Public Document Pack

CommitteeName

Date: **MEETINGDATE**

Time: MeetingTime

Venue: **MEETINGLOCATION**

Members: MembersExpectedRolesColno1of2Rows MembersExpectedRolesColno2of2Rows

Enquiries: **MeetingContact**
MeetingContact_2

Lunch will be served in the Aldermen's Dining Room at the rising of the Court of Aldermen

Chris Duffield
Town Clerk and Chief Executive

AGENDA

INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Wednesday, 6 September 2017 at 6.30 p.m.

C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

	Representing
Chair:	
Councillor Clare Harrisson	INEL JHOSC Representative for Tower Hamlets Council
Vice-Chair:	
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Members:	
Councilman Christopher Boden	INEL JHOSC Representative for City of London Corporation
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representive for London Borough of Hackney
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Shiria Khatun	INEL JHOSC Representative for Tower Hamlets Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council

The quorum for this body is the presence of a member from each of three of the four participating authorities.

Contact for further enquiries:
Daniel Kerr, Strategy, Policy and Performance Officer,
Tel: 0207 364 6310
E-mail: daniel.kerr@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Scan this code for electronic agenda:

MAP OF LOCATION (PAGE 1)

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

Any Member of the Committee or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

3. MINUTES (Pages 3 - 14)

To agree the minutes of the meeting held on 26 June 2017.

REPORTS FOR CONSIDERATION

4. EAST LONDON HEALTH AND CARE PARTNERSHIP: CONSULTATION ON PAYMENT DEVELOPMENT (Pages 15 - 50)

5. SINGLE ACCOUNTABLE OFFICER FOR EAST LONDON HEALTH AND CARE PARTNERSHIP (Pages 51 - 52)

Date of the next Meeting:
The next meeting of the Committee will be held on Thursday, 9 November 2017 in the C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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Travel to Tower Hamlets Town Hall Offices

By Bus

The site has excellent bus links which connect it to East and Central London and beyond.

The 277 bus route begins and ends at the site, and the 15 begins and ends a 3 minute walk away at Blackwall Station. There are a number of other bus stops close by.

Most local bus services are listed overleaf and shown on the map, with the closest bus stops clearly marked on the enlarged map below.

By DLR and Tube

East India and Blackwall DLR Stations are in the immediate vicinity of the Town Hall site, with many other DLR stations within a short walk.

The closest Tube stations are Canning Town or Canary Wharf (both Jubilee Line).

For further information visit www.tfl.gov.uk/journeyplanner

By Foot

An approximate 20 minute walk from the site is shown by the blue circle (on the map overleaf). Many DLR and both Tube stations are within this zone.

There is pedestrian access to the site from all directions, allowing good access to the surrounding area.

For more information on walking in Tower Hamlets see www.towerhamlets.gov.uk/walking

For walking directions see www.walkit.com

HEALTHY BOROUGH PROGRAMME

tower hamlets becoming a healthy borough

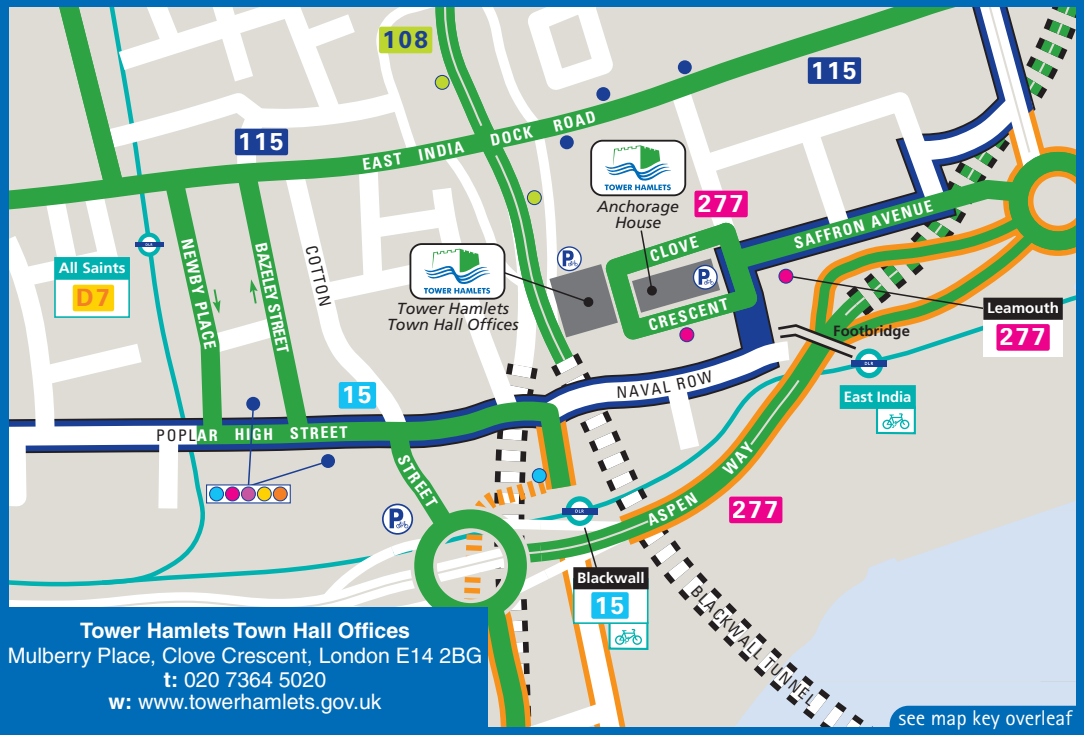
change 4 life

This map has been funded as part of the Tower Hamlets Council Travel Plan which aims to boost the number of staff and visitors travelling to the site by sustainable modes of transport.

Tower Hamlets is one of 9 areas designated as a 'Healthy Town' and has been awarded Government funding to tackle the environmental causes of overweight and obesity. Active Travel (cycling and walking) plays a major role in the programme.

www.towerhamletshealthyborough.co.uk

Design, digital cartography and print by Pindar www.pindar.com 03.10



Tower Hamlets Town Hall Offices
Mulberry Place, Clove Crescent, London E14 2BG
t: 020 7364 5020
w: www.towerhamlets.gov.uk

By Bike

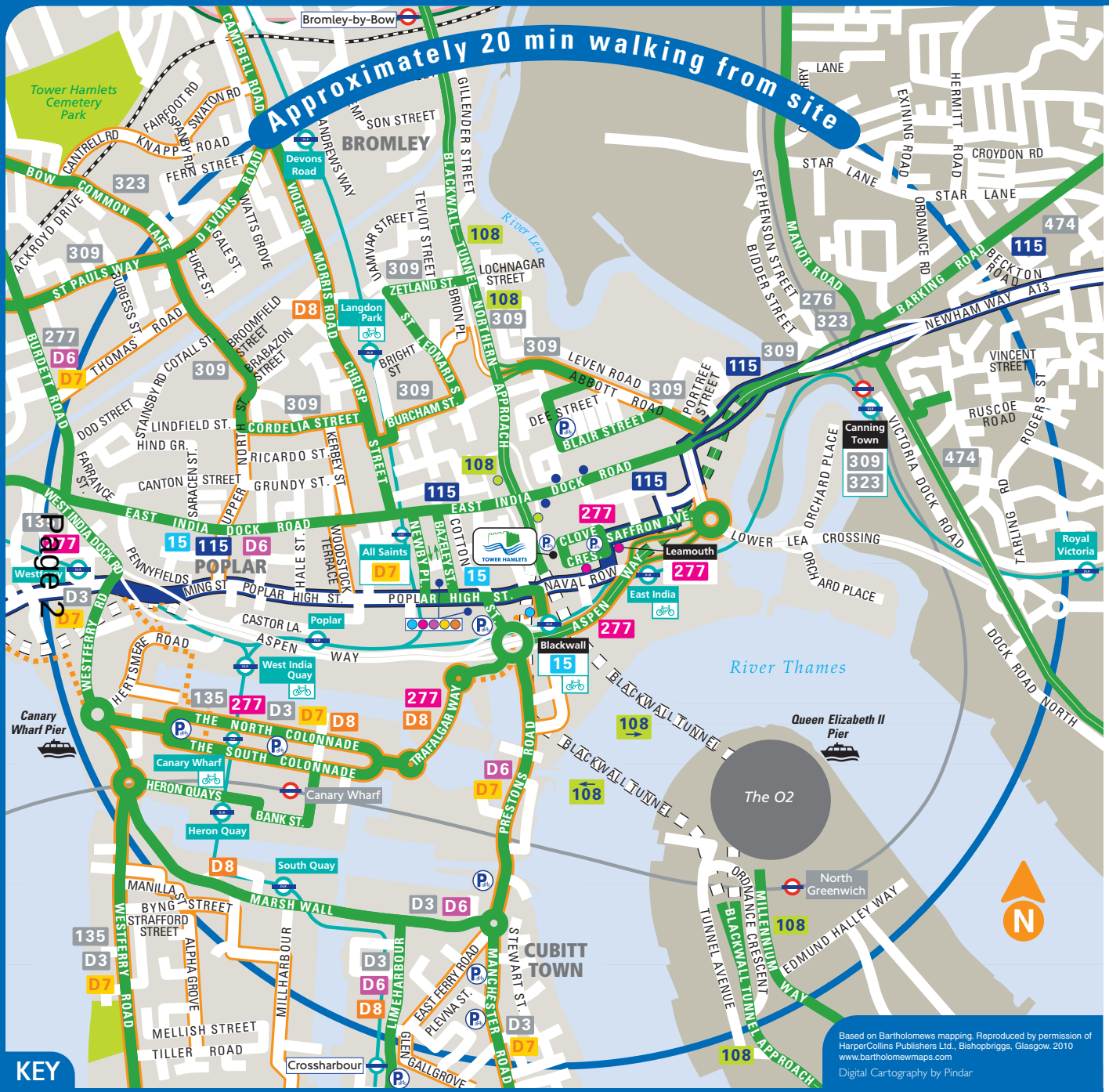
The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

Cycle parking facilities for visitors are provided at ground level – see map (left).

