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

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

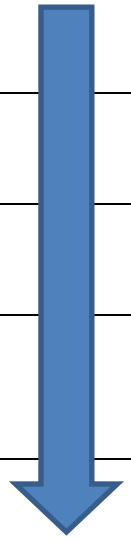
2.4 A report and presentation was made to the ESBT Scrutiny Board in April 2016 about the characteristics that are common to all Accountable Care models. A summary of these can be found in Appendix 1 of this report.

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.

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BACKGROUND DOCUMENTS

None