Appendix 3 – Developing the Evidence Base for a Local Accountable Care Model

1. Summary

1.1 This paper summarises and explains why the features of Accountable Care make the provision of quality health and care services affordable and sustainable in the East Sussex Better Together (ESBT) area building on our initial research in August 2014[1], and the further research and local discussions that have taken place since its publication

1.2 Key points

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.

2. Integrated strategic planning and commissioning

2.1 To ensure that we make fully integrated decisions about the collective use of the available £846 million 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 single budget covering collective health and social care investment, including a single control total
- An integrated Strategic Plan to prioritise investment
- A unified Outcomes framework and a single performance management process
- A virtual devolution of budgets to localities

3. Integrated service delivery – establishing a sustainable provider landscape

3.1 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 bridge an anticipated funding gap of approximately £200 million by 2021[2].

[1] 'Moving to Accountable care in East Sussex' (East Sussex Better Together, 2015)

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

3.2 In the Autumn of 2015 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 (MCPs) and Primary and Acute Care Systems (PACS) 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.

3.3 This work was backed up by the NHS Five Year Forward View, published in Autumn 2014[3], which strongly encouraged local areas to be innovative in thinking about new models of care outlining some parameters, for example MCPs and PACS which were helpful in guiding our initial thinking. In the context of the Five Year Forward View and the Sussex and East Surrey Sustainability and 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.

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 **group of providers** 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*

4 Common features of Accountable Care systems

4.1 The Kings Fund[4] has identified that although there are several organisational approaches to Accountable Care models, all 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.

[3] www.england.nhs.uk/ourwork/futurenhs/

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

- 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.

4.2 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.

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)

4.3 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

4.4 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 NHS Foundation 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.

5 Why a new model of Accountable Care will help in East Sussex

5.1 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

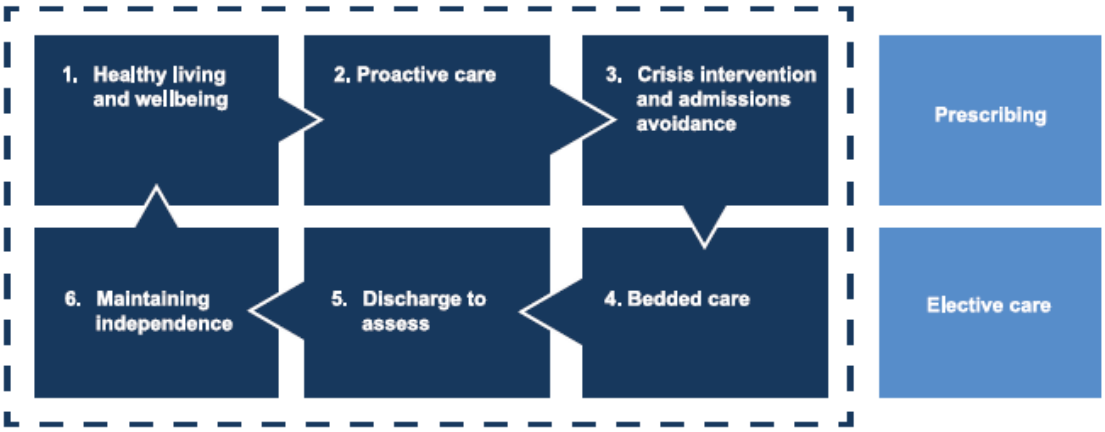
health (keeping people well) and promoting independence and wellbeing, while ensuring we have high quality hospital, care and specialist services when people need them. This approach is already being used successfully in other countries around the world.

5.2 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[5].

5.3 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"[6]. 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.

5.4 We also understand that improving chronic care and that of long term conditions is largely a matter of proactive disease management in a strong and resilient primary and community care setting; this has long been our vision under ESBT (our 6+2 box pathway) and we are putting in place integrated services and pathways to 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 are additional areas where we want to improve the quality and affordability of services.

