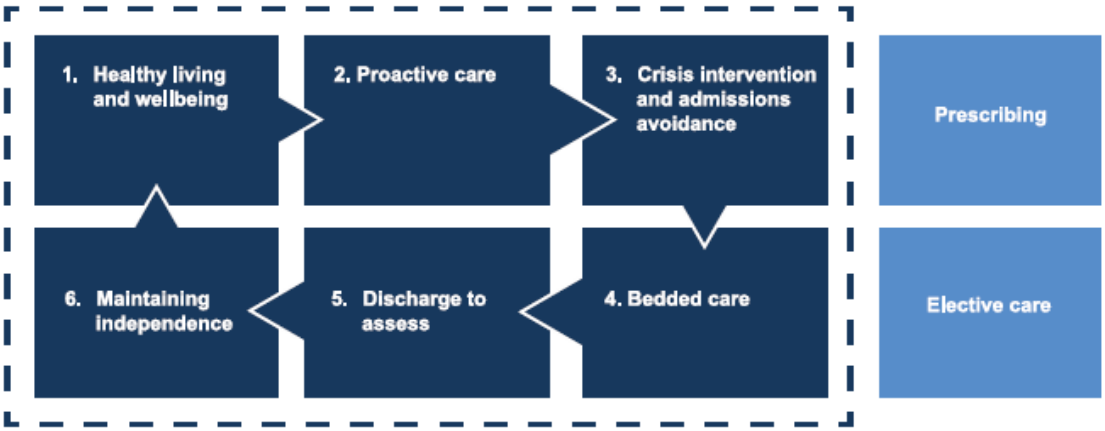
8.1 The 'Accountable Care' models we have explored focus on delivering local health and social care services based on the outcomes, or results, for patients and service users. Put simply, it means the whole health and care system is geared towards preventing ill health (keeping people well) and promoting independence and wellbeing, while ensuring we have high quality hospital, care and specialist services when people need them. This approach is already being used successfully in other countries around the world, and is now being tested here through the national NHS Vanguards programme.

8.2 We know that the change in our population structure is driving unprecedented levels of unplanned (non-elective) activity in our acute care hospitals locally - more detail about this can be found in the companion paper to this report 'The Case for Change in East Sussex (Accountable Care)'. We have this in common with many hospitals both in the UK and in other high-income countries, for example KPMG have found that caring for older people with multiple conditions accounts for "more than half of the typical caseloads of hospitals….and more than 70% of occupied bed days" that they work with[9].

8.3 Studies from health and care systems across the world also "show that between 20 – 25 percent of all patients could be cared for in different settings, quite frequently at home"[10]. This means there is a real opportunity to transform to a model which can truly support prevention, early intervention, and proactive care to deliver the lowest level of effective care and support, and where enabling patients, clients and carers to be more in control of their conditions, health, and wellbeing is at the heart of the model.

8.4 We also understand that improving chronic care and that of long term conditions is largely a matter of proactive disease and care management in a strong and resilient primary and community care setting; this has long been our vision under ESBT and our 6+2 box pathway (figure 1) and we are putting in place integrated services and pathways to help make this a reality. The six boxes describe the services and support required throughout the whole cycle of an individual's care and support – from prevention through to bedded care, mental and physical health, primary and secondary services. Two further boxes, prescribing and elective (planned) care, are additional areas where we are taking action to improve the quality and affordability of services.

Figure 1: The ESBT 6+2 box framework



8.5 A brief summary of progress with key service and pathway redesign to support our ESBT 6+2 framework is listed below (more information can be found on the ESBT website):

8.6 Community and personal resilience

- **Overarching strategy** – developed an ESBT wide strategy and undertaken comprehensive engagement in partnership with third sector about system leadership and key priorities for the programme
- **Locality Link workers** – seven posts appointed to strengthen an asset based approach to improve both personal and community resilience at the local level
- **Telecare** – significant investment to improve and extend home support across health, social care and housing

[9] In Search of the Perfect Health System: Britnell M(2015)
[10] In Search of the Perfect Health System: Britnell M(2015)

