CABINET

TUESDAY, 24 MAY 2016

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - Councillor Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, Chris Dowling, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons and Sylvia Tidy

A G E N D A

1 Minutes of the meeting held on 26 April 2016 *(Pages 3 - 4)*

2 Apologies for absence

3 Disclosures of interests

Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4 Urgent items

Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5 Principles and Characteristics for a local Accountable Care Model *(Pages 5 - 14)*

Report by Director of Adult Social Care and Health

6 Public Health Grant 2016/17 and Budget Update *(Pages 15 - 20)*

Report by Director of Adult Social Care and Health

7 Any other items considered urgent by the Chair

8 To agree which items are to be reported to the County Council

PHILIP BAKER
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16 May 2016

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www.eastsussex.gov.uk/yourcouncil/webcasts/default.htm

CABINET

MINUTES of a meeting of the Cabinet held on 26 April 2016 at Council Chamber, County Hall, Lewes

PRESENT Councillors Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, Chris Dowling, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons and Sylvia Tidy

Members spoke on the items indicated

Councillor Barnes	-	items 5 and 6 (minutes 60 and 61)
Councillor Blanch	-	item 7 (minute 62)
Councillor Daniel	-	items 5 and 6 (minutes 60 and 61)
Councillor Field	-	item 5 (minute 60)
Councillor Forward	-	item 5 (minute 60)
Councillor Galley	-	items 5 and 6 (minutes 60 and 61)
Councillor Howson	-	item 5 (minute 60)
Councillor Keeley	-	item 5 (minute 61)
Councillor Pursglove	-	item 5 (minute 60)
Councillor S Shing	-	items 5 and 6 (minutes 60 and 61)
Councillor Shuttleworth	-	items 5 and 7 (minutes 60 and 62)
Councillor St Pierre	-	items 5 and 6 (minutes 60 and 61)
Councillor Stogdon	-	items 5 and 6 (minutes 60 and 61)
Councillor Taylor	-	items 5 and 6 (minutes 60 and 61)
Councillor Tutt	-	items 6 and 7 (minutes 61 and 62)
Councillor Whetstone	-	items 5 and 6 (minutes 60 and 61)
Councillor Ungar	-	item 7 (minute 62)

57 MINUTES OF THE MEETING HELD ON 8 MARCH 2016

57.1 The minutes of the meeting held on 8 March 2016 were agreed as a correct record

58 DISCLOSURES OF INTERESTS

58.1 Councillor Barnes declared a personal, non prejudicial interest in item 5 (Countryside Access Strategy) as the Vice Chairman of the Friends of Rye Harbour and the Vice Chairman of the Rye Harbour Nature Reserve Management Committee

59 REPORTS

59.1 Copies of the reports referred to below are included in the minute book

60 COUNTRYSIDE ACCESS STRATEGY

60.1 The Cabinet considered a report by the Director of Communities, Economy and Transport

60.2 It was RESOLVED to:

1) note the draft Countryside Access Strategy and agree that it is publically consulted on for a 12 week period; and
2) agree to increase the car parking charges as set out in Appendix 5 of the report

Reason

60.3 The draft Countryside Access Strategy sets out how the County Council proposes to meet its statutory obligations in respect of public rights of way and countryside site management while maximising the contribution they can make to the Council's priorities. The Cabinet has agreed that the draft strategy be subject to a 12 week public consultation. The Cabinet has also agree to increase the car park tariffs at the Seven Sisters Country Park as set out in Appendix 5 of the report as these charges have not been increased since 2009

61 SCRUTINY REVIEW OF HIGHWAY DRAINAGE

61.1 The Cabinet considered a report by the Economy, Transport and Environment Scrutiny Committee and a report by the Director of Communities, Economy and Transport with observations on the Scrutiny Committee's report.

61.2 It was RESOLVED to (1) note the report of the Scrutiny Committee; and
(2) recommend the County Council to welcome the report of the Scrutiny Committee and to agree the response of the Director of Communities, Economy and Transport to the recommendations and their implementation as set out in the action plan attached as Appendix 1 to the report.

Reason

61.3 The Scrutiny Review has highlighted the importance of the drainage asset and aligns with the Council's ambitions for the new highways contract around improving our drainage assets.