Figure 1 The ESBT 6+2 box framework



5.5 A summary of the improvements we are making under the ESBT 6+2 box framework is as follows

- Streamlined point of access for referrals - Health and Social Care Connect
- Multi-disciplinary proactive care, crisis response and single integrated Health and Social Care Locality Teams
- A new model of urgent and emergency care

[5] In Search of the Perfect Health System: Britnell M(2015)
[6] In Search of the Perfect Health System: Britnell M(2015)

- Primary prevention, self-care and self-management and assistive technology – all designed to put patients, clients and their carers in more control of their condition
- Supporting and growing the contribution and role of wider voluntary and community sector
- Elective (planned) care – making improvements to variations in outcomes and cost across a range of inpatient and outpatient procedures and operations
- Medicines optimization – implementing our strategy to reduce waste in the use of prescribed medication

5.6 These improvements will however only take us so far. We recognise that we need to change some longstanding barriers within our providers to create a system 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:

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[7] - 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[8]. 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 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

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

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

	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[9] - 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 provider	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.

5.7 Through our ESBT whole systems programme we have made a strong start to create the 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 that journey by establishing an affordable and sustainable provider landscape with the above aspects at the heart of the care model, that is embraced by a new operational and business environment that is fully integrated and incentivised to deliver these objectives.

6 Impacts of Accountable care models

6.4 As in many parts of the country, demand for health and social care services is growing, and if the use of services grew in line with overall changes in population, the system would be unlikely to cope through organic growth alone. We also know that services are disproportionately used by older people, who are also our fastest growing population in the County, and that the complexity of care needs is increasing across 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)'.

6.5 The evidence supporting impact of Accountable Care models on reducing cost is not extensive, but where it has been measured, a reduction in running costs of between 17-25% has been achieved. A summary of some of the available international evidence is presented in the table below[10].

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

[10] PricewaterhouseCoopers source: IHP integrated care toolbox

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 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%

6.6 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 independent contractor status with which the integrated care provider has a delivery relationship. 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 £200million funding gap in 2020 and significant local workforce challenges, this highlights the need to make a start with a transitional period of collaborative development and learning about Accountable Care in shadow form, starting in April 2017.

7 Local dialogue to develop an Accountable Care Model

7.1 There is no 'off the shelf' Accountable care model that will work in East Sussex; it needs to be understood and locally designed in order to work in the specific 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. Research and local discussions have taken place between June - October 2016 to shape the content of the development plans for Accountable Care, and 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:

- A seminar on the impact of future models on health and social care in East Sussex
- Multi-agency Steering Group discussions
- ESBT Accountable Care Strategic Investment Plan discussions as part of RPPR during September and October 2016 focussing on the activity and capacity changes needed to effect a move to community based prevention and proactive care

7.2 Work is also currently taking place with GPs, and other primary, community and acute care professionals to agree a shared understanding and high level plan for the system transformation required to deliver sustainable provision across primary, community, acute, mental health and social care by 2020/21, based on the five year financial assumptions detailed in our Integrated 5 Year Strategic Investment Plan[11]. Discussions about this and the arrangements for the transitional year are taking place in a range of arenas and forums.

7.3 Sessions have also taken place with County Council Members at the ESBT Scrutiny Board on 4th October, Whole Council Forum on 11th October, and there has also been a presentation and discussions at a special Health Overview and Scrutiny Committee (HOSC) session 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.

7.4 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.

7.5 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 seen in UK Vanguards sponsored by the NHS[12]:

- 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.

7.6 Strong progress has been made in all of these areas under the ESBT Programme, however, this won't be enough to close the anticipated £200million funding gap to secure an

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

[12] New Care Models: Integrated Primary and Acute Care Systems, NHS September 2016

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.

8 Contractual model and funding options

8.1 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[13]:

Model	Advantages	Disadvantages
Virtual arrangement: commissioners and providers are bound together by an alliance agreement	Establishes a shared vision, ways of working and the role of each provider in the Accountable Care system. Represents a pragmatic step forward with least disruption especially if GPs have already come together to operate at scale	Overlays rather than replaces traditional commissioning contracts, adding an extra layer to 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

8.2 After local deliberation it was 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, it is equally the case that formal integration on this scale would represent significant risks to all organisations involved.

[13] New Care Models: Integrated primary and acute care systems (PACS) – describing the care model and the business model (2016)

This further emphasises the need for a transitional year of Accountable Care in shadow form, under a virtual alliance arrangement, which will allow for the collaborative learning and evaluation to take place between the ESBT Programme partners and other key partners, to further develop the modelling and evidence base locally for increased levels of formal integration, designing the appropriate contractual and funding arrangements to suit local preferences.

9 Organisational form options

9.1 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.

9.2 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. Suggested options to explore as part of local determination 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