- **Health Help Now App** – interactive media app launched to signpost health and social care services
- **Health in Mind** - primary-care based mental health service aligning nurses to practices, providing information, advice and support, patient assessments and directed access as well as short-term interventions
- **HALO** – significant investment in Health Active Little One's programme performance

8.7 Integrated care

- **Health and Social Care Connect** – fully implemented a single point for health professionals to access support services for patients
- **Integrated Locality Teams** - established integrated social care and community health care teams under a single management structure, aimed at reducing the boundaries between the NHS and Social Care to develop a single operating process.
- **Frailty Practitioner service** – service aimed at over 75s and/or their carers to provide education, support and advice with a view to keeping the frail out of hospitals
- **Proactive Care teams** – providing monitoring and support to patients identified within practices as being high risk of developing acute need
- **Crisis Response** – 72hr nurse led admission avoidance team
- **Self-management** – development of core self management tools to be delivered across the system following survey of over 700 people with long term conditions

8.8 Urgent care

- **Integrated service model** - developed following extensive engagement
- **Primary Urgent Care** - co-designed a new service model in conjunction with Hastings Federation and IC24 – to be piloted in the Autumn.
- **NHS 111/ Local clinical hub** - developing a clinical triage and assessment service directly linked to local urgent care services.
- **Integrated Urgent and Emergency Care department** - integrated workforce plan agreed for front of each hospital site: EDGH and Conquest with extended multi-disciplinary support seven days a week – including extending voluntary services such as Take Home and Settle and introducing a non-clinical navigator role, implementing and testing extended scope physio for injuries at weekends
- **Clinical Pathway and Flow management** - all day workshop held to agree pathways into and out of the hospital, ensuring timely access to senior decision making and specialist input and advice

8.9 Primary care

- **Over 75s scheme** - enhanced GP support for proactive management
- **GP Prime pilot** – identifying patients most at risk within practices
- **Improved interface between primary and secondary care** to better support workload in primary care
- **Piloting remote consultations** with patients
- Introduction of primary care **service development fund**
- Establishment of **locum bank in partnership with ESHT**
- Implementation of **Bursary and Fellowship schemes**
- Establishment of **ESBT Community Education Provider Network**

- Development of strategic plan in response to 5 Year Forward View including plans to **jointly manage primary care estate**

8.10 Enabling workstreams that underpin the shaping of health and social care

- **Planning** - agreed approach to integrated strategic planning and joint commissioning framework. Integrated management team in place to oversee the implementation.
- Developing a **Single ESBT Strategic Investment Plan**, creating the conditions for a single system balance sheet
- **IM&T** - Digital roadmap for information agreed across the system
- **Housing** – Framework and governance agreed and in place with key health, housing and social care stakeholders to develop comprehensive accommodation and bedded care strategy including Districts & Boroughs and registered providers
- **Workforce** - System wide workforce strategy group in place, draft overarching strategy developed and CEPN established

8.11 It is understood that these improvements, though strong, will only take us so far. We recognise that we need to tackle some longstanding issues within our provider landscape, to change the way we organise and pay for services to create a system without barriers that works better for our clients and patients and is more sustainable in the long run. The central platform of a future Accountable Care operating model includes[11]:

Transformation	Rationale
Create active and engaged patients, clients and carers to be equal partners in their own care	Sustainable health and care and a health-conscious society relies on patients and clients who are active in decisions, and who are empowered and supported to manage their conditions through personalised care, health coaching and patient support groups as well as better use of technologies. Patients who are active and equal partners in their own healthcare have been found to 'consume' between 8 – 21% less care, feel more satisfied and have better outcomes[12] - and this represents enormous potential to be unleashed at scale. This should include approaches at the end of life as well as from the beginning.
Putting our staff in control	Our health and care workforce is our greatest asset and there is a chronic workforce shortage while demand for services is growing, whether this primary and acute care physicians and nurses, social workers, therapists and occupational therapists or independent sector care workers and assistants. Low levels of staff autonomy have been found to undermine recruitment and retention and adversely affect patient care[13]. Devolving integrated health and care budgets to local teams will give our staff control over the financial resource they are responsible for using, enabling stronger links to be made with the natural assets in the communities where they are delivering services. We need to work together as a local system on workforce

