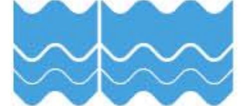


The Future ESBT Model Options Appraisal Exercise

1 Introduction

East Sussex Better Together (ESBT) is our whole system (£860million) health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population.

The first 150-week phase focussed on galvanising the cultural shift to enable us to establish excellent whole system partnerships, scoping the issues and solutions, and agreeing the necessary framework for the delivery of whole system care pathways. Having made very significant progress in all these aspects, it is clear that this is not enough in itself to deliver long term sustainable and high quality services for the population we serve. Our next phase is to ensure we fully exploit the opportunities of accountable care. ESBT is now business as usual

We are a partnership comprising Eastbourne Hailsham and Seaford (EHS) Clinical Commissioning Group (CCG), Hastings and Rother (HR) CCG and East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT). The programme covers a population base of approximately 370,000.

We have a combined resource of £860million, the majority of which is used to commission primary, community, acute, mental health and social care services from East Sussex NHS Trust (ESHT), Sussex Partnership Foundation Trust (SPFT), GP Practices and providers in the independent care sector and voluntary sector.

Our shared vision is that by 2019, there will be a fully integrated health and social care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as independently as possible and achieving the best outcomes. This includes strengthening community resilience, through an asset-based approach that enables local people to take ownership of their own health and well-being through proactive partnerships. Ultimately by working together we aim to achieve high quality and affordable care now and for future generations and improve the safety and quality of all the services we commission and deliver.

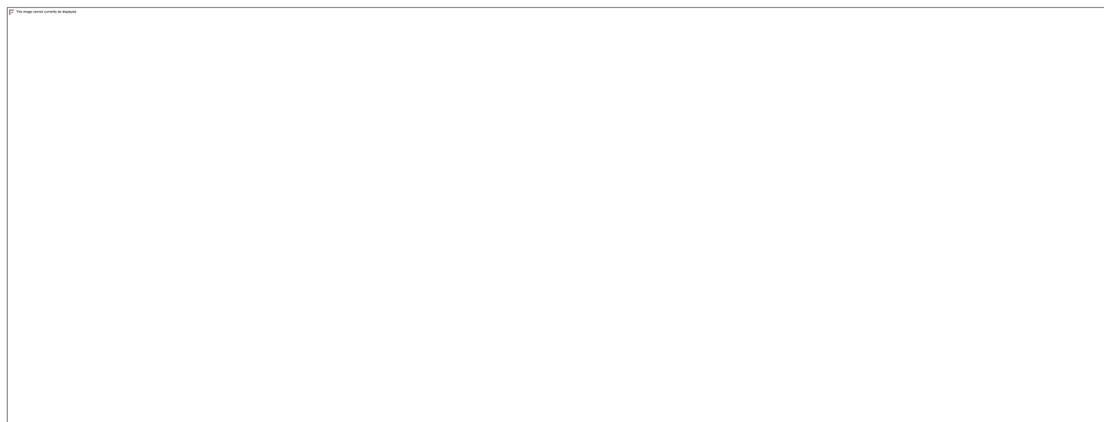
2 Background

- Having been formally designated a Challenged Health Economy back in 2012/13, an economic analysis conducted by PricewaterhouseCoopers (PwC) concluded that the long standing financial difficulties in the county needed significant transformation. This analysis showed that reconfiguration of our hospitals, in and of itself, would not help; and to achieve long-term sustainability we would require a whole system transformation to tackle the underlying causes.
- Our response was to set up the ESBT whole system transformation programme covering 100% of everything we do in order to spend our total available resources wisely rather than cut discrete services badly. All services are covered; acute, community, primary care, mental health and social care, and all parts of the care pathway, for both children and adults i.e. 100% of what we do and 100% of what we say.

- We developed a plan (support by financial and activity analysis and activity planning and intervention modelling by PwC) that set out our case for change.