Extensive cycling facilities are also available for staff who wish to cycle to work; email cycling@towerhamlets.gov.uk for details.

Further information on planning your journey by bike can be found at www.tflgov.uk/cyclejourneyplanner or visit www.towerhamlets.gov.uk/cycling for more information.

Map ▸▸▸



Page 2

Bus Frequencies

15 Blackwall - Paddington Basin — Daily

Blackwall DLR - All Saints DLR - Limehouse DLR - Aldgate - Fleet Street - Charing Cross - Oxford Circus - Paddington - Paddington Basin

Monday - Friday daytime 6-10 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 6-10 minutes

Operated by East London

108 Lewisham - Stratford — 24 Hour

Lewisham DLR - North Greenwich - Blackwall Tunnel - Bromley-by-Bow - Stratford DLR

Monday - Friday daytime 8-10 minutes. Saturday daytime 10-14 minutes. Evenings and Sundays 20 minutes.

Operated by London General

115 East Ham - Aldgate — Daily

East Ham - Upton Park - Plaistow - Canning Town DLR - All Saints DLR - Limehouse DLR - Aldgate

Monday - Friday daytime 5-9 minutes. Saturday daytime 8-12 minutes. Evenings and Sundays 10-12 minutes.

Operated by East London

277 Leamouth - Highbury — 24 Hour

Leamouth - Canary Wharf DLR - Westferry DLR - Mile End - Hackney Central - Highbury & Islington

Monday - Friday daytime 5-8 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 9-12 minutes.

Operated by East London

D6 Hackney - Crossharbour — Daily

Hackney Central - Cambridge Heath - Bethnal Green - Mile End - All Saints DLR - Crossharbour DLR - Crossharbour ASDA

Monday - Friday daytime 6-10 minutes. Saturday daytime 7-11 minutes. Evenings and Sundays 15 minutes.

Operated by First

D7 All Saints - Mile End — Daily

All Saints DLR - Island Gardens DLR - Canary Wharf DLR - Westferry DLR - Mile End

Monday - Friday daytime 8-12 minutes. Saturday daytime 7-10 minutes. Evenings and Sundays 15 minutes.

Operated by First

D8 Crossharbour - Stratford — Daily

Crossharbour - Canary Wharf DLR - All Saints DLR - Bow Church DLR - Stratford DLR

Monday - Friday daytime 9-13 minutes. Saturday daytime 11-12 minutes. Evenings and Sundays 20 minutes.

Operated by First

For further information call 020 7222 1234 or visit www.tfl.gov.uk

KEY

277 Convenient Bus Routes
309 Other Bus Services
Cycle Super Highway
On Road Cycle Route
Off Road Cycle Route
Cycle Parking
Closest Bus Stops (colour coded by service)
Leamouth 277 Route Terminus
East India DLR Station
Canary Wharf Underground Station
Approx. 400m in 5 mins

Inner North East London Joint Health Overview and Scrutiny Committee 6th September 2017 **Minutes of the previous meeting**	Item No **3**

OUTLINE

Attached please find the draft minutes of the meeting held on 29th June 2017

ACTION

The Committee is requested to agree the minutes as a correct record.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

HELD AT TIME NOT SPECIFIED ON MONDAY, 26 JUNE 2017

C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)	INEL JHOSC Representative for Tower Hamlets Council
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representive for London Borough of Hackney
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Susan Masters	INEL JHOSC Representative for Newham Council

Others Present:

Paul Haigh	Chief Officer, Clinical Commissioning Group for City of London and Hackney
Steve Gilvin	Chief Officer, Clinical Commissioning Group for Newham
Selina Douglas	Deputy Chief Officer, Clinical Commissioning Group for Newham
David Maher	Deputy Chief Executive & Programme Director
Richard Fradgley	Director of Integrated Care, East London NHS Foundation Trust
James McMahon	Programme Manager, East London Health and Care Partnership
Rhiannon England	Mental Health Clinical Lead, Clinical Commissioning Group for City and Hackney
Paul Binfield	Personal and Public Involvement representative
Jane Milligan	Executive Lead, East London Health and Care Partnership

Ian Tompkins	Director of Communications and Engagement, East London Health and Care Partnership

Officers Present:

Denise Radley	Corporate Director of Health, Adults and Community
Joseph Lacey Holland	Senior Strategy, Policy and Performance
Daniel Kerr	Strategy, Policy and Performance Officer
Anthony Jackson	Democratic Services Officer

1. APOLOGIES FOR ABSENCE

There were no apologies for absence.

The Chair welcomed everyone to the Committee and asked for introductions.

2. DECLARATIONS OF INTEREST

Councillor Ben Hayhurst, from Hackney Council, declared a pecuniary interest as he sat on the Council of Governors at Homerton Hospital.

3. MINUTES

The Committee agreed the minutes of the meeting, held on 19 April 2017, subject to the following amendment:

On page 2, Denise Radley – Corporate Director of Health, Adults and Community being added to the list of officers present.

4. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; ACCOUNTABLE CARE SYSTEM

Jane Milligan, Executive Lead for the North East London Sustainability and Transformation Plan (NEL STP) introduced this item. She pointed out that there had been minor updates to the item which had been circulated. She confirmed that, nationally, there had been a significant amount of discussion on the subject of accountable care and that a lot of work had been done, some under the banner of devolution. She confirmed that, at some point soon, there would be a clear taxonomy, whilst pointing out that the population base was important when considering how to deliver the plan.

Paul Haigh, Chief Officer of the Clinical Commissioning Group for the City of London and London Borough of Hackney, stated that there were four work streams that brought together commissioners and providers. Mr Haigh confirmed that the work streams would look at the totality of funds and would identify exactly what they were trying to achieve.

Selina Douglas, Deputy Chief Officer of the Clinical Commissioning Group for the London Borough of Newham, confirmed that the building blocks for integrated care were in place and that they needed to consider how it would be taken forward. She referred to the fact that the CCG in Newham was hoping to streamline their services and pointed out that it was important that all concerned were working towards the same goal. Ms Douglas explained that they were hoping to significantly transform the service in July 2017.

Steve Gilvin, Chief Officer of the Clinical Commissioning Group for the London Borough of Newham, referred to the challenging position they were in and stated that it was important to step away from the system of financial incentives.

Councillor Munn referred to page 17 of the revised slides, specifically no.5 in the list of questions that the WEL ACS had asked themselves – "how should we go about the move to an ACO/ACS (assuming we agree that we want to)?" Councillor Munn asked why they would not want to move to an ACO/ACS. She also referred to no.14 and enquired whether they had come up with any solutions. Ms Douglas stated that it was important to adopt a different approach however she conceded that they were not sure what that approach might look like. She confirmed that the focus would be on integrated care and that a system framework needed to be developed on accountability. She stated that they would want the system framework to be as borough-based as possible.

Councillor Masters referred to the circulated revised document and asked how the London Borough of Newham felt about the prospect of capitalised budgets. Mr Gilvin stated that the London Borough of Newham already had capitalised budgets and gave the view that this was an opportunity to look at how they worked with providers. He stated that the funds were for the public and therefore needed to be spent in the appropriate way to potentially achieve financial viability. Mr Gilvin confirmed that an in-principle view had been given on how the money would be spent, but stated that a lot more detail was required before there was confirmation.

Councillor Masters asked for an explanation of Primary Care at home. Ms Douglas responded that there were a number of budgets nationally for Primary Care at home and that work was underway with care practitioners to decide the best way forward. She gave data as an example, stating that it needed to be decided how it would work, what systems would be used and how to make the information that becomes available meaningful for the ACS. Ms Douglas then referred to the importance of having a system that provided the desired outcomes and that each area was organised around the needs of the population.

Ms Milligan confirmed there were similar models in Tower Hamlets around supporting integrated care – including mental and physical health. She pointed out that it was important to ensure there was a learning platform in not

just inner London, but also Outer London. Ms Milligan explained that there was a big focus on prevention and that they were moving forward in terms of implementation.

Denise Radley, Director of Adult Services, explained that Tower Hamlets Council was very much focussed on Tower Hamlets Together as a core partnership. She also confirmed that there had been significant investment in developing a new framework, however they were not yet in the position where a detailed model could be agreed.

Councillor Hayhurst asked if it was planned to take funding allocated to the CCG and redistribute that sum around the three ACS. Mr Gilvin confirmed that there was a borough based partnership with the aim to deliver that approach. He stated that the London Borough of Newham would prefer a borough based arrangement as the Council was trying to move away from compartmentalisation.