[11] Paraphrased from: 'In Search of the Perfect Health System' Britnell, M (2015)

[12] Patients with lower activation associated with higher costs: delivery systems should know their patients' "scores" Health Affairs (2013)

[13] 'Reducing patient mortality in hospitals: the role of human resource management, Journal of Organizational Behaviour (2006)

	motivation and development to broaden the portfolio and skills base of our health and care professionals, and encourage a more flexible and sensible approach to task delegation to make the work more attractive – reducing costly demarcations that don't serve patients' and clients' interests and making attractive opportunities for career development the norm.
Full integration at a system-wide level	Whilst the changes we are making under ESBT to integrate care pathways and services will have a positive impact on the quality and overall affordability of our health and social care system, there will remain a funding gap if we don't resolve the issue of provider sustainability. Our research has shown that this can be overcome through moving away from individual care providers towards a fully integrated 'care system', that is large enough to be accountable for the full continuum of care and achieving the 'triple aims' of improving health, quality and affordability[14] - something that it is currently impossible for any single organisation in our provider landscape to achieve.
Change the fragmented annual activity-based, fee for service payment model and moving to a single capitated budget payment mechanism, backed up with a longer-term contract	If we leave payment arrangements as they currently are our hospitals have no incentive to reduce the numbers of patients they see and income, as they are paid by activity and volume (fee-for-service) – the numbers of outpatients' appointments, day cases, operations and procedures. Conversely there is also little incentive for an already over-stretched primary care to undertake more work without extra resource. Changing the payment mechanism to whole population capitation and a longer-term contract means we will be able to move away from an annual cycle of revenue investment based on activity, and invest in a fundamental shift in the model of care to, chronic disease management, prevention and population health - dynamically shifting resources around the system to support this.
Reduce transactions between commissioners and providers	We currently spend time and money transacting the business as separate commissioners and providers. By moving to a more unified and integrated approach to commissioning, and performance managing the outcomes we want to achieve as a single system and sharing the risks to both commissioning and delivery of services, we can both improve the resilience of our commissioning organisations and reduce costs with a smaller commissioning infrastructure.

8.12 Through our ESBT whole systems programme we have made a strong start to create the partnerships and conditions we need for this whole system integration and a fundamental shift in the model of care. Moving to an Accountable Care model represents the next step in the journey to establishing an affordable and sustainable provider landscape with the above aspects at the heart of the care model, encompassed within a new operational and business environment that is fully integrated and incentivised to "simultaneously improve care, improve population health and reduce costs per capita"[15]

9 Impacts of Accountable care models

9.1 As in many parts of the country, demand for health and social care services is growing in Eats Sussex, and if the use of services grew in line with overall changes in

[14] 'Achieving Healthcare reform: How physicians can help' New England Journal of Medicine (Fisher E.S. et al (2009)

[15] Institute for Healthcare Improvement – Triple Aim for Populations

population, the system would be unlikely to cope through organic growth alone. We also know that as we age we are likely to need more services and support, and this is the fastest growing population in the county, and that the complexity of care needs is increasing across all the care groups we cover. This is more fully documented in the companion piece to this paper - 'The Case for Change in East Sussex (Accountable Care)'.

9.2 In the context of the collective £169 million funding gap faced by the ESBT health and social care economy, where it has been measured, a reduction in running costs of between 17-25% has been achieved by international Accountable Care models. A summary of some of the available international evidence supporting the impact of Accountable Care models on reducing cost is presented in the table below[16]

System	Benefits	Key features of the model
Veterans Administration (USA)	20% lower budget than if patients were Medicare funded	Substantially lower drug costs 55% fewer bed days than US average
Kaiser Permanente (USA)	19% lower costs than competing providers and health plans	NHS Average Length of Stay (ALOS) was 3.5x as high as Kaiser's (2005) ALOS in NHS increases with age – not at Kaiser
Geisinger (USA)	21% lower plan costs (not-for-profit provider)	Over 5 years, reduced bed days for diabetes patients by 43%, Health navigators reduced admissions by 20%
Gesundes Kintzigtal (Germany)	17% overall lower health system costs over 4 years	Focus on guided self-care Improved healthcare outcomes for the population
Valencia Region (Spain)	25 % lower costs than rest of Spain	Tendered provider care management of entire population to private consortia that are also liable for cost of running hospital Reduced ALOS by 30%

