

**Report to:** Cabinet

**Date of meeting:** 18 July 2017

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

**Title:** East Sussex Better Together (ESBT) Alliance Accountable Care Model: Future Organisational Arrangements

**Purpose:** To consider the preferred future legal vehicle for the East Sussex Better Together (ESBT) Accountable Care Model, and the map for phased implementation

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## **RECOMMENDATIONS**

**Cabinet is recommended to agree:**

- 1. A new health and care organisation (Option 4) as the preferred option for the ESBT Accountable Care Model and agree the proposed map for implementation by 2020 (Appendix 5), noting that the key next steps and phasing for implementation will take place over the summer.**
- 2. Strengthening the current ESBT Commissioner Provider Alliance arrangement by April 2018 by implementing the following elements:**
  - A single point of leadership for strategic commissioning;**
  - A single pooled budget for our ESBT health and care economy with Eastbourne Hailsham Seaford and Hastings and Rother Clinical Commissioning Groups (CCGs);**
  - A fully integrated governance structure to support a single pooled health and social care commissioning budget;**
  - A single point of leadership for delivery and how services are organised, and;**
  - Reinforcing performance and monitoring against an integrated Outcomes Framework**

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## **1. Background**

1.1 East Sussex Better Together (ESBT) is our whole system (£1billion) 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. Our partners in ESBT are Eastbourne, Hailsham and Seaford (EHS) 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 approximately £1.042billion, the majority of which is used to commission primary, community, acute, mental health and social care services from ESHT, SPFT, GP Practices and providers in the independent care sector and voluntary sector.

1.2 Our shared vision is that by 2020, 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.

1.3 The first 150-week phase of the programme has focussed on redesigning and transforming services to improve health and social care outcomes. As a consequence we have established a range of integrated services including Health and Social Care Connect, Joint Community Re-ablement and Locality Teams that have improved client and patient experience and supported more people. We have also established excellent whole system partnerships, scoping the issues and solutions, and agreeing the necessary framework for the delivery of whole system care pathways. We have made significant progress in all these aspects, and much of our initial transformation work is now core business. As reports to Cabinet have however previously highlighted, it is clear that this is not enough in itself to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the future structure needs to look like to embed all the changes we have already made.

1.3 As our initial 150 week transformation programme draws to a close our next phase is to ensure we fully exploit the opportunities of accountable care, and as we transition to the new ESBT Alliance arrangement we are ensuring a keen focus on delivering in-year improvements as a system and developing the governance to identify the best legal vehicle for the delivery of ESBT into the future. We are now focusing on building a new model of care, accountable care, 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 £860m collective resource we spend every year to meet the health and care needs of the people of East Sussex.

1.4 In line with this, in November 2016, Cabinet approved work to develop a local fully integrated Accountable Care Model (ACM) across the ESBT footprint, involving a transitional year in 2017/18, and to establish a commissioner-provider alliance as the most effective way to develop the evidence base further in East Sussex. Cabinet delegated authority to the Chief Executive, in consultation with the Leader, to finalise the Alliance Agreement and other arrangements for the 2017/18 year. The Agreement and other arrangements have now been finalised and agreed by each of the ESBT Alliance constituent organisations and were collectively agreed by the ESBT Alliance Governing Board on 27<sup>th</sup> June.

1.5 This report focusses on the outcomes of the options appraisal exercise undertaken in June 2017 to identify the most appropriate future delivery vehicle for our ESBT model of care, and the future strategic commissioning role of the Council that is required to deliver it, in order that recommendations can be made to Cabinet in July 2017.

## **2 Progress in 2017/18**

2.1 The Alliance Agreement and underpinning governance structure provide the framework to enable us to rapidly develop our capacity to manage the health and social care system collectively as an Alliance partnership, operating as an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in 2017/18 and in the longer-term. To date we have developed the following elements of our shadow accountable care system:

- A formal ESBT Alliance Agreement to provide the framework to operate as an ESBT Alliance
- An integrated governance structure, and a framework for the Alliance arrangement itself, detailing which organisations in the health and care system are involved and in what capacity
- A Strategic Commissioning Board (SCB) with EHS CCG and HR CCG to jointly undertake responsibilities for population needs assessment and commissioning health and social

care through oversight of the Strategic Investment Plan (SIP), as well as overseeing and assuring the delivery of health and social care services in the 2017/18 test bed year