62 EXTERNAL AUDIT PLAN 2015/16

62.1 The Cabinet considered a report by the Chief Operating Officer

62.2 It was RESOLVED to approve the External Audit Plan for 2015/16

Reason

62.3 The Plan sets out the work the external auditors will conduct in order to audit the Council's 2015/16 accounts. The Plan reflects any relevant issues that have arisen as a result of the audit of the 2014/15 accounts and other work carried out by KPMG eg the Value for Money assessment

63 ITEMS TO BE REPORTED TO THE COUNTY COUNCIL

63.1 The Cabinet agreed that item 6 should be reported to the County Council

[Note: The item being reported to the County Council refers to minute number 61]

Agenda Item 5

Report to: **Cabinet**

Date of meeting: **24 May 2016**

By: **Director of Adult Social Care and Health**

Title: **Principles and Characteristics for a local Accountable Care model**

Purpose: **To propose the principles and characteristics to be used as the framework for evaluating options for the design and implementation of an Accountable Care model to deliver health and social care services in East Sussex**

RECOMMENDATIONS: The Cabinet is recommended to:

1) agree to the development of the detailed full business case for Accountable Care in East Sussex, which will be reported to Cabinet in November 2016; and

2) agree the proposed principles and characteristics for a local Accountable Care model as set out in the report as the framework for evaluating the options

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1 Background

1.1 The County Council holds the budget and makes decisions about the deployment of resources for Adult Social Care, Children's Services and Public Health. Budgets available to the Council for these services are facing significant pressure over the next medium term financial plan, and are contributing an overall funding gap of £135million across health and social care by 2020. As part of preparing for the Reconciling Policy Performance and Resources (RPPR) process the Council is developing an integrated plan for the commissioning of health and social care with East Sussex Better Together (ESBT) programme partners, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG), for inclusion in the 2016 State of the County report. This is a significant step forward in planning collectively for our shared resources and reflects the need to make collective decisions about priorities in order to get best value for the public purse.

1.2 This integrated approach to planning means that from 2017/18 onwards a significant proportion of Council revenue budgets across Adult Social Care, Children's Services and Public Health will be covered by a joint plan with EHS and HR CCGs. This is critical to making coherent decisions for the future and to testing aspects of an Accountable Care model in 2017/18. Work is also in train to develop an alternative programme for integrated services for the population within the High Weald Lewes Havens (HWLH) CCG area, following the CCG's decision to withdraw from the ESBT programme.

1.3 Previous reports to Cabinet have provided detail about the Council's lead role in the ESBT programme, initiated in August 2014 to deliver fully integrated health and social care services and a sustainable local health and social care economy for future generations. An ESBT Scrutiny Board has been set up to enable Members to focus on these transformation plans, and strong progress has been made with redesigning local care pathways and services. We now need to consider the delivery and future design of our health and social care provider landscape, to make sure our ambition of a sustainable integrated health and social care system is fully realised.

1.4 Our research indicates that Accountable Care models are the most effective way to achieve the best possible outcomes with the resources we have jointly available across our health and social care economy, through bringing improvements that are needed in the health of our population, the quality of the care received and the efficiency with which it is delivered. Our original research into Accountable Care models can be found at www.eastsussex.gov.uk/accountablecare. A short description of the characteristics that are common to Accountable Care models across the globe is contained in Appendix 1.

2 Supporting information

2.1 Accountable Care models move away from activity based contracts and payment for episodes of treatment and elements of care to positively incentivising the system through outcomes based contracting and a capitated budget payment mechanism. The model entails a provider (or group of providers) being held jointly accountable for achieving a set of outcomes for a defined population over a period of time and for an agreed cost under a contractual arrangement with a commissioner. A summary of the international evidence base on the benefits of Accountable Care models is contained in Appendix 2.

2.2 The ESBT Programme Board agreed to explore the Accountable Care models further in December 2015, as a means of meeting the Council's and two CCGs' objectives for a transformed and sustainable health and social care economy. The exact details of how the model would be structured, the services that would be in scope and the financial commitment and risk involved are all yet to be determined, and will be detailed through the process of developing a robust full business case which will be brought to Cabinet in November 2016.