9.3 It is recognised that even these world-class examples of integrated care organisations do not always consider their journey to 'full integration' as being complete. For example in the Valencia region in Spain, operating in its current form since 2001, primary care has always had independent contractor status where contractors are in a delivery relationship with the integrated care provider.

9.4 It is also understood that it takes time to reach the levels of whole system organisational working to deliver benefits on this scale. Given the pace and scale of the transformation needed to meet the challenges faced by our local health and social care economy, including an anticipated £169 million funding gap in 2020/21[17] and significant local workforce challenges, this highlights the need to make a start with a test-bed year of collaborative development and learning about Accountable care in shadow form, starting in April 2017.

10. Local dialogue to develop an Accountable Care model

10.1 There is no blue print for an Accountable care model that will work in East Sussex; it needs to be understood and locally designed in order to take account of the specific

[16] PricewaterhouseCoopers source: IHP integrated care toolbox

[17] Draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)

circumstances and pressures on the ESBT health and social care economy. It is also something new to local organisations and stakeholders, which necessitates an immense amount of dialogue and engagement across a range of stakeholder interests, both to grow understanding and build trust as it heralds a very different form of collaborative working.

10.2 An initial phase of early discussion took place as a result of sharing the research paper in Autumn 2015, resulting in a set of key principles and characteristics being agreed in May 2016 (see paragraph 7.2 in this paper) that were felt to be important locally in informing the next phase of design discussions.

10.3 Further research and local discussion has taken place between June - October 2016 to shape the content of the development plans for Accountable Care, and this will continue, to consider the basis of the future vision for our local Accountable Care model and the arrangements for a transition year of Accountable Care in 2017/18. This has been taken forward through:

- System wide seminars and workshops, including representation from the Local Medical Committee (LMC) and Healthwatch East Sussex, on the impact of future models on health and social care in East Sussex
- Multi-agency Steering Group discussions between statutory partners
- ESBT Strategic Investment Plan discussions, as part of budget-setting processes, focussing on the activity and capacity changes needed to effect a move to community based prevention and proactive care
- Discussions at GP Locality Meetings, Membership Engagement and Learning Events, and a well-attended evening meeting with GPs to fully explore the relationship between resilient and sustainable primary care and the ACM
- Partnership engagement events and meetings, such as Shaping Health and Care events and provider forums, meetings of the ESBT Communications and Advisory Group, and other workshop sessions and discussions
- Staff engagement, commissioned through Healthwatch, across partners to test understanding and inform future communications and engagement
- Transparent and open communications about Accountable Care including explanatory videos and other material uploaded to the ESBT website to grow understanding and engagement
- Discussion at each meeting and joint seminar of the CCG Governing Bodies since publication of our original research on Accountable care in Autumn 2015

10.4 Clinical Commissioning Group Governing Body member input has been sought in formal, informal and seminar meetings during 2015 and County Council member input has been sought in a range of ways including through the ESBT Scrutiny Board on 4th October, Whole Council Forum on 11th October, and there has also been a presentation and discussions at a Health Overview and Scrutiny Committee (HOSC) seminar on 18th October. Discussion with the wider stakeholders in the voluntary and community sector and independent care sector have taken place including the October Shaping Health and Care events and this will continue through a range of forums.

10.5 Building on our initial description of the key principles and characteristics underpinning our local Accountable Care model (see paragraph 7.2 in this paper), through discussions a common understanding has been reached that Accountable Care models bring together a new care model (whole person, community based, preventative care) with a new payment, contracting and organisational model (population based capitated budgets

and payment mechanisms housed within a longer-term contract). This brings new flexibility to incentivise the shift to preventative and proactive care in the community, and organisations using this model have been able to improve population health and wellbeing, improved quality as well as a reduction in the per capita cost of care, at times to the scale of 17-25% compared to the running costs of equivalent health and care systems that are run on a more traditional and non-integrated basis.