The Chair agreed that compartmentalisation was one of the risks when three such models were developing. She then asked for some detail on the London Borough of Hackney's approach. Mr Haigh explained that the London Borough of Hackney's model had emerged from devolution and was similar to the models of the other boroughs represented at this meeting. He stated that the Council preferred a borough based model around a set of outcomes.

Ms Milligan stated that payment per item did not support a partnership approach. She said that it was important to identify a number of key thresholds as this would add extra benefit. She also explained that it was important to find a way to develop whilst ensuring that, for example, urgent primary care was available without the need to attend Accident and Emergency. Ms Milligan stated that the biggest challenge was the fact that they do not know what the outcomes will look like. Mr Gilvin added that, with this approach, there was a risk that it would not incentivise clinicians to do right by their patients. He also said that providers needed to be financially viable going forward. The Chair enquired as to whether he was referring to care providers only and Mr Gilvin responded that a comprehensive piece of work was required on this subject.

Ms Radley referred to discussions that had been had at Tower Hamlets Council on the broader social care market. She stated that, should accountable care be integrated, then it would need to focus on the broader social care market.

Councillor Hayhurst stated that he was concerned that the local authority and CCG would lose control as things progressed and asked for clarification on timescales in relation to the budget. Ms Milligan explained that CCG had statutory decision making powers and that the timescales were being developed. She said that by December 2017 it was important to have reached an understanding of what the timescales would be as the plan was to test the proposals by 2018/19.

Councillor Hayhurst asked for thoughts on Hackney Council's proposal to pool all relevant budgets. Ms Milligan confirmed that there was a commitment to integrated budgets. She stated that it was important to consider where resources should be allocated to be most effective. She pointed out that providers might need support in order to get the best outcomes.

Councillor Hayhurst referred to the fact that there was a budget shortfall and expressed concerns at the proposal to re-evaluate and come up with a new system when the money to fund that system was not available. Ms Milligan explained that previous experiences had yielded positive outcomes and said that there was evidence that such approaches had a positive impact. She gave dementia as an example.

Councillor Masters asked what proportion of local budgets would be included in the ACS for Newham and Tower Hamlets Councils. Mr Gilvin explained that the proportion would depend on the range of acute services that would be provided. He confirmed that further discussions were needed on this subject.

Councillor Masters referred to a task and finish group that had been set up and asked whether it had completed its work and for clarification on who was on the group. Mr Gilvin confirmed that the group ensured structured collaboration. He explained that it was the intention to liaise with all community providers within the London Borough of Newham. He said that work had commenced, however, there was some further work required on establishing the sub-groups which would sit beneath the task and finish group.

Councillor Masters then asked whether a strategy had been developed for ACS proposals. Mr Gilvin stated that, as a test, a number of events had been organised in Stratford in order to develop a strategy. He said the next stage was how the ACS would deliver the strategy.

Action: Councillor Masters asked that a list of all the working groups be provided to Members of the Committee.

5. NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN; MENTAL HEALTH

Ms Milligan introduced this item, together with Mr Fradgley, and explained that the report would provide Members with an overview of the work being undertaken to develop mental health services as part of the North East London Sustainability and Transformation Plan.

Mr Fradgley referred to the fact that there was now significant drive to make mental health a national priority. He stated that investment in that area was needed as much as it was in acute illnesses. Mr Fradgley then explained that inner North East London had the highest level of mental illness in the country and that there was significant increasing demand for mental health services. He also stated that there had been a 10% increase in those with mental

health issues requiring primary care and that it was expected that that growth would continue. Mr Fradgley highlighted the fact that good mental health services were provided in inner North East London and that they were leading the way in terms of innovation.

Mr Fradgley pointed out that they were focussing on mental health inequality and the fact that mental health issues were often a problem for those with complex needs. He confirmed that 51% of those with complex needs had a mental health problem. He also pointed out that East London NHS were focussing on improving access to talking therapies for those from BME communities.

Mr Fradgley then referred to the following key priorities for East London NHS around mental health:

- Improving the number of mental health sufferers in the inner North East London area
- Suicide prevention
- Helping those with mental illnesses to find employment
- Improving access and parity in relation to mental health services (whilst keeping the waiting list to two weeks)
- Considering how mental health would fit into the ACS system

Mr Fradgley went on to explain that approximately 50% of those individuals who were known to mental health services were under 65 years old. He stressed the importance of ensuring mental health services were not placed at risk and the need to give due consideration to how the above priorities would be delivered.

Rhiannon England, Mental Health Clinical Lead for the City of London Corporation and the London Borough of Hackney, referred to the innovative models that they had developed. She pointed out how important such services were as there was a high need for mental health services due to the high levels of deprivation in the borough concerned. Ms England stated that there was a very strong level of primary care in her boroughs and that a particular area of interest and focus was frequent users of primary care services. She pointed out that many frequent users had a mental health problem.

Ms England also referred to the difficulty in balancing good patient care with a lack of funding. She confirmed that inner North East London could learn from the outer North East London boroughs in relation to crisis care. She explained that the number of children and young people requiring crisis care was small and thus, it was difficult to provide a good service. She stated that a 24 hour crisis phone line was a consideration and could potentially make the service more efficient and effective.

Paul Binfield, Personal and Public Involvement (PPI) representative, referred to a set of priorities set by PPI, including the fact that there was a significant

amount of work needed to challenge an existing stigma around mental health which he described as a big barrier. He referred to a project currently being implemented involving a mental health worker engaging with the public on the Docklands Light Railway. He also explained that there was work being undertaken to raise awareness of mental health issues. Mr Binfield pointed out that clinical work was only one aspect and that it was also important to consider social and health education.

Mr Binfield stated that considering practical options was also a priority, such as assisting users of the service to find employment. He gave an example of certain individuals using the PPI service and being trained to become fitness instructors.

Mr Binfield confirmed that PPI had a wealth of experience and expertise on how to engage people on the subject of mental health. He offered that expertise to other organisations represented at the meeting to assist in delivering positive outcomes and explained the importance of a community approach to mental health issues.

David Maher, Deputy Chief Executive & Programme Director for the City and Hackney, explained the importance of allowing people with mental health issues to live normal and independent lives. He referred to the issue of substance abuse, giving the view that the issue should sit with public health and pointed out that relevant organisations had an opportunity to undertake joint work on this issue. He stated that everyone involved should be proud of the work that has been done by this committee.

The Chair agreed that linking up relevant systems was important, especially in relation to individuals with mental health problems having access to housing and employment. She referred to the fact that there were many undiagnosed people with mental health problems and pointed out that finding new methods of accessing relevant services was paramount.

Councillor Maxwell referred to page 2 of the report which stated “The Development of additional psychological therapies so that at least 19% of people with anxiety and depression access treatment…” She asked how that 19% was prioritised and what would happen to the remaining 81%. Mr Maher explained that they work closely with providers to prioritise and explained the importance of ensuring there was a system in place for people to rise through the system should their mental health needs escalate.

Ms England suggested that that the system be prescribed and evidence-based as many people might show recovery from mental health symptoms in ways that are unseen by relevant professionals, for example, faring better in relationships or gaining employment. She also pointed out that housing was a big problem for many suffering from mental health and stated that the solution for many might not be prescribed medication, but a more practical solution such as access to housing.

Councillor Masters asked how mental health was being integrated into GP services. Mr Gilvin confirmed that there were additional mental health services from General Practitioners and that practices were being consolidated which was helping to improve quality.

Councillor Hayhurst asked whether they were a victim of their own success. Mr Fradgley explained that they had experienced success in reducing the length of patients' stay, however, given the financial situation with regard to the NHS, it was important to consider how beds would be managed in the future. Councillor Hayhusrt asked whether there was a possibility of consolidating sites and Mr Fradgley responded that there were no plans for consolidation and that they were looking at available options.

Councillor McAlmont referred to highest spend per head, saying that the trend seemed to be upwards for the London Boroughs of Newham and Tower Hamlets especially. He asked what was being done and how much was being spent on prevention. In response, Mr Binfield explained that part of a nurse's role was to provide support to whoever came in to them. He also said that challenging the stigma associated with mental health would go a long way to raising awareness and encourage people to seek help earlier.

Councillor McAlmont asked for a breakdown of the number of mental health sufferers who were in employment. Mr Binfield confirmed that approximately 5% of mental health sufferers were in employment, compared with 8% nationally. He stated that there was a need to look at the strategic priority. Mr Binfield added that Job Centre staff in the London Boroughs of Hackney, Newham and Tower Hamlets were being trained to identify mental health issues.

The Chair stated that BME communities were a hard to reach group in terms of mental health and asked why there was such a low take up on talking therapies. Councillor Beckles agreed and pointed out that some communities had their own stigmas. He asked what was being done to alleviate the issue. Mr McMahon explained that there was a work-stream being developed around prevention and workplace prevention. He said that he hoped that this issue would be looked at as part of the work-stream and that they were considering their approach. He added that the plan was to look at establishing a work place health charter for smaller organisations. Ms England confirmed that there was a lot of work being undertaken on the BME community. She expressed the importance of looking at recovery rates as those of the Turkish and Kurdish communities very low. Mr Maher said that recovery rates were very low for the Turkish community when IAPT talking therapies were used, however he pointed out that when local engagement methods were used, such as gardening, recovery rates were excellent.

Mr Binfield explained that they were working closely with the Metropolitan Police, whilst explaining that some boroughs were more receptive than others. He stated that the national Police did not receive adequate training on mental health however he said that the situation was improving. Mr Maher referred to

a pilot that was currently running on street triage. Councillor Beckles asked if those participating in the pilot were trained. Ms England confirmed that those involved were mental health professionals who were receiving training by observing on the job.