2.3 The initial phase of work has been to establish the core principles and characteristics of an Accountable Care model for East Sussex. These will serve as the evaluation criteria that will be used to judge the options as part of the production of the detailed business case. This has involved lead officers and clinicians from across the Council, CCGs, East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT) participating in four themed seminars facilitated by PricewaterhouseCoopers (PwC) to get a stronger technical understanding of the following elements:

- Payment reform and incentivisation
- Procurement and contractual options
- Governance and management of risk
- The longer term vision and how to get there

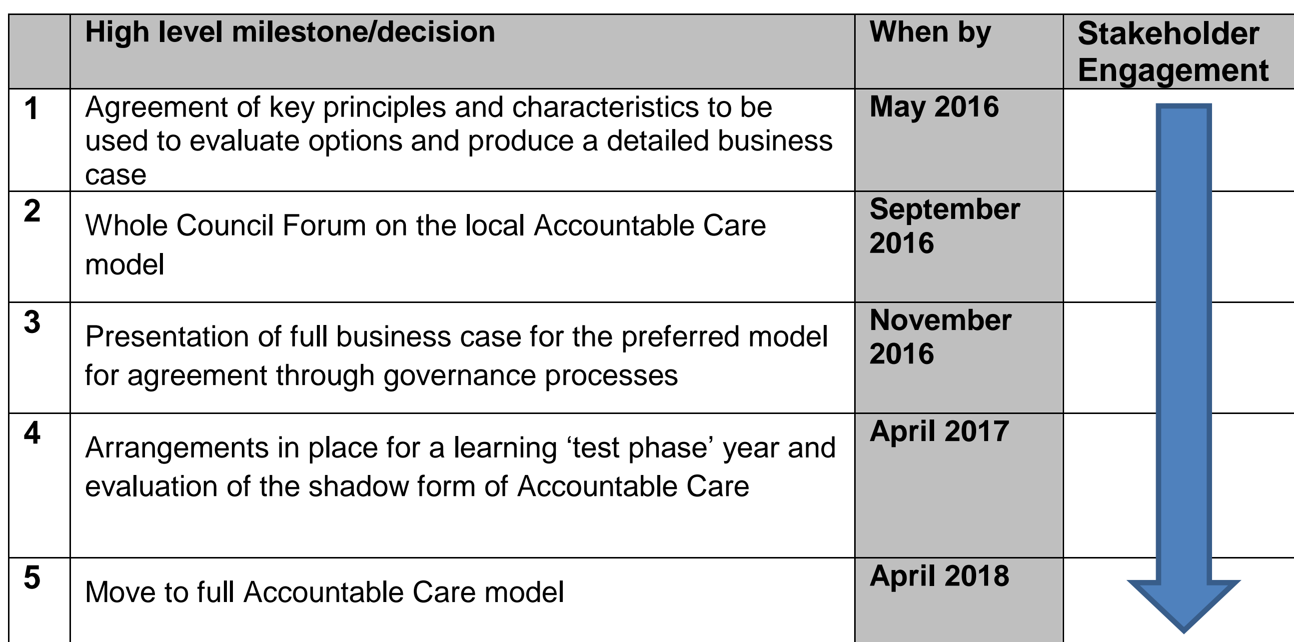
2.4 A report and presentation was made to the ESBT Scrutiny Board in April 2016 about the characteristics that are common to all Accountable Care models. A summary of these can be found in Appendix 1 of this report.

2.5 As a result of initial discussions we have established local consensus about a set of principles and characteristics that we propose would be used to judge the options in the next phase of detailed business case development. These are as follows:

	Key principles / characteristics of a local Accountable Care model
1	All health and social care services are in scope – primary, acute District General Hospital (DGH), community, mental health, social care and public health services for children and adults. Those that are ruled out will be by exception, for example where feasibility may be an issue. 'Whole person' care needs to be supported by a whole population approach rather than segmenting or subdividing the population by conditions or age. We want to avoid having different models of care for different people within the population.
2	Having a positive impact and delivering outcomes that are important to local people – both health outcomes and experiential outcomes
3	The outcomes based contract and capitated budget should be sufficiently large to achieve the economies of scale needed to tackle a £135 million funding gap.
4	There should be a focus on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adding in transaction costs through operating parallel models.
5	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

6	A strong culture of whole system working on the ground that actively empowers staff to be able to ‘do the right thing’ and putting patient’s and client’s needs first within a single health and social care system covering primary, acute DGH, mental health, social care and public health services
7	An organisational form for the model that enables learning and development to take place in stages to share and manage risks between commissioners and providers towards an endpoint of full Accountable Care 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	A model that inspires and attracts health and social care professionals and maximum levels of clinical and staff engagement and leadership, with a positive impact on workforce recruitment and retention
9	A model that secures accountability and the sovereignty of the partners.