10.6 Further to this, due to the interconnected nature of primary, community, acute, mental health and social care across the ESBT footprint, and the size of the financial challenge we need to address, we are committed to developing an Accountable Care model that has all of these services in scope, plus elements of specialist care where this is appropriate. This will enable optimum levels of flexibility across our health and care system to effect the following changes, some of which are already being taken forward by the ESBT Programme and can also be seen in UK Vanguards sponsored by the NHS[18]:

- A focus on prevention and population health management and a recasting of the relationship between local people and their health and care services, connecting people with assets and resources in communities to keep them well as well as using person-level and population data to organise care around people's needs and preferences.
- Providing urgent care that is integrated with primary, community, mental health and social care, reducing the need for emergency or unplanned hospital admissions. Our hospital-based services will only be used to meet appropriate in-patient needs.
- People's ongoing care needs are more coordinated through services in home and community based-settings. This will be delivered through integrated multi-disciplinary local area teams based in communities, and by linking hospital specialists to community and primary based care through greater use of technology to deliver care remotely.
- As far as possible people who have the most complex needs will have care and support delivered in the community, enabling a reduction in the number of hospital beds and inpatient care only for those who need intensive or complex care.

10.7 Strong progress has been made in all of these areas under the ESBT Programme, however, this won't be enough to close the anticipated £169 million funding gap[19] to secure an affordable and sustainable health and care system in the long term. Moving to Accountable Care will transform the way we do business as a health and social care system and economy in order to fully realise the benefits of service and pathway transformation and integration.

11 Contractual model and funding options

11.1 In order to secure the benefits of moving to a fully integrated Accountable Care system there are three main contractual models to consider, which can be summarised as follows[20]:

Model	Advantages	Disadvantages
Virtual arrangement: commissioners and providers are bound	Establishes a shared vision, ways of working and the role of each provider in the	Overlays rather than replaces traditional commissioning contracts, adding an extra layer to

[18] New Care Models: Integrated Primary and Acute Care Systems, NHS September 2016
[19] Draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)
[20] New Care Models: Integrated primary and acute care systems (PACS) – describing the care model and the business model (2016)

together by an alliance agreement	Accountable Care system. Represents a pragmatic step forward with least disruption especially if GPs have already come together to operate at scale	an already complex set of arrangements and can be weak in terms of deploying resources flexibly
Partially integrated: a contract is let for the vast majority of health and care services with a single budget	The contract can include social care and services delivered by the voluntary and independent care sector. It could also include aspects of local enhanced primary care services in the contract and by agreement QOF and directed enhanced services.	A procurement process would need to be undertaken to identify a contract holder potentially resulting in collaborative working relationships being undermined. The contract holder would have to integrate directly with primary medical services delivered under general medical services, personal medical services and alternative provider medical services contracts, and integration would not follow a whole population funding model impacting on benefits
Fully integrated: single contract for all health and care services (children's and adults) operating under a single whole-population budget	This could include primary medical services as part of the full range of services in scope, under a contract held by the Accountable Care delivery organisation. Best reflects the logic of the new accountable care model with the greatest freedom to secure the benefits of a fully integrated health and care system.	Most complicated route to take as this is furthest away from the status quo

11.2 Reflecting local deliberations it is felt that although some form of fully integrated model of Accountable Care is the likely most desirable option in the long term, as it offers the most opportunity to deliver the full benefits on an integrated system. However, it is also the case that we need to keep testing what will work for the organisations involved in East Sussex, further emphasising the need for a test-bed year of Accountable Care in shadow form, under a virtual alliance arrangement. This will allow for the collaborative learning and evaluation to take place between the ESBT Programme partners and other key partners, to further develop the model and evidence base locally for increased levels of formal integration, and to design the appropriate contractual and funding arrangements to suit local preferences and circumstances.