3 What have we achieved so far

- We developed a single framework to bring together the entire spectrum of services people need to be fully supported at every stage of their health and care needs; this is called the 6+2 model.
- The first six boxes bring together our aspirations to focus on proactive care in order to meet people's needs, make sure services are joined-up and prioritise services that help people be more independent.
- The remaining two focus on 'prescribing' and 'elective care' (e.g. surgery and other planned care) where we believe we can make big improvements in value and service quality
- The framework makes sure we think about all of our populations, whatever their needs, in a way that focuses on the individual.
- This approach and methodology is firmly embedded in our local processes for Health Overview and Scrutiny, and Health and Wellbeing Board, including an ESBT specific scrutiny board within the Council, where members are all sighted on programme progress and developments as well as planned moves for new models of care.
- We have matured our partnership over three years and have robust relationships across our health and social care commissioners and providers that have ensured the foundations for success.



As we conclude our galvanising 150 week first phase of ESBT, we can demonstrate positive, mature relationships across our system-wide partnership that have enabled an integrated approach to achieving system-wide financial balance through our shared integrated 5 year Strategic Investment Plan (SIP) to deliver an increase in primary and community based services, reduce over-reliance on the acute element of our system, deliver in-year constitutional targets and integrate health and care.

We have made significant improvements in care pathways across health and social care. We have established:

- Health and Social Care Connect: an integrated adult health and care access and triage point that ensures that patients and clients, whether self-referred or referred by social care and clinical professionals, receive the right package of health and social care support quickly. In 2016/17 HSCC supported 119,488 people: c53,000 received

information, advice and signposting; and c66,000 received community health and care services; a 14% increase on the previous year of establishment.

- Our nurse-led Crisis Response Teams, which take referrals from general practice and help prevent unnecessary hospital admissions by arranging the right care, in the right place, at the right time for people whose long term conditions are deteriorating or who are suffering early signs of illness. This newly established service supported c.550 people in the community during its start-up year, with plans to increase this to over 1,500 in 2017/18.
- Our integrated health and care locality teams which bring together social and health community staff into integrated teams such as the Joint Community Rehabilitation and Reablement teams, and the multidisciplinary Frailty Teams. The area is divided into six such localities; three led by managers from social services and three led by managers from health. The locality teams are growing in strength and will be the focus through which we develop local alliances across the health, social, and voluntary sectors to identify service priorities and develop joint responses to them.
- We have seen a 4.3% reduction in our emergency admissions during 2016/17 compared with the previous year.

More information about improvements already made can be seen on the ESBT website https://news.eastsussex.gov.uk/east-sussex-better-together/,in addition to our key performance indicators demonstrating reductions in emergency hospital admissions and improvements in population health.

We have built on the widespread formal public consultations for significant service improvements and reconfigurations regarding maternity and paediatrics and orthopaedics, general surgery and stroke. Since 2013 we have ensured an ongoing programme of extensive public and stakeholder engagement that informs everything we do. This has included engagement to inform the establishment of ESBT, engagement in programme design, co-design of pathways and services; co-design of how we engage, citizen engagement in our governance, and improvements made based on people's experiences.

This engagement is the cornerstone of our approach and underpins our commitment to move beyond care pathway redesign as our original ESBT programme moves into business as usual, to focus on securing fully the triple aims of improved health and well-being, improved experience, and financial sustainability through integrating commissioning and delivery of our health and social care system.

4 Our move to accountable care

Care pathway redesign is not, in itself, enough to ensure the transformation required to secure a sustainable health and care system. We need to build a new model of care – 'an accountable care system' – that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care, so that we can demonstrably make the best use of the £1billion we spend every year to meet the health and care needs of the people of East Sussex.

The key elements in such a system are:

- Pooled budget and shared management and risk in managing that budget to meet the health and social care needs of the population
- Ability to offset investment in one part of the system by benefits arising in another part (e.g. investment in social care relieving costs of hospital stays)

- Ability to spread investment and benefit across a five year timescale rather than single year budgeting.

We have now launched our ESBT Alliance to test the most effective ways of working as a system to provide the best and most sustainable services for local people. This is a formal commissioner – provider alliance arrangement for 2017/18 as a transition year to operate 'as if' we are an accountable care system, while currently remaining separate organisations.

To support this we have an Agreement, together with an integrated 5 year whole system strategic investment plan which describes the Year of Care costs over the five years, and the shifts between care settings that we need to see.