2.6 The next steps in the process are to develop the full detailed business case. A summary of that is contained in Appendix 3. This will follow the anticipated high level timeline set out below. The involvement of the ESBT Scrutiny Board will be ongoing throughout this process, alongside wider public and stakeholder communication and engagement activity. A specific Whole Council Forum will be arranged during September 2016 to give Elected Members the opportunity to work through the detail of the Accountable Care model as it emerges from the business case development activity over the summer.



	High level milestone/decision	When by	Stakeholder Engagement
1	Agreement of key principles and characteristics to be used to evaluate options and produce a detailed business case	**May 2016**	
2	Whole Council Forum on the local Accountable Care model	**September 2016**	
3	Presentation of full business case for the preferred model for agreement through governance processes	**November 2016**	
4	Arrangements in place for a learning ‘test phase’ year and evaluation of the shadow form of Accountable Care	**April 2017**	
5	Move to full Accountable Care model	**April 2018**	

3. Conclusion and reasons for recommendations

3.1 The initial phase of work highlights that there is strong agreement and appetite across our local system to explore and design an Accountable Care model appropriate for East Sussex, as the best way to achieve the best possible outcomes with the resources we have jointly available. Senior officers and clinicians from ESHT and SPFT have participated in initial discussions alongside the Council, EHS and HR CCGs, and the Local Medical Committee and Healthwatch East Sussex have also been involved. There has also been initial endorsement from the Health and Wellbeing Board and ESBT Scrutiny Board.

3.2 Cabinet is therefore requested to agree the move to the next phase of detailed business case development, with the suggested principles and characteristics set out in this paper being used as the framework for evaluating the options for the local model. The business case will be brought to Cabinet for decision in November 2016.

KEITH HINKLEY
Director of Adult Social Care and Health

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BACKGROUND DOCUMENTS

None

Common characteristics of Accountable Care models **Appendix 1**

Accountable Care models positively incentivise the whole system to deliver improved health outcomes and quality of care, whilst containing costs and improving efficiency. These models are forms of joint health and social care delivery that have emerged in response to the need to improve preventative care and reduce the costs associated with poorly planned care. In essence the model involves a provider, or group of providers, taking responsibility for all health and social care for a defined population, under agreements with a commissioner about the sharing of financial risks. The models have the following characteristics in common.

Source: PricewaterhouseCoopers

Structure	• **Network of organisations** involved in managing and delivering the health and care for a population. Often within a single contract/agreement. • Ability to **manage and co-ordinate the care of individuals** along the care continuum through care management • Strong and **effective primary care** through models such as the Patient-Centred Medical Home
Care model	• A focus on **integration and collaboration** resulting in more multi-disciplinary working • Differentiated offer and **management of defined population groups** • **Alternative settings** based on the health and care needs of the individual
Enablers	• **Integrated IT solutions** to support collaboration and sharing of information • **Innovation and learning** across the system • **Alternative payment and contracting** models • A **shared and flexible workforce** focused on outcomes and value

The Kings Fund[1] have also identified that although there are several organisational approaches to Accountable Care models, all models share the following common characteristics of Accountable care models:

- 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 a '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 collective business intelligence
- Greater attention to actively involving, engaging and supporting patients 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