6. URGENT BUSINESS

Accountable Care Officers

The Committee was informed by the NHS that they were recruiting a single Accountable Care officer for Inner North East London and Members requested a discussion on the subject, as the appointment could potentially represent challenges to local accountability of health services.

Councillor Munn expressed concerns about the removal of accountable care officers from individual CCGs. She explained that if there was just one Accountable Officer, this would change the way the NHS operated with little transparency or legal basis for the change.

Councillor Hayhurst pointed out that the loss of Accountable Care officers could potentially result in a lack of local control and leadership.

Councillor Masters concurred with Councillors Munn and Hayhurst. She added that she was concerned that there was not a clear breakdown of what issues would be dealt with at the Accountable Care officer level.

Ms Milligan explained that the removal of Accountable Care officers had not yet been agreed by CCG Boards as it was still at the design stage. Mr Haigh added that they were still in the early stages of discussion and confirmed that firm proposals would be put to each of the CCG bodies in July 2017. He added that the change of the management process was complicated and how the ACS would be regulated needed to be considered. He stated that the relevant budget would stay with the CCGs and that the only way the budget could move would be via risk share. He stressed the importance of transparency around how the money would be spent.

Ms Milligan explained that it was intended to work closely to try and free up resources and time to support borough developments. She added that the proposed singleAccountable Care Officer would benefit Londoners. She referred to the fact that there were challenges concerning the addresses of patients with larger providers. She said that local arrangements were not necessarily being moved.

The Chair gave the view that local authorities needed to be involved in relevant discussions and should be considered a key partner.

Councillor Munn asked for an explanation on the duties undertaken by an Accountable Care officer. Mr Gilvin explained that the role was set out in their

constitution, however, he confirmed that the officer's powers were those delegated to them by the CCG. He added that clarity was needed around the arrangement of functions and stated that a strong commissioning team would be required.

Councillor Hayhurst stated that a formal case for the proposals should be put before this committee and asked for a commitment that this would happen as, otherwise, the committee would be signing off a model which had not been subject to scrutiny. Ms Milligan explained that timelines were still being worked out. Mr Gilvin confirmed that he would take councillors' comments back to relevant officers for discussion.

The meeting ended at 8.45pm

Chair, Councillor Clare Harrisson
Inner North East London Joint Health Overview & Scrutiny Committee

Inner North East London **Joint Health Overview and Scrutiny Committee** 6th September 2017 **East London Health and Care Partnership:** **Consultation on payment development**	Item No **4**

OUTLINE

The East London Health and Care Partnership (ELHCP) have recently launched an engagement exercise to gather the views of stakeholders and partners across the ELHCP on payment reform

The ELHCP is working to achieve its objective to protect and sustain vital services and provide better treatment and care built around the needs of local people. To support this aim, the ELHCP need to ensure the right relationships and systems are in place between organisations within the ELHCP, including those holding the budgets for health and care services and those providing them.

This includes having the right approach for the payment of those services – one that is fit for purpose given current and future demand, and enables the right outcomes for our population.

This paper outlines the changes being made to the payment system and the consultation process the ELHCP are undertaking with key partners and stakeholders.

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

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East London Health and Care Partnership:

Consultation on payment development and drivers for change

Published 11 July 2017
Updated on 13 July 2017 to reflect extended deadline for consultation responses
Author Katie Brennan

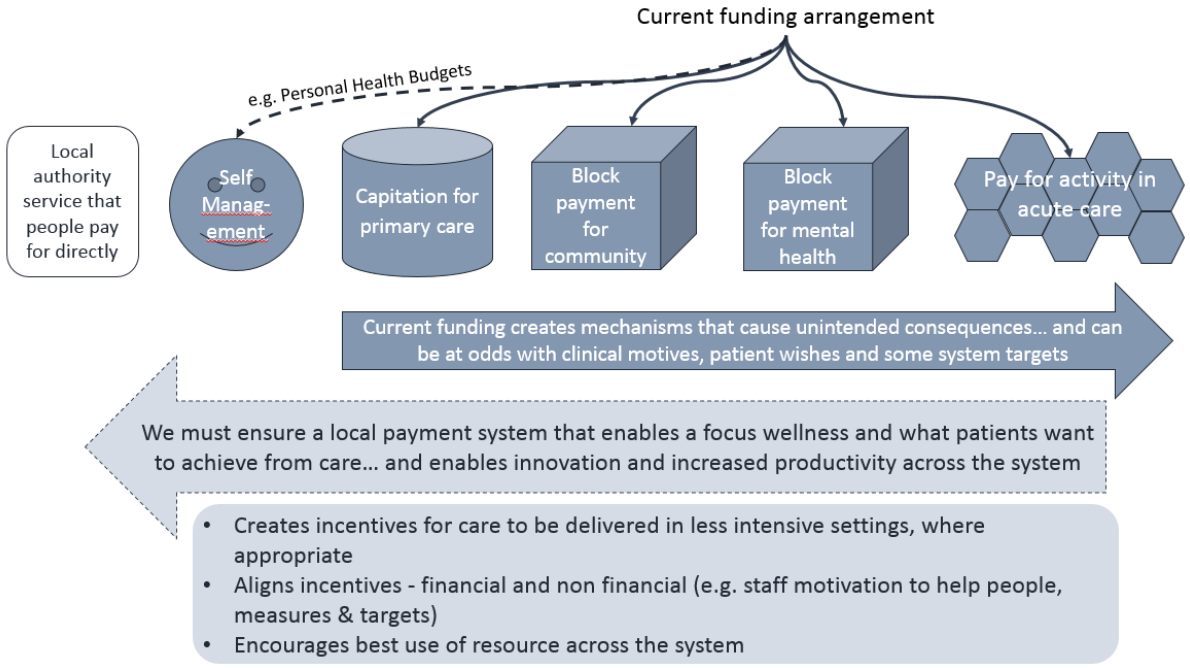
Summary

East London Health and Care Partnership (ELHCP) is working towards a new approach to managing health and care across East London, working together in a more integrated way and taking shared accountability for delivering improved outcomes for local populations. As part of this, the three sub-systems within ELHCP (i. City and Hackney; ii. Waltham Forest, Newham and Tower Hamlets; and iii. Barking and Dagenham, Havering and Redbridge) are developing Accountable Care Systems (ACSs) and are keen to use a consistent approach. To support this, it is important to examine current payment mechanisms and consider where changes to payment can support system development in East London.

There is a need to reduce variations in the quality of care and develop care packages that provide a patient-centred and coordinated approach. Alongside this, by the 2020/21 financial year the overall funding gap in East London is projected to be £578 million. We will not be able to rely on external funding to solve these issues. Improvements to services will need to be made and the funding gap will need to be closed using a combination of service redesign and improved productivity. The way the system currently pays for services and works together as organisations make it harder to successfully meet these challenges.

Service design and ways of working will be the primary route to meet system challenges. There are a number of payment options and combinations of payment approaches that may enable incentives within the system to operate in a more coherent way, and more effectively enable the delivery of system objectives. At present in East London there are a variety of contractual payment mechanisms running concurrently depending on the type of organisation.

The diagram below gives an illustration of challenges:



As a system we must consider what configuration of payment will most effectively support system objectives. Examples and evidence from other areas, including NHS vanguards, can be drawn on to inform our thinking.

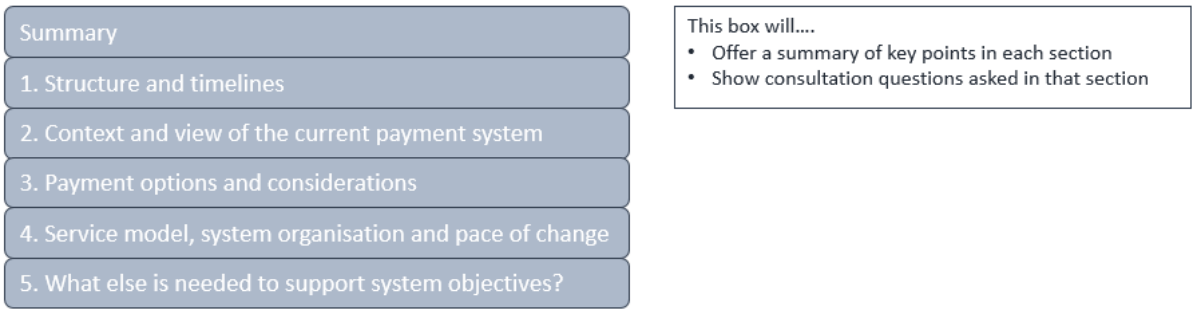
We recognise that, on its own, changing payment will not solve all the system issues. Payment systems can support strategy, but should not drive it. Therefore, new governance arrangements are also needed to ensure ELHCP can deliver genuinely accountable, coordinated care. These arrangements need to be underpinned by improved data collection and use of analytics for strategic commissioning as well as continual improvement to care. New contracting frameworks and payment mechanisms can feed into this and support clinical improvement.

The ELHCP is clear that work to develop payments should not be used (or perceived) as a programme to cut costs. The aims of this work are to ensure the system is maximising use of the resources available to it and to support ELHCP discussions about improving service delivery and prioritising care in a transparent and evidence-based way.