- A pilot integrated Outcomes Framework has been developed to support the role of the Board (SCB) in the 2017/18 test-bed year.
- An integrated Strategic Investment Plan (SIP) was agreed for 2017/18 by the Leader and Lead Cabinet Member for Strategic Management and Economic Development, enabling the Council and EHS and H&R CCGs to align health and social care investment, as part of a medium-term financial plan, to deliver the transformation in how care is provided across the ESBT footprint and establish a clinically and financially sustainable system.
- An integrated financial reporting system to enable the planning and control of ESBT resources through regular monitoring of expenditure against the plan, with corrective action to be taken in year, if required, by the Strategic Commissioning Board.
- Arrangements for patient and citizen integration into the governance framework

2.2 The recent learning from the Kings Fund<sup>1</sup> based on the UK NHS Five Year Forward View Vanguards and international examples of best practice<sup>2</sup> indicates that forming a commissioner-provider alliance for the transitional phase puts us in a strong position to make significant progress within the current regulatory framework. We are now moving into a phase of undertaking the necessary learning and development, with support from NHS Improvement (NHSI), NHS England (NHSE) and the Care Quality Commission (CQC) as the system regulators, to design our future ESBT Alliance ACM, which in the longer-term would be structured around a single organisation, alliance or partnership holding the capitated budget to make sure we have integrated delivery of high quality services for our population.

### 3 Options appraisal of the future ESBT legal delivery vehicle

3.1 The vehicle 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. In particular the future organisational form must enable us to deliver the following benefits:

- a reduction in variation and improved outcomes for local people;
- improved population health and wellbeing;
- improved experience of health and care services;
- achievement of our ESBT objective of system balance by 2020/21 and;
- improved connections with other elements of service delivery where working on a larger population basis within the Sussex and East Surrey Sustainable Transformation Partnership.

3.2 In order to design our future ESBT Alliance ACM, we have developed and carried out an appraisal of the options for the delivery vehicle of our future model with our ESBT partners. As signalled in discussions with our stakeholders, the latest learning from the Kings Fund and NHS Vanguards<sup>3</sup> indicates that there are a small number of clear options to explore to help us deliver the future ESBT new model of accountable care:

- **Prime Provider or Prime Contractor (Option 1)** - where one provider holds the contract and acts as an integrator of the services through a subcontracting model.
- **Corporate Joint Venture or Special Purpose Vehicle (Option 2)** – where parties agree to form a limited company or limited liability partnership 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.

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<sup>1</sup> New care models – emerging innovations in governance and organisational form (Kings Fund, 2016)

<sup>2</sup> The Quest for Integrated Health and Social care, A case Study in Canterbury New Zealand (Kings Fund, 2013)

<sup>3</sup> *New Care models: Emerging innovations in governance and organisation form* (Kings Fund, October 2016)

- **Alliancing: Commissioners and Providers (Option 3)** – a virtual arrangement where parties agree to work together in an Alliance without forming separate legal entity or physically changing existing organisational structures.
- **Forms of organisational merger or new organisation (Option 4)** – for example this could mean building on the NHS Trust legal framework to establish a new East Sussex Health and Care NHS Trust, that would take a lead role across the system, providing the majority of services in the ESBT area.

3.3 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 any recommendation is at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented. There will also be clear milestones from April 2018 onwards, of what we need to achieve and by when in order to ensure the necessary momentum for success.

3.4 To reflect this, the ESBT Accountable Care Development Group (ACDG), which brings together key stakeholders such as the Local Medical Committee (LMC) and Healthwatch with leads from each partner in the ESBT Alliance, has taken steps to ensure we have a robust process that builds consensus locally. This comprised developing and agreeing evaluation criteria and an options appraisal exercise to test appetite locally for the four options.

3.5 The focus of this exercise is about the way the ESBT partner organisations arrange themselves in the future to deliver our aims and objectives in the most effective way i.e. it is a potential 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 service improvements with local populations and will continue to involve local people and others in improvements to specific care pathways and services.