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

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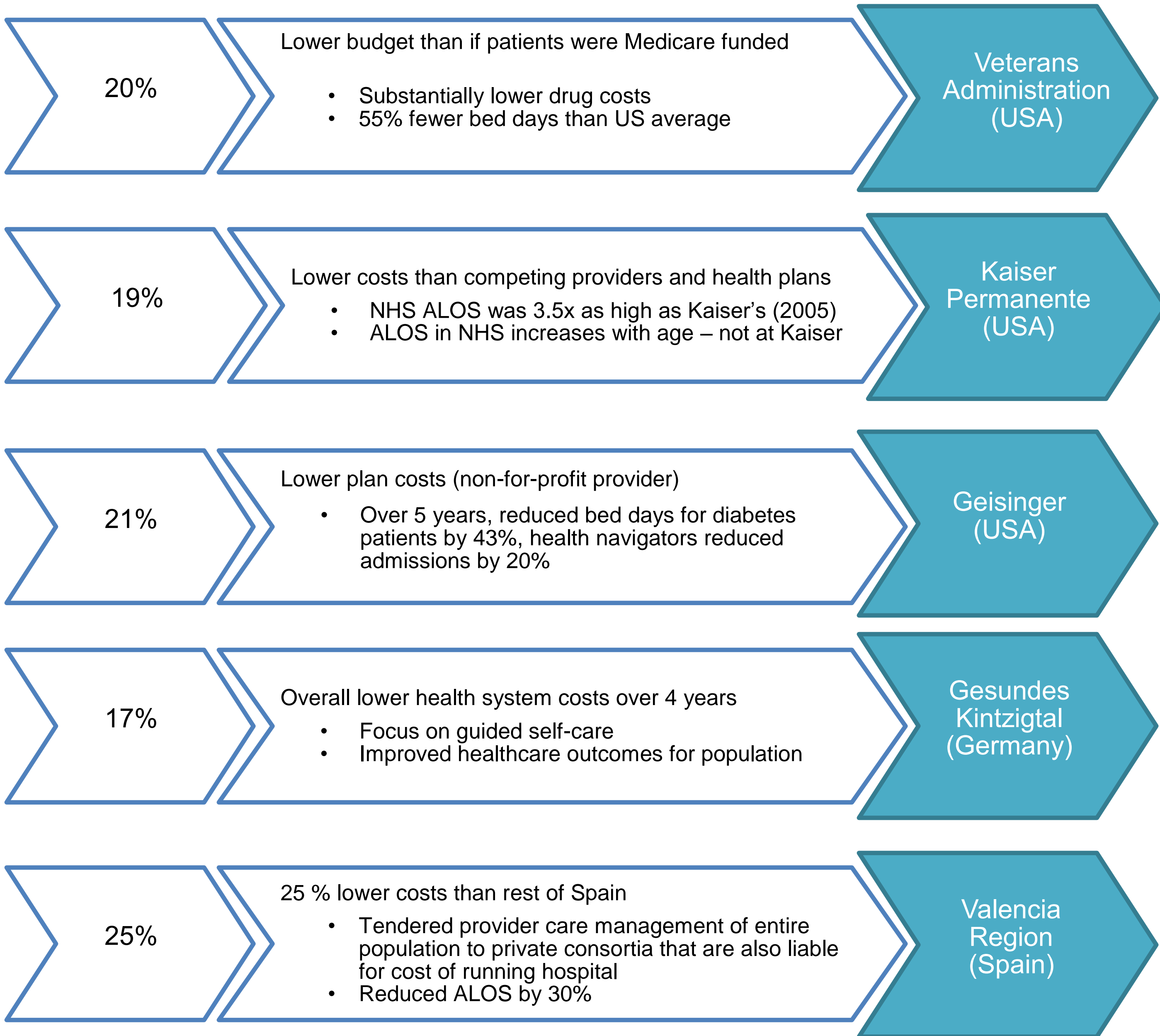
Benefits associated with international Accountable Care models

Appendix 2

Source: PricewaterhouseCoopers, (ALOS = Average Length of Stay)



Notes

The evidence for these models' impact is still evolving and experts such as PricewaterhouseCoopers and the Kings Fund both advise that delivery of financial benefits is interdependent with the overall maturity of the Accountable Care model. However, the evidence does suggest that Accountable Care may be playing a role in slowing the rate of increase in health care spending and bringing improvements to the quality of care. For example the Ribera Salud Accountable Care organisation in Alzira, Spain has developed an integrated system-wide model for health that is operating at a cost base of 25% lower than other parts of the Spanish healthcare system.

It should be noted that translating Accountable Care models into the English health and social care system raises a number of questions and practical challenges. International evidence is that the benefits of greater integration may take several years to fully realise. It is important to also acknowledge that some elements necessary to the delivery of Accountable Care models in England are likely to require lobbying for policy or statutory guidance changes.