Alongside an integrated governance structure[1], this now gives us increased flexibility in the way we use our resources as a system, to test new ways of working and improve services for our local population in 2017/18 and in the longer term. This paves the way for a future model that integrates our whole system, and by July 2017 we will also have completed the work to agree the legal vehicle for our future model.

Detailed development work is now underway to determine what the best vehicle will be to deliver our aims in the future. This includes exploring the available legal forms and contractual models, and developing the menu of options for primary care to engage with our Accountable Care system with GPs in order to enable the stability of a continued GMS model, alongside testing flexibilities of salaried GP options, shared functions, primary care extended delivery at scale, and outcome based local schemes that align with the objectives of ESBT. This work includes developing options for an integrated health and care strategic commissioning function and resource at our place-based level that can operate in a sufficiently agile way to ensure whole population, outcomes based local commissioning with delegation as appropriate up to STP level commissioning and down to our ACS and localities in order to plan and deliver care at the lowest effective level.

5 High level milestones

	High level milestone plan	***Complete by***
1	Launch ESBT Alliance transitional year	April 2017
3	Report on legal vehicle recommendations to Alliance Governing Board	June 2017
4	Recommendations to sovereign bodies of ESBT Alliance Organisations	July 2017
5	Implementation *(plans to be confirmed and further milestones to be set in line with agreed recommendation)*	August 2017
6	New ESBT Alliance model arrangements *(commencement date to be confirmed in line with agreed recommendation and outline implementation plan at milestone 5)*	April 2018

[1] (item 35/17 http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/publications/?categoryesctl10153982=19060&assetdet8760137=448030&categoryesctl10288306=20694)

6 The future ESBT model

East Sussex Better Together (ESBT) has created the partnership conditions to enable the testing in 2017/18 of an ambitious, whole system model of care that has drawn from the best national and international exemplars to build an evolving model that is right for East Sussex.

Our model has a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services, allowing care to delivered increasingly out of hospital and at the lowest level of effective care.

We know that accountable care models (ACM) are now under active development in a number of areas across the country as a response to growing financial and services pressures; they are considered to the best structure for delivering transformation. We are at the forefront of this change.

The organisational form for our future model must provide the right platform to enable us to improve the quality of services, improve health outcomes and reduce inequalities across the ESBT footprint offering integrated, person-centred care in a clinically and financially sustainable way. Our engagement to date has created the following key principles and characteristics for the model:

	Key principles and characteristics of a local Accountable Care model
1	Our evidence-driven, place-based model will firmly embed the first principle of a prevention-led approach across ESBT as our ‘place’ that contributes to the Sussex and East Surrey Sustainable Transformation Plan (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 individual choice and be consistently simple for people 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, as well as communicating about them.
5	The outcomes based contract and capitated budget will be sufficiently large to achieve the economies of scale needed to close the 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' and carers' 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 form in the ESBT area 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.

These agreed principles have been built upon to shape proposals and describe a model which is being discussed and tested across the system with professionals delivering services, commissioners, stakeholders, patients, clients and carers. This has contributed to shaping our proposals so far, and is based on the possibilities outlined in the NHS Five Year Forward View and its March 2017 update[2], and published guidance about new models of care. The likely future organisational form of this has yet to be agreed, and will be subject to an options appraisal exercise to inform decision-making. To date this describes a future model that proposes the following:

- The commissioning and provision of services across East Sussex should be 'single and simple'.
- There will be a single overarching system that is responsible for directly and indirectly (by sub contract) delivering health and care services to the population.
- There will be a uniformly high standard of the management of long term conditions by integrated primary care, specialist, and community service teams such that people with those conditions have an optimal standard of health. People with multiple conditions will have a personalised care programme.
- Through this model of care, we will also aim to empower and enable people to manage their own health and care whenever that's possible. This means ensuring individuals understand how to access services that can assist them, as users of services or as part of a family or wider community, to improve their own health and wellbeing. This is at the same time also being able to access appropriate care and

[2] https://www.england.nhs.uk/five-year-forward-view/

treatment from professionals when they need it, in the best place and at the right time.