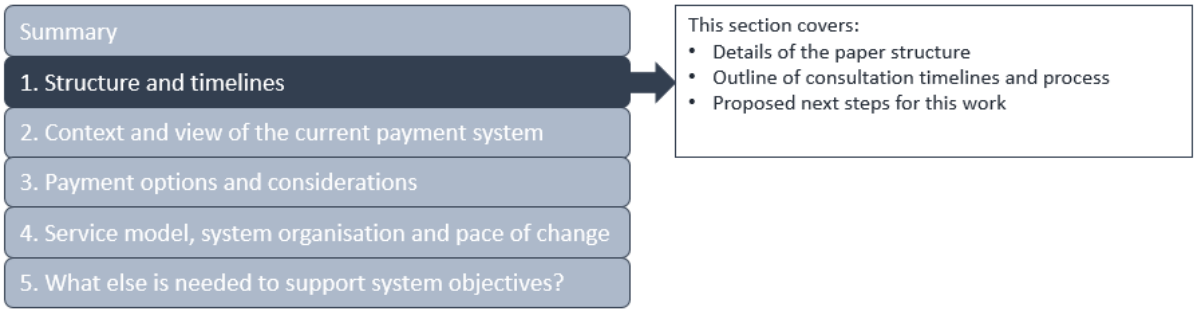
Table of Contents

To help readers navigate this document the following diagram is located at the front of each section of this document. It will highlight:

- What section the reader is on
- Content and themes covered in that section
- Consultation questions asked in that section



1. Structure and timelines



1.1. This paper considers the strategic objectives for ELHCP and asks: how appropriate are existing payment systems to deliver shared Sustainability and Transformation Plan (STP) objectives? It is broken into five sections.

- Section one provides an **overview** of the paper structure and content as well as the consultation process
- Section two sets out the **challenges faced by health and social care** over the coming years, nationally and within East London.
- Section three outlines **payment options in use across** Ea**st London** and seeks to describe the benefits and issues with these approaches. It also considers alternative payment options and looks at examples of local health and care payment approaches developed elsewhere.
- Section four considers options for **contractual form and scope and scale of service models** that payment may cover. It also outlines possible timelines for transitioning to a new payment approach that may be developed.
- Section five notes **other workstreams** that are needed at an STP level to complement development work around payment design. Without these other components any change in payment will not drive the desired change in the system.

1.2. Throughout this document are thirteen questions. They are clearly labelled at the end of each section and are intended to generate a base understanding of each organisation's views. An eleven week engagement period will start on Tuesday 11 July 2017. The consultation will take account of both written and verbal feedback. Verbal feedback will be captured through workshops – which will include engagement with providers, commissioners, voluntary sector, front line staff, patients, residents and carers.

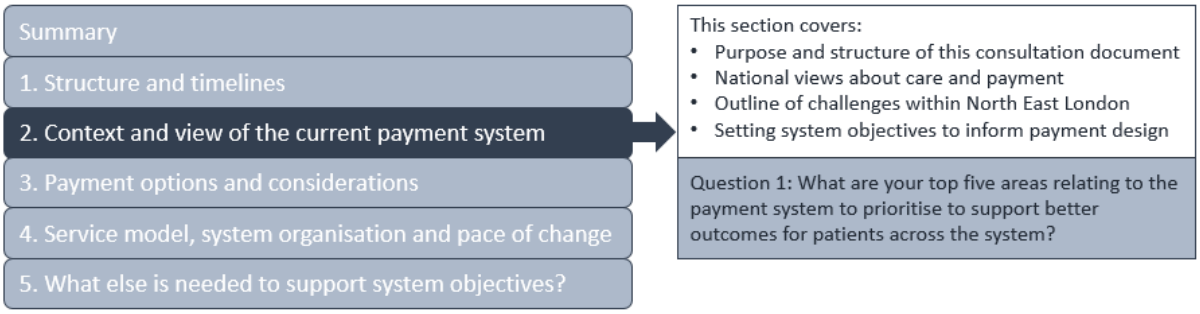
1.3. Further to this, each organisation is asked to draft a written response. The eleven-week engagement period has been set to give organisations the opportunity to engage their Board and other leaders in their response. Therefore, feedback should reflect organisational consensus.

1.4. Written and verbal feedback will be consolidated to generate an understanding of areas of consensus and points of difference, and inform next steps. **Written responses should be sent to enquiries@eastlondonhcp.nhs.uk by 18:00 on Friday 29 September 2017.** This is an extension from the original deadline of 4 September. If you have general questions about this document or the consultation process please send them to the email address above or Katie.brennan1@nhs.net.

1.5. For ease of reference, the list of thirteen questions is available in the annex to this document. This is a simple template that can be copied into another document to allow for free text responses.

1.6. Next steps: pending feedback, a working group will be established to develop recommendations.

2. Context and view of the current payment system



Background and context

2.1. Across East London providers and commissioners must meet increased financial pressures and a need to provide more person-centred care. There are practical challenges and barriers that prevent us from achieving this:

- The practicalities of working across team and organisational boundaries are often a major challenge, running contrary to existing cultural and structural characteristics.
- In all sectors, financial pressures and increased workload can have an impact on the ability to innovate and transition to change.
- Some providers face substantial fixed costs, commitments that cannot be shifted within short or medium term time horizons.
- East London faces a total financial gap of £578m in the 'do nothing' scenario to reach a break even position by the 2020/21 financial year. Achieving a 1% surplus target for commissioners increases the gap by another £30m to around £610m.

2.2. East London Healthcare Partnership (ELHCP) is comprised of providers, commissioners and local government representatives covering the eight local government footprints. Across the ELHCP, health and care partners have an ambition to develop more effective and coordinated approaches to delivering care across the local health systems. To meet these challenges ELHCP organisations will need to confirm common objectives, agree ways of working, develop governance arrangements and consider service model design. These will be central drivers of change. Payment development and the availability of good quality data and analytics both have an important role to play to support that work and align incentives across the system.

2.3. Historically, the majority of NHS healthcare has been paid for on an activity basis. This was introduced to encourage activity and investment in the system when funding was increasing and waiting times needed to be reduced. The payment approach was initially effective at driving investment and reducing waiting times. However, it has had the unintended consequence of drawing health and care resources towards operational capacity for measurable units of treatment, with insufficient focus on improving the

outcomes and wellbeing patients experience. It also limits the opportunity for targeting investment in a more flexible and effective way.

2.4. Today, our health and care systems face new challenges. The system must deliver improved quality, a more patient-centred approach to care, better support for population health and more effective use of resources.

2.5. The challenges our partnership faces are consistent with the issues described in the Five Year Forward View[1], published in October 2014, and the accompanying 'Next Steps'[2] document, published in March 2017. They set out objectives for care that is patient-centred, focused on recovery, prevention and early intervention. They also set out the need for a health and care system that makes best use of resource and treats people in the lowest intensity setting - providing care 'closer to home' where ever possible. This need is primarily driven by what people say they want and need from health and care services.

2.6. Messages from national bodies have been increasingly consistent when it comes to possible solutions. They are encouraging local health and care systems to adopt a more coordinated approach to find solutions to the challenges they face. Those in prominent national roles have advocated implementation of a capitated payment linked to outcomes as the best way to support needed change. In any case, there is a clear move in national policy to encourage payments linked to person-centred outcome measures. This has been signalled as a desirable direction of travel from NHS England and been enshrined in the tariff. For example, as of April 2017 NHS England and NHS Improvement require mental health providers and commissioners to adopt transparent payment approaches based on capitation or episodic payment, which must be linked to achievement of agreed outcomes. In ELHCP, work is underway to comply with these requirements using existing data and information. Plans to develop improved patient level data for mental health will support this work further in future.

2.7. NHS England and NHS Improvement support development of local solutions that are co-developed and can demonstrate positive impacts on ways of working and system goals. This means local areas have an opportunity to drive their destiny, but they must take active steps to develop a local approach. If not a solution may be imposed by national bodies. Within ELHCP we need to consider and develop the best payment approach for our local system.

[1] The Five Year Forward View, NHS England (23 Oct 2014) https://www.england.nhs.uk/ourwork/futurenhs/
[2] Next Steps on the NHS Five Year Forward View (31 March 2017) https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

Specific challenges within East London

2.8. Often, payment development is perceived to be about transferring risk from one part of the system to another, or from one organisation to another. However, to be successful, payment development must be about enabling new ways of working. This means:

- ensure those in the health and care system with the power to change how care is delivered have the right incentives to do so – and that incentives within the system are aligned with one another;
- remove barriers to organisations and staff working in a more coordinated way;
- a cultural change, so the system works together towards collective, local objectives and system partners are empowered to take a more patient-focused approach to service design; and
- ensure risk is shared across the partnership in the safest way.

2.9. Within London there is a recognition that care needs to change and a desire to innovate. Below are two examples that illustrate issues that are more difficult to address in the context of the current payment structure.

- Outpatient care:
  - There is a desire to move to new ways of working for delivery of outpatient care. The way current payment levels are set across the system and payment mechanisms interact can provide a disincentive to coordinate care and develop person-centred service models. For example it makes it more difficult to:
    - increase advice and guidance provided to people and patients to prevent issues arising and allow them to manage their wellbeing;
    - move towards more non-face to face consultations, where appropriate; and
    - make better use of scarce hospital capacity and enable patients to have access to specialist consultation without the inconvenience of an often unnecessary hospital visit.
  - Other issues include:
    - The variation between payments received for non-face to face versus face to face is too large;
    - There are no mechanisms for income to reflect fixed costs and stepped costs that may become ‘stranded’; and
    - There is no national tariff guidance or advice about how to address issues identified within ‘pay for activity’ frameworks.