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Full Business Case and model development **Appendix 3**

Scope of services
Purpose: working through and refining what is really meant by 'all services in scope'

Geography and lots
Purpose: clarity and decisions about the area covered by the model and whether to subdivide by lots

Financial envelope
Purpose: based on the in-scope services defining the current contract value and projected value of the desired contract length

Outcomes selection
Purpose: designing an outcomes framework to form the basis of the new commissioning model, how we're going to measure success and designing the performance management regime that aligns incentives across providers

Existing contract analysis
Purpose: understanding all terms of existing contractual arrangements to identify any constricting terms, and where necessary setting new novation terms with providers

Contract design and development
Purpose: designing the approach required to move to a population capitation and outcome based model of payment, developing the new payment mechanism on the basis of the outcomes framework

Procurement process
Purpose: designing and running the procurement process if this route is chosen, including bringing together and engaging with providers in the market

Governance and organisational construct and programme governance
Purpose: designing the appropriate accountability and legal arrangements to manage the capitated budget and risk sharing. Agreeing the process for making decisions as co-commissioners

Public engagement
Purpose: produce public communication material and public consultation as required

Stakeholder engagement
Purpose: internal and external engagement, including providers

Organisational development
Identifying new skills and capabilities required and ways in which you will acquire them

Regulation
Purpose: engaging with key regulation bodies such as NHS England, NHS Improvement and CQC to secure agreement to the preferred scope of services in the new model

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Report to: **Cabinet**

Date of meeting: **24 May 2016**

By: **Director of Adult Social Care and Health**

Title: **Public Health 2016/17 Grant and Budget Update**

Purpose: **To update Cabinet on the 2016/17 Public Health Grant allocation and impact on the budget**

RECOMMENDATIONS

Cabinet is recommended to:

1) Note the 2016/17 Public Health Grant Allocation; and

2) Agree the revised allocation of Public Health savings, as set out in Appendix 1of the report.

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1 Background

1.1 As part of 2016/17 Reconciling Policy Performance Resources, the planning assumption for the level of Public Health Grant, guided by Department of Health and Public Health England public consultation, was a reduction of £4.813m, from £31.036m to £26.223m.

1.2 A planned reduction in Public Health Grant was approved by Cabinet on 26 January 2016. Attached at Appendix 1 is the revised proposed allocation of savings taking into the better than expected grant allocation. Details of the initially agreed savings are also included within Appendix 1.

2 Supporting information

2.1 Public Health Grant funding, which remains ring fenced, has now been confirmed at:

2016/17	£28.697m
2017/18	£27.990m

2.2 The confirmation of Public Health Grant funding at £28.697m is a reduction of £2.339m, rather than the approved reduction of £4.8m, on the 2015/16 grant. This has enabled a review of the original savings plan to ascertain which of the previously agreed savings satisfy the ring fenced criteria, and can consequently now be funded through the grant. Should the revised allocation be agreed by Cabinet, the only savings that will be made are those that do not have a direct impact on services. This is because the proposed savings are service efficiencies or budget reductions where funding is no longer required due to less demand. Appendix 1 shows the range of services that will be maintained as a result of the higher than expected grant allocation.

3. Conclusion and reasons for recommendations

3.1 This revenue budget income is ring fenced for a specific purpose and does not raise additional commitments for future years beyond 2017/18. There is now a need to agree the allocation of this funding, for 2016/17, within the parameters of the funding conditions. Once

allocated, performance targets for the year will take into account the additional funding. Cabinet is therefore recommended to note the 2016/17 Public Health Grant allocation and agree the revised Public Health savings plan.

KEITH HINKLEY
Director of Adult Social Care and Health

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Local Member(s): All

BACKGROUND DOCUMENTS

Appendix 1: Public Health 2016/17 Savings Plan

Link to Grant Allocation: https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2016-to-2017

Appendix 1

Public Health Savings Proposals:

Service type and originally agreed saving	Description of service and impact assessment	Revised savings proposals
1.1 Short term interventions to improve Public Health outcomes **Original savings proposal £2,294,000**	Budget used for short term interventions to improve areas of lower performance against Public Health Outcomes Framework. Initial proposal was to cut the whole of this budget but the proposal is now to reduce. No impact on exiting services but funding available for one-off projects will decrease.	**1.1 It is recommended to proceed with a reduced savings proposal of £1,646,000.**
1.2 Staffing **Original savings proposal £125,000**	Staffing was to reduce to reflect cut in overall level of services but proposal is now to maintain current posts. No impact.	**1.2 It is recommended not to proceed with this savings proposal.**
1.3 Overheads **Original savings proposal £75,000**	Budget reviewed and efficiencies have reduced costs. No impact.	**1.3 It is recommended to proceed with the savings proposal of £75,000.**
1.4 Commissioning Grants Prospectus **Original savings proposal £111,000**	Initially a 20% reduction for voluntary sector services was proposed but it is now recommended to maintain existing investment. No impact.	**1.4 It is recommended not to proceed with this savings proposal.**

Service type and originally agreed saving	Description of service and impact assessment	Revised savings proposals
1.5 Partnerships – Creating Healthy Communities **Original savings proposal £64,000**	These are community interventions to improve health through physical activity and healthy eating. The reductions arise as contracts cease. There is a potential impact on protected characteristic groups who are more likely to experience health inequalities. The reduction however represents 12.5% of overall funding of £508,000 and the remaining sum will be focused on addressing health inequalities and thus potential impact on protected characteristic groups will be fully mitigated.	**1.5 It is recommended to proceed with the savings proposal of £64,000.**
1.6 Obesity – Healthy Eating and Physical Activity for Adults **Original savings proposal £78,000**	These are primary care and wider system capacity development interventions to improve health. It is now proposed to continue with current investment. No impact.	**1.6 It is recommended not to proceed with this savings proposal**
1.7 Smoking Cessation **Original savings proposal £305,000**	Contract value for specialist service decreased when re-commissioned to release resource for wider tobacco control. A reduction in wider tobacco control activity may lead to an increase in smoking related diseases impacting on demand for health and social care services and so it is proposed that this investment is now maintained. No impact.	**1.7 It is recommended to proceed with a reduced savings proposal of £152,000.**
1.8 Smoking Cessation **Original savings proposal £95,000**	This is an estimated saving through better management of prescribing activity. No impact.	**1.8 It is recommended to proceed with the savings proposal of £95,000.**
1.9 Tobacco Control **Original savings proposal £51,000**	Removal of general tobacco control programme is no longer proposed. No impact.	**1.9 It is recommended not to proceed with this savings proposal.**

Service type and originally agreed saving	Description of service and impact assessment	Revised savings proposals
1.10 Health Improvement and Health Promotion **Original savings proposal £20,000**	It is no longer proposed to proceed with the reduction in training budget for wider public health workforce. No impact.	**1.10 It is recommended not to proceed with this savings proposal.**
1.11 Alcohol Strategy **Original savings proposal £25,000**	It is no longer proposed to reduce investment in alcohol prevention services. No impact.	**1.11 It is recommended not to proceed with this savings proposal.**
1.12 Emergency Planning and Infection Control **Original savings proposal £88,000**	Staffing arrangements reviewed to ensure infection control work is covered by the Health Protection Specialist role. It is therefore proposed the saving is taken but there will be no impact.	**1.12 It is recommended to proceed with the savings proposal of £88,000.**
1.13 Warmer Homes **Original savings proposal £75,000**	It is no longer proposed to reduce spend on fuel poverty programme. No impact.	**1.13 It is recommended not to proceed with this savings proposal.**
1.14 Sexual Health Advice **Original savings proposal £15,000**	It is no longer proposed to reduce investment in sexual health advice services. No impact.	**1.14 It is recommended not to proceed with this savings proposal.**
1.15 Sexual Health **Original savings proposal £219,000**	Reductions arise from savings against out of area tariff recharges. No impact.	**1.15 It is recommended to proceed with the savings proposal of £219,000.**

Service type and originally agreed saving	Description of service and impact assessment	Revised savings proposals
1.16 Drugs and Alcohol **Original savings proposal £911,880**	It is no longer proposed to reduce investment in drug and alcohol services. No impact.	**1.16 It is recommended not to proceed with this savings proposal.**
1.17 Children's Public Health Services **Original savings proposal £261,173**	Reductions are no longer required in Children's public health services. No impact.	**1.17 It is recommended not to proceed with this savings proposal.**