- The model will work under a long term and rolling (potentially five year) contract from the County Council and Clinical Commissioning Groups representing NHS England (NHSE). There will be an annual review of this contract with a revised annual mandate for the services that is based on the democratic accountabilities of those commissioning bodies.

- The model will be informed by the commonly owned whole system single 5 year Strategic Investment Plan; we anticipate that approximately 50% of the accountable care model's services would be directly delivered, and approximately 50% would be commissioned by the accountable care system. The 50% commissioned by the ACM would incorporate both voluntary and independent sector providers locally, as well as specialist commissioning for the 'hotter' end of acute care pathways.

- The management of risk would therefore sit within the system to manage demand and capacity across the system and to incentivise delivery of quality outcomes within cost.

- Approximately 80% of the current transactional commissioning functions across health and social care would sit within the ACM, with the remainder retained to ensure strong, whole population needs assessment, strategic intent to meet these needs and accountability for the outcomes-based contract with the ACM.

- The arrangement will ensure we can develop a menu of employment and remuneration options for key professionals, e.g. GPs (including federations): we might expect that most GPs will be contracted from within the accountable care system and retain continuity of GMS based contract. We also know that some GPs are expressing a preference to become employees of the model, and there are also a range of enhanced services that might be invested in differently for example through a federated model.

- Both organisational and individual incentives will be aligned around outcomes-based commissioning principles. The regular review of how the ACM is performing against objectives, the management of risk and agreement of variations to Service Level Agreements (SLAs) will be undertaken collectively and transparently in whole-system workshops. The core measures of ACM success will be based on analysis of the impact of upstream investment of the £2,300 per person Year of Care cost.

- There will be one integrated care record and one system of data management and reporting.

The options for the legal delivery vehicle (organisational form) will each be subject to assessment as to how well they deliver the above model. The nature of this exercise is about the way the ESBT partner organisations arrange themselves in the future to deliver the ESBT aims and objectives in the most effective way i.e. it is a change to the way we structure our organisations in order to deliver better services, rather than a change to services themselves. We have widely discussed ESBT with local populations and will continue to involve local people and others in improvements to care pathways and services.

7 Organisational form options

The learning from the Vanguards and the Kings Fund[3] indicates that there are a number of clear options to explore for new models of accountable care organisational form. These can be summarised as follows:

1. **Prime Provider/Prime Contractor** – for example where one provider holds the contract and acts as an 'integrator' of the services through a subcontracting model

2. **Provider Collaboration/Contractual Joint Venture or Corporate Vehicle (Special Purpose Vehicle)** - for example ESBT Alliance partners forming a limited company or limited liability partnership (LLP) e.g. a forming a new corporate joint venture or special purpose vehicle to deliver a single contract for the whole population, or parts of it. Parties to the joint venture may be share-holders or members and would need clear decision-making rights over the running of the future model and its budgets. A joint venture company would need to be sufficiently robust to hold a contract as a single legal entity with the commissioner
3. **Alliancing: Commissioners and Providers** - a virtual arrangement where parties agree to work together in an Alliance without forming separate legal entity or physically changing existing organisational structures

4. **Forms of organisational merger or new organisation** - for example this could mean building on the legal framework provided by an existing NHS Trust to establish a new East Sussex 'Health and Care' NHS Trust, that would take a lead role across the system

It is also possible to choose a hybrid model based on combination of the above options. A critical step is to understand how these organisational forms would work and add value in the ESBT context, including how the relationship with primary care could be structured. So that we can appraise these options fully we are also exploring NHS Vanguard and Integrated Care Pioneer sites such as South Somerset, Mid-Notts and Torbay, as well as the possibility of arranging fact-finding visits for representatives from across our health and care system.

8 Contractual form options for new models of care

Once we have reached agreement about the preferred legal form out of the four options above, we will then be in a position to consider the shape of the type of contracting model we choose. The current guidance published by NHSE[4] suggests there are three contractual available approaches emerging for new models of care that can be used to bring together services delivered by a range of providers, and these are can be described as virtual, partial or fully integrated. They can be summarised as follows:

- **Virtual arrangement:** commissioners and providers are bound together by an alliance agreement

- **Partially integrated:** a contract is let for the vast majority of health and care services with a single budget

[3] *New Care models: Emerging innovations in governance and organisation form (Kings Fund, October 2016)*

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

- **Fully integrated**: single contract for all health and care services (children's and adults) operating under a single whole-population budget.