12 Organisational form options

12.1 In order to encourage more coordinated care between health and care providers, an Accountable Care delivery vehicle will have to bring together a range of services that currently sit across a number of different providers. Local discussions have also taken account of the need to develop and agree an organisational form, and also decide how the prospective Accountable Care providers will relate to GP Practices, other staff groups, and

providers in the independent and voluntary sector, as well as the communities where they provide services.

12.2 A number of options are available to be explored in order that local determination of organisational form can take place. This would build on the virtual alliance arrangements so that the Accountable Care delivery vehicle can be a formal legal entity, or group of entities acting together, capable of bearing financial risk and which has clear governance and accountability arrangements in place for both clinical and care quality and financial management. With a strong stated desire to keep things 'simple and single' coming out of local discussions the suggested options to explore as part of the test-bed year include:

- Using NHS legislation to establish a new NHS Trust Board, to include social care and Public Health provision
- Partners on the ESBT Programme Board forming a limited company or limited liability partnership (LLP) e.g. a forming a corporate joint venture vehicle to deliver the single contract for the whole population
- Other organisational models such as Community Interest Companies and Mutual Companies

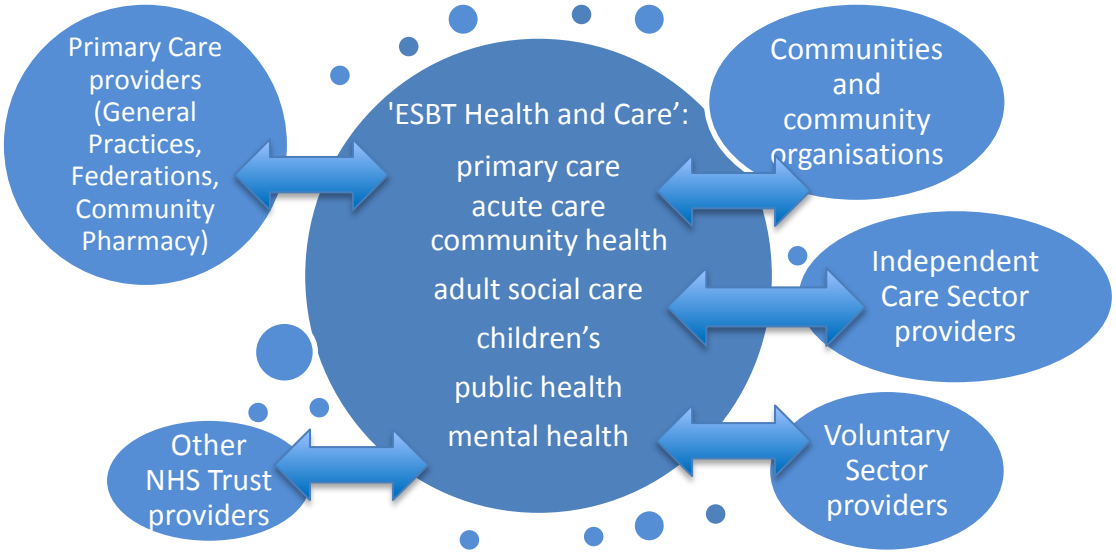
13 Emerging features of the future local Accountable Care Model (ACM) post 2017/18

13.1 The principles and characteristics that were agreed as the essential components of a local ACM in May 2016 have been built on to help develop the plans and business case for our new model of care, and this is being discussed and tested across the system with professionals delivering services, commissioners, stakeholders, patients and carers.

13.2 There is a clear consensus on the need to build a whole system model of Accountable Care that incorporates primary prevention, primary and community care, social care, mental health, and acute and specialist care. In line with this ESHT and SPFT formally joined the ESBT Programme Board in September 2016 enabling a full alliance between commissioners and providers. A new ESBT Clinical Leadership Forum has also been formed whose purpose is to act as the primary resource for primary and acute care pathway, service specific and medical workforce advice to the ESBT Board and constituent organisations.