- End of life care:
  - Current service provision within the STP footprint is poor overall and only a small proportion of patients currently die at home or at the place of their choosing. Sufficient payment levers are not currently in place across both the health and care system to be able to realign this.
  - There is no incentive for providers from different sectors to work together and provide joined up care.

- Existing financial mechanisms are skewed by payment for activity, which has a tendency to incentivise care to take place within a hospital even if that is not in line with the patient's preference.

2.10. It is clear that the system must adapt to address these pressing challenges.

- Evidence from work in the NHS as well as international examples[3] suggests providers and commissioners need to work more collaboratively and take a system/population view of care and resource use.

- A number of structural and cultural changes are needed to support this:
  - payment development;
  - improved use of data and analytics; and
  - governance arrangements that enable organisations and front line staff to work in a more coordinated way.

2.11. There are a range of ways health and care systems have delivered this type of change in England and abroad (examples include Oxfordshire Mental Health[4], and see footnote 3 above for international examples). Improved accessibility and use of linked data sets and payment reform have featured as a key part of achieving these goals. An agreed set of objectives and clear vision for the system is also important, the vision for the payment system should be fully in line with the vision for the wider health and care sector. The ELHCP now needs to decide what the right approach is for our populations and health and care economies. Can this be achieved via tweaks to the existing payment system, or is more comprehensive payment development needed?

Setting objectives and agreeing priorities

2.12. Lessons from other health and care systems within the NHS demonstrate the need for a clear vision and set of priorities to mobilise thinking and focus efforts toward common goals[5]. All parties within the health and care sector that want to implement new ways of working need to be clear about what the system is trying to achieve. When setting these objectives it is important to put patient and population needs at their centre. This promotes a patient-centred approach to solutions and aligns system objectives with those of front line staff and the population. It is also important to be

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3 International examples include:
http://www.pwc.co.uk/government-public-sector/healthcare/assets/lessons-from-spain-the-alzira-model.pdf
Struijs JN & Baan CA (2011). Integrating Care through Bundled Payments – Lessons from the Netherlands. N Engl J Med, 364:990-991. March 17, 2011.
http://ccn.health.nz/Resources/OutcomesFramework.aspx
https://www.kingsfund.org.uk/publications/population-health-systems/kaiser-permanente-united-states

4 https://improvement.nhs.uk/documents/234/MH_outcome_based_commissioning_update_note_v2.pdf

5 http://www.pwc.co.uk/industries/government-public-sector/healthcare/insights/shifting-to-accountable-care-characteristics-and-capabilities.html:
'Experience from accountable care organisations operating across the world shows that the successful delivery of accountable care requires capability in eight key areas: 1. Strategy & vision: There is a compelling vision and clear strategy for managing and delivering clinical, patient and service user outcomes. This is shared by all organisations involved in the delivery of health and care.'

open about local opportunities, and challenges that need to be addressed. It is important for payment to be developed and configured in a way that supports agreed system objectives.

2.13. From a patient perspective, the ELHCP[6] sets out areas for improvement:

- Apart from City and Hackney all East London areas are below the national average for success in getting a GP appointment and 'ease of getting through to someone at a GP surgery on the phone' (based on patient surveys).
- Address inconsistent patient experience for A&E, inpatients, maternity, and outpatients and for mental health providers (based on Friends and Family Test).
- Many patients do not die in their preferred place (as few as 22-29% in some areas. See example above on end of life care).

- One year survival rate for all cancers is lower across all seven CCGs than survival rates across England.

2.14. In most cases what local people want from their interactions with the health and care service is consistent across geographies – and the list is likely to resonate with each of us as service users. The patient representative group National Voices has set out what service-users say they want and findings from Barking and Dagenham, Havering and Redbridge (BHR) and Tower Hamlets echo these national themes:

- the ability to plan my care with people who work together to understand me and my carer(s);
- allow me control; and
- bring together services to achieve the outcomes important to me[7].

2.15. To deliver better outcomes for patients and address the strategic system challenges, providers and commissioners across ELHCP will need to focus on the following:

- incentivising early intervention and prevention for whole populations;
- encouraging all providers collectively operate within costs constraints of the system; and
- removing the barriers that currently block care coordination.

[6] ELHCP October 2016, apart from the first bullet, which represents updated data (as of 7 July 2017) from the NHSE's GP Patient Survey https://gp-patient.co.uk/

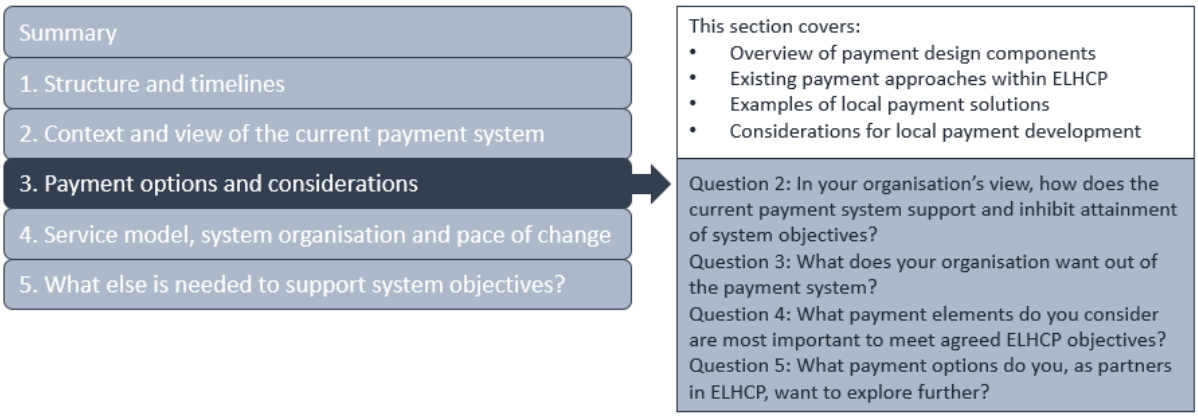
[7] http://www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf

2.16. Change will not happen overnight. Improvement processes can be overstretched and become unfocused unless they have clear priorities. It is important that system leaders agree clear system-wide objectives and, given that, decide which areas of work to prioritise. Possible areas to prioritise include:

i. Incentivise better outcomes rather than increased volume of interventions.
ii. Reward delivery of care that enables patients to control decisions regarding their own health and care.
iii. Manage financial risk between organisations.
iv. Manage transformation and the process of transition.
v. Design a contractual framework that aligns providers and commissioners objectives to deliver collective outcomes.
vi. Improve quality-linked patient-level data across the whole system.

Question 1: What are your top five priority areas relating to the payment system to support better outcomes for patients across the system?

3. Payment options and considerations



3.1. Across health and care systems a range of payment approaches are generated using adaptations of a standard set of payment tools: fee for activity, block payment, capitated payment, payment for outcomes, cost and volume arrangements and so on. Drawing on these tools, and using them in combination, there are an infinite number of payment options that may be developed and implemented locally. This section considers system goals that payment needs to support, outlines common payment approaches used in East London, examines a range of payment approaches available and offers real world examples of different local payment approaches.

Overview of payment forms (this list is not exhaustive)

3.2. Payment cannot drive transformation, but it has an important role to play in supporting system change. This section provides an overview of a range of payment forms that can be drawn on when developing local payment approaches. All have benefits and drawbacks. The important thing when designing a payment approach is to ensure that incentives across the system are appropriately aligned to support desired outcomes and reduce the risk of unintended consequences.

3.3. *Block payments* offer a fixed amount of funding to a provider to deliver care to an agreed population over a fixed period of time. This provides a stable source of funding to enable investment and delivery of quality care. It is calculated based on historical expenditure and can be adjusted to reflect expected efficiency gains, trends in patient needs (demographic growth and changes in case mix) and cost uplifts. Non-acute providers using block contracts have a clear awareness of their cost envelope and can organise their service availability to match it. However, since they then have limited capability to flex their staffing they have little incentive to attract additional work. To manage demand they may extend waiting times, take a measured approach to acute discharge and actively move patients on to alternative care settings.

3.4. *Primary care per capita* is payment for core GP services allocated on a per capita basis, using an average payment per patient based on the GP patient list. In principle, this arrangement incentivises GPs to take on new patients. In addition to core services, commissioners provide specific additional payments for items of locally prioritised

activity, for example locally-enhanced services linked to clinical outcomes for specific long term conditions. The bulk of primary care funding and costs, therefore, are relatively predictable, enabling them to remain financially sustainable as providers. GPs provide direct treatment, but they also have a significant role diagnosing and referring patients to alternative care settings. The increasing constraints on GP time and the increase in the number of appointments/contacts they are required to make potentially creates a perverse incentive to avoid risk and refer patients for tests or acute diagnoses rather than undertake measures available out of hospital that might be viable alternatives. The limitation on their resource can also limit their capacity to provide preventative care in the most effective way.