The guidance states that all three of these options for contracting are voluntary, and decisions will be based on the degree of formal integration that each local area wants to achieve, the appetite for change and the pace and scale at which they wish and are able to proceed. It also notes that developing a new model of care is an organic process, such that a single national contracting solution will not work everywhere. A summary of the emerging contractual options taken from the NHSE Guidance[5] is set out in the table below.

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 *NB This wouldn't necessarily mean discontinuation of the GMS contract, as it could mean the ACS/ACM could continue to contract for GP services using the*	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 system or 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

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

existing GMS contract and held by the CCGs within the current existing delegated arrangements.		

9 Options appraisal criteria

Using the latest learning from the UK NHS New Models of Care Vanguards and the Kings Fund as well as local perspectives, a set of design criteria is being finalised to use to assess the options for the organisational form. This will be used in conjunction with our original agreed principles and characteristics for our ESBT Accountable Care model and the description of the future model of care we want to deliver.

In order to inform the ESBT partners' decisions about the delivery vehicle for the future model, we will establish an options appraisal panel that will review all the available evidence and score the organisational form options against a set of suggested key criteria. These scores will then form part of the material the ESBT partners will use to inform their decision-making processes to identify the best vehicle to deliver the ESBT objectives. The Alliance Governing Board agree the shape and composition of the options appraisal panel, which is planned to take place on 22nd June, as well as proposals to involve a range of key stakeholders, including the Local Medical Committee and Healthwatch, to support the discussions.

These criteria are standard measures which have been chosen because they are already well known and understood. They have been previously developed with input from stakeholders for use in relation to previous local options appraisal exercises to assess different delivery options for health and care services and have since been further tested. The criteria are as follows:

- Quality and safety - 15
- Clinical and professional sustainability - 20
- Access and choice - 15
- Deliverability - 10
- Financial sustainability - 10

To reflect the nature and ambition of this whole system options appraisal, two additional key criteria have been added to this appraisal exercise to reflect the need to make judgements about the right organisational form to provide the framework for a transformed health and care system:

- Transformation - 20
- Governance and accountability - 10

The weighting of the criteria was tested in discussions with stakeholders, where Access and Choice was felt to be of high importance followed equally by Transformation, Financial Sustainability and Quality and Safety. The approach taken to weightings reflects the nature of the options appraisal exercise which is aimed at ensuring long term sustainability for all health and care services in the ESBT area, through identifying the best delivery vehicle for achieving this. All options will be expected to demonstrate ability to deliver high quality safe services that are accessible and support choice, however, the final preferred option would

also be expected to demonstrate to a high level the ability to effect the system transformation needed to deliver workforce and financial sustainability within an appropriate timescale.

All options for organisational form will also need to demonstrate that they can meet the system regulatory frameworks for example CQC compliance, and Local Government standards.

10 Sub criteria

Within each of the seven criteria, there is a list of sub criteria against which each organisational from option will be scored. The sub criteria will draw out in more detail the outcomes we are seeking to achieve with the proposed future model, focussing on the benefits that the organisational form would be expected to bring to the ability to deliver those outcomes. The sub criteria have also been cross-referenced with the original principles and characteristics of our proposed model, and sense-checked against the updated NHS Five Year Forward View[6] and the NHS Integrated Support and Assurance Process (ISAP)[7].

Once the initial list of sub criteria have been agreed the intention is to test this further with key stakeholders to refine then ahead of using them in the options appraisal exercise.

The table below sets out the criteria, and sub criteria, against which the options for organisational form of the future model will be considered and scored.