13.3 The new model will involve changing the local system from one of separate organisations to managing the way we pay for and deliver health and social care on an integrated, system-wide basis, based on delivering the outcomes that matter to local people rather than, as currently, based on activity. The features emerging from dialogue and engagement so far about the future model for Accountable Care in East Sussex is describing a model that lends itself to a single overarching alliance or organisation that is responsible for directly or indirectly (by sub contract) delivering all health and care services to the population. This builds on the principles and characteristics previously agreed as referenced earlier in this paper, and includes commitment to ensuring local people are at the heart of our health and care system. Previous discussion noting mechanisms such as outcomes based capitation used to drive improvement, reduce variation in practice and deliver a comprehensive programme of primary prevention will underpin our work as we develop further.

13.4 The diagram below provides an illustration the potential whole population scope of the future ESBT ACM and the relationships with providers, organisations and groups it would need to develop to deliver outcomes for the whole population. This will be further worked through in the next phase of development as we consider organisational form and contractual options for the future ACM in detail during 2017/18.



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14 Possible options for the relationship between General Practice and the future Accountable Care Model

14.1 There has been discussion on the different ways that GPs could relate to or be part of the new ACM, with a specific session for GPs taking place on 27 October 2016, to explore Accountable Care and test out what matters most to our local GPs, to inform how we develop the relationship and menu of options for primary care. The session reflected a range of views on the appetite for change and how this can best be achieved. The ambition is to create a menu of options that can help support the significant primary care workforce challenges we have locally and contribute meaningfully to a sustainable and resilient primary care workforce in the future, as well as accommodate different preferences for individual GP Partnerships. All solutions sit within the context of ensuring high quality services for our local populations that meet the needs of today.

14.2 Although all options would be voluntary some early stage thinking suggests that some options might be:

- GPs being sub-contractors or independent contractors with the ACM
- GPs becoming partners or stakeholders in the ACM
- GPs being direct employees of the ACM
- Practices tapping into the infrastructure of the ACM for back office support for example around workforce and recruitment, IT and estates

14.3 Options around the General Medical Services contract and enhanced services might be:

- Independent contractors or sub-contractors covering core GMS services
- Core GMS services undertaken by GPs, and the ACM contracting for some aspects of enhanced services and quality
- Practices within a Federation that works with the ACM on their behalf of to offer enhanced primary care at scale over larger areas e.g. leading on specific specialties and care pathways
- Federations, having a direct stake in the Accountable Care Organisation (ACO) taking over the budget for services on behalf of the ACO to deliver better outcomes for patients

- Any other options that arise from local discussions with GPs

14.4 There are a number of ways in which these options can work within current legislation and practice and these are being fully explored to help inform and design a menu of options that supports a thriving primary care and is right for East Sussex.

14.5 This is not intended to be an exhaustive list, and all options that are likely to come into play around the delivery relationship and future contracting arrangements between primary care and the future Accountable Care model will be subject to further discussion with GPs, as we move into the next stage of considering the future organisational form and contractual options for the ACM in more detail.

14.6 In addition to the organisational and contractual arrangements for GPs and primary care discussions about the primary and acute care pathway have started to be taken forward by the ESBT Clinical Leadership Forum, a body of experts initially drawn from our locally employed medical workforce. At a high level these discussions have covered potential action needed to support better outcomes for patients and reducing variation across all care, including:

- Reducing barriers between primary and acute and mental health care for the benefit of patients, for example introducing virtual clinics for some specialties in Practices
- Improving direct day-to-day liaison between GPs and consultants
- Establishing universal principles for all care pathways to reduce waits and improve patient experience and outcome
- Providing the forum for developing the collective clinical leadership (approximately 400 GPs and Consultants) of the health and care system in East Sussex

14.7 It is anticipated that we will grow the Clinical Leadership Forum to encompass other professional groups from across the clinical and care spectrum.

14.8 Moving forward this work will need to link with the discussions taking place about the development of emerging GP Federations to create a successful partnership between acute care and the collective voice of primary care providers, to ultimately deliver an expanded primary and community care offer in conjunction with the Integrated Health and Social Care Locality Teams as a part of a single system geared towards prevention and proactive care in community settings.