3.5. *Fee for service* means a care provider is paid separately for each component of an interaction with a patient. This means there is a specific price for each individual resource used (ice pack, splint, serum, etc.) and for each care action taken (scan interpretation, drawing blood, physical examination, etc.). Some private insurers in the United States use this approach for payment. Provided fees are set at or above efficient cost levels, it offers remuneration for all activity and resources used to treat a patient, but does not create incentives for early intervention, preventative care or coordination between care providers.

3.6. *Payment by activity* (as per the current national tariff).This is payment by event or episode. It was developed over a decade ago, at a time when the NHS had a specific set of priorities to reduce waiting times and increase acute activity[8]. However, it can limit incentives for coordinated care or care focused on early intervention and recovery. Further limitations of this approach are explored in para 3.10.

3.7. *Cost and Volume payment* is a variant of payment for activity, and often incorporates caps and collars. This payment mechanism helps to manage volume risk. It involves a block element for the core service, allowing for variable costs and/or case adjustment between a threshold and a ceiling. This works particularly well for services that have to be provided come what may, where it is clear what the core service costs for example, A&E services have to be provided 24 hours a day seven days a week. The contract can be set assuming a certain level of patient attendances and acuity, with additional payments up to a ceiling that are flexed if more people attend than expected. This type of approach can be useful to address a specific volume risk in one service, but on its own does not support reduced demand risk or integrated approaches to care.

3.8. *Outcomes based payment* is where organisations link a portion of payment to attainment of agreed objectives. Evidence suggests that outcomes based payment is most effective at supporting transformation when focused on a small set of measures that are aligned to patient and population outcomes rather than more specific and lengthy list of clinical outcomes. It is also more effective when framed as a payment rather than a penalty, and supports innovation best when it accounts for a relatively

[8] https://www.kingsfund.org.uk/press/press-releases/current-payment-systems-not-suited-current-challenges-facing-nhs-new-report

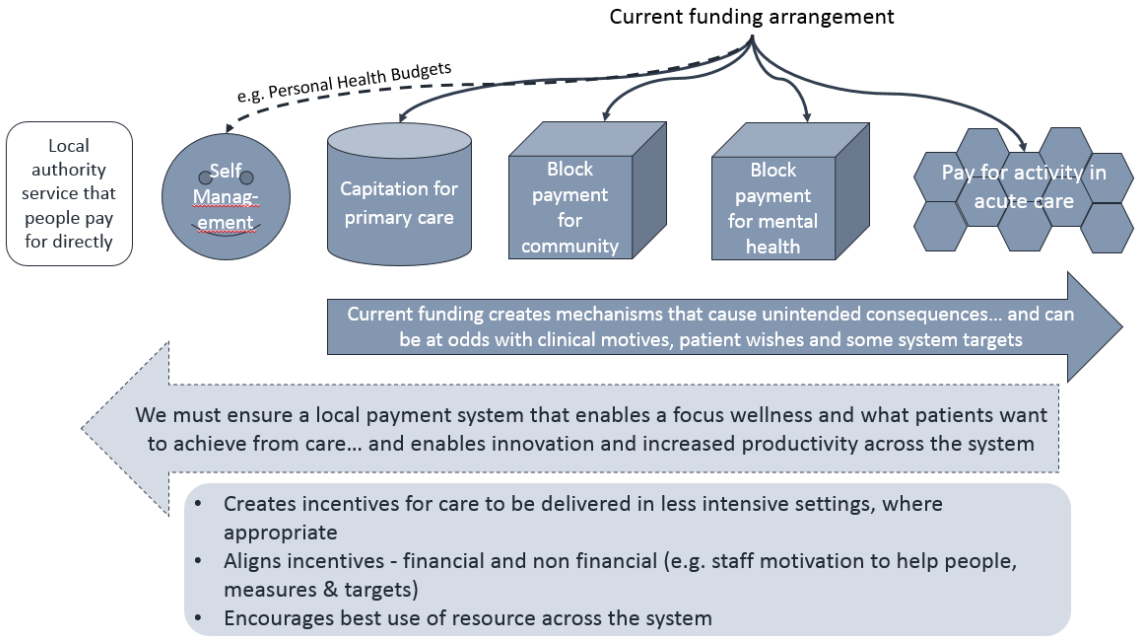
small share of total payment. If the size of the outcomes-based payment as a share of the total payment is set too high, the agreed metrics are likely to focus on clinical outcomes that can be easily achieved rather than more ambitious person-centred outcomes. Successful outcomes based payments require co-development of appropriate metrics and the existence (or development) of supporting data systems allow agreed outcomes to be measured in a direct way, limiting proxy indicators wherever possible.

3.9. *Gain and loss share arrangements* can give providers an opportunity to have a stake in the success of the system. It can allow them to retain a share of savings they are able to generate for the system or have to absorb a share of losses incurred. They can also be deployed to mitigate financial risk to individual organisations that are due to switching to a new integrated care model, by redistributing changes in revenue from one part of the system to another. In financially constrained health and care systems the ability for gain and loss share arrangements to operate effectively is more limited, as any funds in the pot will need to be held back from funds that may be needed to provide care. In this case it may be more appropriate to have an agreed risk pool across providers and commissioners that is ring-fenced to manage unanticipated changes in demand.

Payment approaches widely used within East London Health and Care Partnership

3.10. This section looks at payment forms used within ELHCP and considers the incentives they place on the system. There are a number of smaller scale commissioning arrangements that are experimenting with different payment forms in order to improve incentives within the system. However, at present, the majority commissioning arrangements within ELHCP combine:

- Fee for activity – or Payment by Results in the acute sector; with
- Block payments for community and MH services; and
- Primary care per capita core payments and outcomes payments.



3.11. The structure of the current payment system as outlined in the diagram above supports some objectives desired by the system, but also presents real barriers to realising the changes required.

- Benefits include:
  - It encourages providers to clear RTT backlogs in acute care, ensuring payment for units of care provided, enabling activity and reducing backlogs.
  - It allows quality of care per intervention to remain to standard in acute settings, through nationally prescribed reimbursement for each unit of care delivered.
  - It encourages quality coding of data for acute care as payment is linked to it.
  - It enables providers to manage, and be remunerated for, unanticipated surges in demand.
  - It stimulates providers to be internally efficient.

- Issues include:
  - It is not designed to promote or support larger scale shifts in care from settings where the prevailing contract form is activity driven, to other settings where care is paid for under a block contract.
  - It is not well suited to promote coordination of a more patient-centred way of delivering care.
  - It provides almost insufficient direct incentive for health promotion and disease prevention at the provider level, locking the vast majority of NHS funding into treating the effects of poor health rather than preventing their occurrence.
  - It does little to support targeted investment of funds to areas that will deliver more effective care, or better efficiency, productivity or innovation across the wider system. I.e. it does not always support allocative efficiency of care across the system.
  - It provides insufficient direct financial incentive for providers to engage in patient flow and demand management programmes across the system. For example, demand pressures may continue to result in activity and referral rates in the acute sector that are above plan. In this case, performance targets may be breached and the cost to the system of acute activity becomes unsustainable.
  - Tariff-based payment rewards delivery of prescribed interventions on a volume basis, which may not always lead to better outcomes for the patient and the system.
  - It can be perceived as complex to understand. This acts as a barrier to engaging staff (in particular clinical staff) to understand the impact the payment system has on care delivery within the local system – this effects the quality of discussions on root cause analysis and solutions when looking to support change.

- Where Trusts are under financial pressure, it can create a tension between (i) the draw to meet local needs and coordinate with local partners and (ii) pressure from regulators to maximise funding streams to shore up financial position.

3.12. Clearly the payment system can act to create pressure and impact adversely on both commissioner and provider organisations. Currently, the tools to address issues in the system are not in the hands of those who have the capability to impact change on the ground.

Question 2: In your organisation's view, how does the current payment system support and inhibit attainment of system objectives?

Examples of local payment solutions

3.13. There is a growing consensus within the English NHS and internationally that having both *payment by activity* arrangements and *block* contracts in place does not create the most effective mechanisms to support co-ordinated, patient-centred, prevention-focused and sustainable care. For example, under this payment system funding must flow to acute providers as their activity increases. In a financially constrained system this means funding may need to be found from other areas of the system (e.g. primary and community care), where the system may otherwise wish to invest. Most health systems working toward transformation and increased accountability for patient outcomes have developed their own local payment system to better align incentives.

Examples of systems starting to form accountable care arrangements in UK

Type (from most to least formal)	Scope	Scale	Risk	Further details
Northumbria ACO: prime provider with full risk share	Health and social care inc. providers (acute, GPs, MH, LAs, ambulances	320,000 people Rural population	Full transfer of risk and responsibilities from commissioners to new provider org Function of CCG reduced	Region has historically strong integrated platform Model will focus on urgent and emergency care
Torbay and South Devon NHS FT: fully merged with some risk share	Acute, community and social care services	675,000 people Budget of £331 million 6,000 staff across 2 sites	Partners each share both underspending and overspending in according to different proportions	Result of merger between several health and social care orgs.
Symphony in South Somerset: corporate JV with some risk share (Outcomes 2.5%)	Secondary, community and primary care	Initially 1,500 people with multiple LTCs Will be expanded to full population of approx. 540,000	Proposed at least 2.5% (aligned with CQUINs) at risk for delivery outcomes increasing over time Further risk share plans to be agreed	JV has a single budget for the population and can delivery care across settings South Somerset is a PACS vanguard
Mid-Nottinghamshire Better Together: memo of understanding without risk share	Services in Primary, secondary, community and social care	310,000 people Budget of £340 million	Combined CQUIN to incentivise a joint outcomes framework	Signed MoU to work together through a strategic partner board and test a shadow capitated, outcomes-based contract
Working Together in South Yorkshire, Mid Yorkshire and North Derbyshire: loose part-nership, no risk share	Acute care only	2.3 million and 7 providers 15 hospital sites Approximately 45,000 staff	Pooled budgets in limited functions such as procurement	Seven trusts in North Yorkshire that pools funds for procurement and is driven through central programme executive

Source: built on work from McKinsey & Company, October 2016, but updated to reflect ongoing developments. Many of these schemes are currently being developed and we will track their progress, and reflect lessons learned as ELHCP payment development work progresses.