		Appraisal Criteria		**Option X**	
Principles and characteristics	**1**	**Transformation**	**Weighting 20**	**Score**	**Weighted Score**
1, 2 ,7, 8, 9	1(a)	How well will the option help deliver sustainability with particular reference to primary care?			
3, 5, 6	1(b)	Does the option create the best configuration for the scope and scale of services to significantly reduce intra-system transactional costs?			
2, 7, 8	1(c)	Does this option make it easy for delivery partners outside the core service provision to work together for the benefit of our local population, including approaches to market development in localities?			
4, 7, 8	1(d)	What is the impact of the option on the delivery of an integrated IT system for staff, patients and clients?			
3, 7, 8, 9	1(e)	How well does the option create a 'system-wide' leadership and management culture?			
1, 2, 7	1(f)	How well does this option deliver a vertically integrated care system, as we as strong integration across			

[6] https://www.england.nhs.uk/five-year-forward-view/
[7] https://improvement.nhs.uk/news-alerts/working-nhs-england-provide-support-complex-contracts/

		primary, community and other statutory and non-statutory partners to deliver flexible locality based services?			
6, 9	1(g)	Does this option enable good acute networks across the wider STP delivery platform			
1, 5, 9	1(h)	Can the option create the conditions to shift the investment profile in order to increase investment in prevention primary and community care (including self-care and self-management) and be consistent with the ESBT Alliance Strategic Investment Plan?			
1, 5, 9	1(i)	How well does the option enable investment in prevention and early intervention and reducing the average per capita Year of Care cost			
1,2, 5, 9	1(j)	Does the option create the right conditions for year on year delivery of the ESBT Strategic Investment Plan?			
1,2, 3, 4, 6, 7, 9	1(k)	How well does the option enable improvements in the key deliverables set out in the next steps of the updated NHS Five Year Forward View?			
1, 3	1(l)	How well does the model deliver primary, secondary and tertiary prevention and embed self- care and self- management to improve health and wellbeing and reduce health inequalities?			
Principles and characteristics	**2**	**Governance and Accountability**	**Weighting 10**	**Score**	**Weighted Score**
4	2(a)	Will the option support optimum levels of citizen leadership and governance?			
5, 6, 8, 9	2(b)	How well does the option enable a phased and assured transfer of risk that can be managed within the model/system?			
9	2(c)	How well does the option enable existing CCG and Local Authority statutory functions to be discharged?			
9	2(d)	How well does the option provide a collective decision-making and governance structure that can align with the ongoing and continuing individual statutory accountabilities of the constituent bodies?			
7, 8	2(e)	How well will the option support			

		clinical and professional governance?			
4, 7, 8, 9	2(f)	How easily will the option be able to create a trusted health and care brand that inspires patient and client confidence?			
6, 9	2(g)	How easy is it to deliver the option within the current regulatory frame work?			
Principles and characteristics	**3**	**Quality and Safety**	**Weighting 15**	**Score**	**Weighted Score**
1, 2, 4, 7	3(a)	Will the option enable uniformly high standards in the management of frailty and LTCs (for example Diabetes, Heart Disease) by integrated primary care, specialist, and community teams?			
1	3(b)	How well does the option provide a framework that enables the provision of care increasingly out of hospital and at the lowest level of safe and effective care?			
6, 8, 9	3(c)	How well will the option enable delivery of constitutional operational standards (A&E, RTT etc.)			
4, 6, 7, 8	3(d)	How well does the option enable a reduction in variation across all services?			
4, 7, 8	3(e)	How well does the option promote a safety culture			
3, 4, 7, 8	3(f)	Does the option enable continuity of primary care practitioner where this exists?			
1, 3, 4	3(g)	How well will the option make use of population health management capabilities (i.e. improved prevention, enhanced patient and client activation) and manage avoidable demand			
	4	**Clinical and Professional Sustainability**	**Weighting 20**	**Score**	**Weighted Score**
7, 8	4(a)	How well will the option create the right conditions for innovation now and into the future?			
1, 7, 8, 9	4(b)	How well will the option provide an effective framework to deliver clinically effective care services at the lowest level of effective care and clinical and care excellence?			
7, 8	4(c)	How well will the option provide a system-wide framework for workforce flexibility and the recruitment, retention and development of excellent staff across all sectors?			