15 Outcomes Framework development

15.1 Work is underway to develop an integrated Accountable Care Outcomes Framework that will encompass a range of outcome measures across experience, quality and safe services, population health and wellbeing and transformed models of care (including use of resources). This will be aligned with the outcomes that matter to local people to arrive at a public-facing balanced scorecard that we can use to measure performance in the test-bed year of Accountable Care. An action plan has been developed with Healthwatch East Sussex outlining the co-design process to support a publicly owned outcomes framework for 2017/18.It includes:

- Undertaking a desk top analysis of existing local intelligence to identify common themes across the range of outcome measures and grouping this against four categories - population health and wellbeing, the experience of local people, quality care and services, and transformed services leading to better use of resources.

- Undertaking a co-design process involving key groups of people to test out and describe in more detail the outcomes and goals within each theme that matter to local people. Some of these might be new and some would be based on the things people have already told us.

- Testing (via survey methodology) more widely with local people and further sense-checking against existing knowledge about what is important.

- Identifying suggested measures or indicators for capturing progress.

15.2 This will be incorporated alongside work with our commissioner provider alliance and the Kent Surrey and Sussex Academic Health Science Network to arrive at a comprehensive outcomes framework that can be used to measure performance in priority areas for the 2017/18 test bed year, so that we know that the action we are taking is having the impact desired.

16 **Summary and conclusion**

16.1 It is proposed that all of the features described above will continue to be discussed in the coming weeks and months. The features will ultimately form the basis of testing aspects of Accountable Care delivery in shadow form in 2017/18, through strengthening the current ESBT partnership arrangements and forming an alliance of commissioner and provider organisations, as this is considered to be the best way to decide on the most appropriate organisational arrangements for our ACM in East Sussex. This would be made explicit through an agreement that sets out the operating arrangements between the ESBT Programme partners and allows us to test and develop:

- the optimum population base for capitation and the devolution of budgets to localities;
- the phasing of the introduction of a capitation payment mechanism;
- the methodologies for organisational and individual incentives to deliver the outcomes; and
- what the menu of options for funding and contracting should be with primary care, voluntary and community organisations and the independent care sector.

16.2 Local determination on the preferred organisational form would also form a key part of the deliberations in early 2017/18, in order that recommendations can be made through individual organisations' governance processes by July 2017 regarding preferred models to consider moving forward (it should be noted that all timescales are indicative at this stage).

16.3 In order to bring together the strategic investment planning process and Accountable Care model development to support further learning and decision-making about the business case and model of delivery for ESBT, the test-bed year will take the following shape:

Current state	Test-bed Year 2017/18
• Partnership working through the ESBT Programme	• Shadow form of Accountable Care commissioner-provider alliance ('virtual' supported by an MOU agreement /partnership contract) • Sovereign organisations retain identity and statutory accountability • Primary care and community services future model(s) identified to enable prevention and reduce demand for acute care
• Separate planning and investment process, with individual governance arrangements • Separate but aligned strategic plans for each organisation	• Integrated strategic investment plan across ESBT organisations • Alignment of plans for ESCC RPPR and NHS planning regime • Single system-wide budget • Single system-wide leadership, across commissioners and providers • Single system-wide integrated performance framework, covering quality and safety as well as system transformation and effectiveness
• Payment by Results being a disincentive to transformation and delivering care in the community • Limited data on the impact of service changes on demand	• Developing a capitation payment model (paying for outcomes for the whole population) which incentivises the delivery of clinically and financially effective care • Testing of outcomes based incentives • Developing evidence-base and options, prior to implementation, of capitation payment model

16.4 In summary this means that the following arrangements are suggested to further evolve partnership working under ESBT, and prepare for a test-bed year of Accountable Care in shadow form in 2017/18:

- Commissioners and providers shifting to an overarching alliance agreement – with partner organisations retaining sovereignty and statutory accountability
- The alliance working co-operatively as a single integrated team to deliver services and test the new approach
- Measuring performance using jointly agreed outcome measures
- Maintaining and/or implementing current service contracts

16.5 It is envisaged that this will create the right conditions to test and develop aspects of Accountable Care models further, and support further decisions on the most appropriate organisational arrangements for an ESBT Accountable Care Model, as part of continuing to progress work to aid the development of the business case for Accountable Care.