## 4 Options appraisal panel

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

- Clinical and managerial leaders from each of the constituent ESBT Alliance organisations who were responsible for making decisions about scoring the options against the criteria, after discussion about each option as a whole panel
- 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, NHS England and Healthwatch. These representatives were invited to contribute views and help agree the scoring but didn't undertake the final scoring.
- Subject matter experts, i.e. members of the Accountable Care Development Group, Workforce Group and IT Board plus others such as Principle Social Workers and Chief Nurses, who were invited to advise the panel representatives on the advantages and disadvantages of specific options but not undertaking scoring.

4.2 We also had early engagement with the NHS national new models of care assurance process, and NHS England also attended the session; we will continue to engage with this as appropriate.

## **5. Options appraisal exercise and evaluation criteria**

5.1 The options appraisal exercise, which took place on 22 June, had the following aims:

- Arrive at a consensus view across our ESBT Alliance about the preferred direction of travel for our Alliance in the future;
- Understand and agree the key steps and the timetable involved to get there, and;
- Agree our priority actions for implementation from April 2018.

5.2 The exercise was facilitated by an independent expert chair.

5.3 A set of evaluation criteria were developed for the options appraisal together with a suggested process, which was tested with key stakeholders and discussed at the local Shaping Health and Care events in May, including views about weightings. The criteria are standard measures which were chosen because they were already well known and understood. They have previously been developed with input from stakeholders 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 with the percentage weightings as are as follows:

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

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

- Transformation (for sustainable services) – 20
- Governance and accountability - 10

5.5 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 sustainability for all health and care services in the ESBT area through identifying the best delivery vehicle for achieving this and our objective of building consensus about our preferred direction of travel for ESBT overall, outlining the key steps to get there and making best use of the flexibilities that are expected to become increasingly available at a national level. All options would 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.

5.6 A series of joint ESBT staff engagement events were also held during May and June to share information about the options appraisal exercise and organisational forms, grow understanding and test the options to inform how the preferred option was reached. The key criteria and the list of indicators of what good looks like in relation to each of the criteria is attached at Appendix 1.

5.7 In addition to the options appraisal criteria the ACDG produced an information pack for the panellists bringing together some general characteristics and issues about the four options; where they are similar; and how they differ. This was not intended to be a comprehensive assessment, but a consideration of the kinds of issues and risks that might be anticipated with each option, based on our current understanding. The Information pack is contained in Appendix 2, and it contains the following detail:

- High level detail about each of the four options, how they might work, general characteristics and potential risks
- A high level Brief Review of HR and workforce implications for each option
- A high level Brief Review of Digital and IT implications for the options
- Key Public Health assessment criteria and technical requirements

5.8 In addition, the following supplementary information was produced to further grow understanding

- Diagrams illustrating the potential governance and decision-making for each of the four options; these are not presented as the definitive article but are intended to be illustrative guides based on our current understanding (attached at Appendix 3)
- Case study examples from other areas in the UK; to give an understanding of how the different options are being implemented (Appendix 4)

5.9 An initial Equalities Impact Assessment (EIA) screen of the four options was also undertaken. In summary this initial screening did not identify any immediate negative impacts on protected characteristic groups but concluded that a full equalities impact assessment would be required as part of the next stage of the process, taking in relevant data, engagement of protected characteristic groups. It also suggested there should be two separate processes to consider implications for both the workforce and the local population. The EIA is available on request.

## 6. Outcomes of the options appraisal exercise

6.1 After all the panellists, contributors and subject matter experts had discussed each option the representatives from the ESBT Alliance member organisations scored each option against the seven weighted criteria, using the guidance set out below:

Score	Scoring Guidance
1	Option fails to meet objectives
2	Option performs ok against objectives but doesn't represent an improvement on the current system
3	Option performs reasonably well against objectives and represents a modest improvement on the current system
4	Option performs significantly well against objectives and represents a significant improvement on the current system

6.2 The overall outcome of the scoring exercise was as follows:

<b>Criteria (weighting in brackets)</b>	<b>Option 1 Prime provider/prime contractor 'integrator'</b>	<b>Option 2 Corporate Joint Venture</b>	<b>Option 3 Alliancing Commissioners and Providers</b>	<b>Option 4 Forms of merger or new organisation</b>
Transformation (for sustainable services) (20)	1.33	1.67	2.33	3.00
Governance and Accountability (10)	1.58	1.75	2.67	3.17
Quality and safety (15)	1.67	1.83	2.75	3.00
Clinical and professional sustainability (20)	1.58	1.75	2.42	2.92
Access and choice (15)	1.67	1.75	2.42	3.08
Deliverability (10)	1.42	1.00	2.58	2.08
Financial Sustainability (10)	1.58	1.17	1.92	2.83
<b>Average weighted score</b>	<b>1.54</b>	<b>1.61</b>	<b>2.44</b>	<b>2.90</b>