Principles and characteristics	5	Access and Choice	Weighting 15	Score	Weighted Score
3, 4	5(a)	How well will the option provide a framework to support choice and personalised programmes of care for children and adults with LTCs, disabilities and long term care and support needs?			
1, 3, 4	5(b)	How well will the option enable access to timely care that includes all sections of the community?			
1, 3, 4, 8	5(c)	How well will the option help deliver evening and weekend access to GPs (target: 100% of the population covered by March 2019)			
1, 2, 3, 4, 7	5(d)	How well will the option enable access to community based services to enable people to remain in their own homes			
3, 4	5(e)	How will the option deliver patient choice for people with elective (planned) care needs, and increase the use of Personal Budgets and Direct Payments, and Personal Health Budgets (PHBs) where these are coming on line.			
Principles and characteristics	**6**	**Deliverability**	**Weighting 10**	**Score**	**Weighted Score**
5, 6, 9	6(a)	Is the cost to implement this option (system costs including capital costs) reasonable and viable?			
5, 9	6(b)	Can the option be delivered within a reasonable timescale and no later than 2020/21?			
5, 6, 9	6(c)	Are the transition costs understood and of reasonable value?			
5, 6, 9	6(d)	Are the tax, VAT, insurance, procurement of care packages and charging implications understood and affordable and are they in line with statutory frameworks?			
2, 6, 7, 8, 9	6(e)	Is the impact on the health and social care workforce understood and manageable (terms and conditions and pensions)?			
6, 9	6(f)	Does the option give rise to additional legal risks that will have a significant impact?			
1, 5, 9	6(g)	Does the option have the potential to impact on the viability of commissioners and providers outside of the ESBT system?			
Principles and characteristics	**7**	**Financial Sustainability**	**Weighting 10**	**Score**	**Weighted Score**

5, 9	7(a)	How well does the option improve the efficient working of the system and thereby reduce operating costs (including transactional commissioning costs)?			
1, 3, 5, 9	7(b)	How well does the option enable the service transformation required to assist with the achievement of financial sustainability			
3, 5, 6, 9	7(c)	How well does the option enable financial risk to be managed effectively			
9	7(d)	How well does the option provide the flexibility to respond to changes in future health and care financial regimes?			
3, 4, 6, 7, 8, 9	7(e)	How well does the option enable the organisation/vehicle to operate as a going concern and meet the financial requirements of regulators and statutory bodies such as HMRC?			
2, 7, 8	7(f)	What impact does the option have on provider productivity and reducing variation?			
4, 7, 8, 9	7(g)	How well does the option enable a framework to incentivise outcomes and performance improvement			

11 Options appraisal panel

The sovereign governing bodies of the constituent ESBT Alliance organisations will ultimately be responsible for making decisions about the delivery vehicle for the future ESBT model, and these organisations will be represented on the options appraisal panel by senior clinicians and managers. In order to make fully informed decisions about scoring the options appraisal, the panel process will be undertaken and supported by three categories of representative:

1) Clinical and managerial leaders from each of the constituent ESBT Alliance organisations who will be responsible for making decisions about scoring the options against the criteria
2) Representatives from other organisations that are integral to understanding how the system operates, and that have a key stake in determining the preferred vehicle to deliver the ESBT objectives, for example the LMC, GP Federations, the STP and Healthwatch. These representatives will contribute views and help agree the scoring but are likely not to be involved in the final decision or vote on the scores.
3) Subject matter experts, for example pensions and VAT, IT and workforce. These are likely to be members of the Accountable Care Development Group, Finance Subgroup, Workforce Group and IT Board plus others (for example the Principle Social Workers and Chief Nurses), who will be invited to advise the panel representatives on the advantages and disadvantages of specific options.

We have tested particular areas of the evaluation criteria with key stakeholders and to enable the widest possible thinking and consensus to develop regarding the right vehicle to deliver our ESBT objectives, we have planned in specific engagement events with staff to support and inform the panel process. This will enable the key areas of the evaluation to be tested as well as growing understanding and testing the options for organisational form, to inform how we reach a preferred option.

It should be emphasised that there is no definitive evidence base for the options over and above what we have learned and recorded from international best practice and the emerging vanguards in the UK in making our case for change. Our learning must be iterative and the recommendation following this options appraisal will be at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will then be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented.

Final Draft

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