6.3 Overall option 4, a new health and care organisation scored the highest on average as it was felt to deliver the best opportunity for long term sustainability overall and significant improvements compared to the way we are currently organised. This was followed by option 3, a more formal commissioner provider alliance arrangement. Options 1 and 2 were the least preferred options, some way behind. The following points were also noted:

- Options 4 and 3 scored the highest overall and tended to score the highest for each category as well.
- Option 4 finished top and option 3 finished second for six of the seven categories, with one notable exception being deliverability, where option 4 finished second to option 3, acknowledging the complexity of implementing a new health and care organisation when compared with a virtual Alliance arrangement.

- There was far less appetite across the panel to implement options 1 and 2, as it was not felt that they would add any value to our current system and these have therefore been discounted.

6.4 A map was discussed, accepting that option 4 has a longer lead in and the aim should be to have this in place by April 2020. Acknowledging that a start on option 3 has already been made with our ESBT Alliance, it was suggested that strengthening our current Alliance arrangement by April 2018 would be a necessary stepping stone. As a result the following practical steps are proposed to accelerate implementation in the context of year on year delivery of improvements:

- Single point of leadership for strategic commissioning;
- A single pooled budget for our ESBT health and care economy with EHS and HR CCGs;
- A fully integrated governance structure to support a single pooled budget of c£850m;
- Single point of leadership for delivery and how services are organised;
- Strengthened performance and monitoring against an integrated Outcomes Framework, and;
- An integrated approach to regulation.

6.5 The level of organisational change needed to incrementally move to option 4, building on what we have already set in train through our current commissioner provider alliance, is set out in the map in Appendix 5. Further detail is being developed to support the map and the phasing of delivery, and comprehensive plans will be established to ensure robust implementation of our preferred direction of travel. Further reports to Cabinet will make recommendations regarding the implementation of specific elements of the map, given the significant potential implications of the proposed changes, both for 2018 and longer-term, for the discharge of the Council's statutory and financial responsibilities.

## **7 Conclusion and reasons for recommendations**

7.1 This report focuses primarily on the ESBT health and social care system. The potential scale of the proposed changes will have a significant impact on ESCC as well as the other partners. The work will continue to be developed with clear consideration of both aspects.

7.2 Strong progress has been made during the first 150-week phase to redesign care pathways and services, and much of our initial transformation work is now core business. As reports to Cabinet have previously highlighted however, it is clear that this is not enough in itself to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the embedded structure for our ESBT model needs to look like in the future, to deliver our objective of a fully integrated and sustainable health and social care system for our local population in the long term

7.3 Cabinet has previously agreed that moving to a fully integrated model of accountable care offers the best opportunity to achieve the full benefits of an integrated health and social care system, and that a transition year of accountable care under an alliance arrangement would allow for the collaborative learning and evaluation to take place between the ESBT programme partners and other stakeholders.

7.4 Discussion and engagement with our stakeholders about the evaluation criteria and the proposed weightings has helped to shape the options appraisal exercise. Undertaking an appraisal of the available options collectively as an ESBT Alliance with the involvement of key stakeholders has contributed to and strengthened our decision-making process. This has helped us to develop consensus locally to identify that overall a new health and care organisation (Option 4) is the preferred legal vehicle to deliver our ESBT objectives, in keeping with the expectations of our local stakeholders.



7.5 Taking practical action during 2017/18 to strengthen our current ESBT commissioner provider alliance arrangement, to incrementally change the way we are organised, will ensure that benefits can be realised both in year, as well as helping us to achieve the longer term objective of implementing a new health and care organisation by 2020. Such action, given the significant potential implications of the proposed changes, for the discharge of the Council's statutory and financial responsibilities will be fully considered in further reports to Cabinet. A map setting this out is included in Appendix 5.

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**LOCAL MEMBERS**

County Council Members whose electoral divisions are in the Eastbourne, Hailsham and Seaford Clinical Commissioning Group and Hastings and Rother Clinical Commissioning Group areas

**BACKGROUND DOCUMENTS**

None