3.14. Within East London, contracts that have developed alternative payment arrangements to support transformation include:

- Tower Hamlets Community Health Services alliance contract, which brings together care across a number of locations, including hospital, community and GP care. Key developments include a new single point of access that is available 24 hours a day, seven days a week; better integration of adult and children services and a single patient record.

- Newham CCG is working closely with the provider based MSK Collaborative to establish a ring fenced contract for MSK activities. The providers will decide how resources are distributed between them. The new contract will provide for incentive payments, risk pools and efficiency savings. Providers have indicated that internal Collaborative transactions will operate on a mixed economy basis - i.e. some components will still comply with National Tariff rules whilst others will be forms that include the potential for block and tolerance[9] type agreement. Providers have the opportunity to minimise risks such as stranded costs via control of a risk pool that will be operated by the Collaborative. There is also an opportunity to link outcomes to this payment arrangement.

3.15. With both NHS and international examples of care transformation, most systems include the following elements as part of their payment systems:

i. Capitated payments[10]: Most NHS vanguard sites are planning to use capitated contracts with incentives or penalties linked to delivery of outcomes. In addition to the table above, NHS examples include Salford, Dudley, Stockport, Kent and Coastal, Sandwell & West Birmingham CCGs and others. Internationally, systems delivering patient-centred, coordinated care have generally used capitation, whether they be risk adjusted to mirror commissioner allocations or not[11].

ii. Outcomes or Incentive based payments:

- Payments linked to patient and population outcomes are a core component of successful systems because they more directly incentivise delivery of desired objectives. This can form a small but important proportion of the overall contract value. Although some areas have developed outcome frameworks, the scope of measures that will be linked to mature contracts has not yet been published by any vanguard area. Some (e.g. Mid-Nottinghamshire Better Together) base contract outcomes on process

[9] The tolerance element relates to elements of growth exceeding expected levels that are driven by higher than expected GP referrals. Further details are TBC as contract negotiations are ongoing.

[10] Capitated payment, or capitation, means paying a provider or group of providers to cover the care provided to a specified population across different care settings. The regular payments are calculated as a lump sum per patient. https://www.gov.uk/guidance/capitation

[11] https://www.kingsfund.org.uk/projects/supporting-new-nhs-care-models/key-choices-designing-new-systems; Struijs JN & Baan CA (2011). Integrating Care through Bundled Payments – Lessons from the Netherlands. N Engl J Med, 364:990-991. March 17, 2011.

measures in the short- term, but will move to patient and population outcomes in time.

- Clinical outcomes, for example the Quality and Outcomes Framework are useful to drive an initial change in behaviour, but can be unsustainable as providers rely on payments to continue that behaviour. Depending on outcomes measured, they can be complex to administer for little long-term gain.

iii. Risk-gain share: This can be used as a component of capitated budgets to manage uncertainty in volumes or flows of patients, or to drive specific changes in provider activity.

iv. Pooled budget arrangements between health and social care (e.g. Section 75[12]): These are a useful tool, already in place in most localities. On their own they are not sufficient to align incentives to promote whole population care. However, as part of addressing the wider determinates of health and wellbeing, it is important consider how payment for relevant care can support improved coordination between staff and improve outcomes for people and patients.

3.16. Any development of the payment system that designs incentives needs to take an objective approach to ensure those incentives are placed in the hands of those most capable of making a difference, rather than where it is most expedient. Such work will also need to consider how any payment flows between organisations may be managed appropriately. Alongside payment development evidence shows it is important ensure the relevant governance, reporting and data sharing arrangements are in place.

Considerations for local payment development

3.17. There is no perfect payment system. In practice local systems need to work together to design payment options that work best for their area. Different types of payment are useful to support different system objectives. The table below illustrate the strengths and weaknesses of different approaches explored above.

[12] Section 75 of the NHS Act 2006 gave PCTs and local authorities legal powers to enter into integrated and lead commissioner arrangements. Where lead commissioning arrangements are in place, commissioning duties are delegated between organisations, and one organisation leads on behalf of the other(s) to achieve a jointly agreed set of aims. The lead commissioner is responsible for commissioning the agreed scope of services, within the relevant budget, and for entering into contracts with providers. Governance of integrated or lead commissioning arrangements are typically set out in a section 75 agreement (along with arrangements for pooled budgets).
https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Options-integrated-commissioning-Kings-Fund-June-2015_0.pdf

	Mechanisms			
	Fixed period of time	Population	Activity	
Impact on...	**Block funding**	**Capitation**	**Episode of care**	**Fee for service**
Increase activity	✗	–	✓	✓
Cost control	✓	✓	✓	–
Primary prevention	–	✓	✗	✗
Secondary prevention	–	✓	✓	–
Care pathway coordination	✗	✓	✓	✗
Person Centred Care	–	✓	✗	✗

Source: based on work from McKinsey & Company

3.18. Payment for outcomes can apply to any of the above payment types.

3.19. It is possible to meet system objectives using the current payment system through local variations to tariff for given services. Local providers and commissioners have already developed a range of 'work around' payment and service solutions for specific types of care. However, without a strategic and coordinated approach to payment across a local health and care system there is a risk that special contract agreements and a proliferation of modifications to service models will lead to increasingly fragmented and incoherent incentives across the system as a whole.

3.20. Any payment development work will need to consider how to support patient choice as part of its objectives. Contract forms for such arrangements can include (i) the commissioner carving out an amount for patient choice from the whole population budget, which is then used to pay out of area providers; or (ii) the identified amount being managed through a prime provider, sub-contractor arrangement – although the latter would require transparent arrangements to address the potential financial conflict of interest. With either arrangement, the amount would be based on an estimated volume of patients. Overspend could be addressed through a risk pool arrangement, however there would be an incentive for providers to maintain and improve quality to encourage patients to choose their service. Analysis based on Service Level Agreement Monitoring (SLAM) data for 2015/16 shows that 87% of total spend on acute tariff-based services within ELHCP is commissioned from providers within the ELHCP footprint.

3.21. Evidence suggests that payment mechanisms that are less complex in structure are easier for all people in the system to understand and react appropriately to. Decisive steps should be taken to minimise complexity, both to enable greater transparency and reduce the bureaucracy associated with a burdensome set of rules and processes.

3.22. Given the challenges the NHS now faces, and the experience of other areas that have implemented reform, there is a strong case to review payment mechanisms to support greater coordination and a patient-centred approach to care.

Question 3: What does your organisation want out of the payment system?

Question 4: What payment elements do you consider are most important to meet agreed ELHC objectives?

Question 5: What payment options do you, as partners in ELHCP, want to explore further?

4. Service model, system organisation and pace of change

This section covers:
- Options for contracting and organisational form
- Scope and scale of service design and payment
- Exploration of the possible 'pace of change'

Question 6: Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?
Question 7: What geographic footprint is appropriate for payment: CCG level; City & Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?
Question 8: What services would be included in a new payment approach?
Question 9: What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?

Options for organisational form

4.1. This consultation is not about organisational form. However, there is an intrinsic link between organisational form and development of a contract form to support it.

4.2. Successful coordinated systems can operate using a range of contractual forms. An 'accountable care system' can operate under one single organisation or, alternatively, governance structures can enable different organisations to operate in a coordinated way. Below is a spectrum of options.

4.3. When considering contract arrangements it will be important to agree the scope and scale of services, as well as what units payment is linked to and what provider(s) payment covers.

4.4. *Scope of payment*: There are two elements to consider

- Setting a 'whole population' scope for payment supports a person-centred approach to care, in which no specific condition or disease is singled out. The rationale for this is that it enables a focus on specific segments of the population, not disease pathways, in order to reinforce and encourage integrated working. This offers less complication about when people transition in and out of a pathway and encourages early intervention and management of conditions. Categories could include: Adults with complex needs, children with complex needs, mostly well adults, mostly well children, older adults, under-5 children, etc.

- Setting a condition based approach, for example MSK services or diabetes care can encourage joint working of providers along a limited care pathway. It may not support integrated care for people with multiple conditions.

4.5. *Scale of payment:* A key consideration for payment development is around geographic scale. Scale could be set in a way that is coterminous with local authorities, i.e. at a CCG level, this would support integration with social care. If the focus is to enable better integration between acute and community services, a wider scale footprint may be more appropriate, for example across i) Waltham Forest, Newham and Tower Hamlets; ii) Barking Havering and Redbridge, and iii) City and Hackney. For some care needs it may be appropriate to consider a single payment approach for the whole ELHCP footprint. This can enable discussions about service configurations across geographies to make the most of resources and capabilities across provider organisations.

Question 6: Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?

Question 7: What geographic footprint is appropriate for payment: CCG level; City and Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?

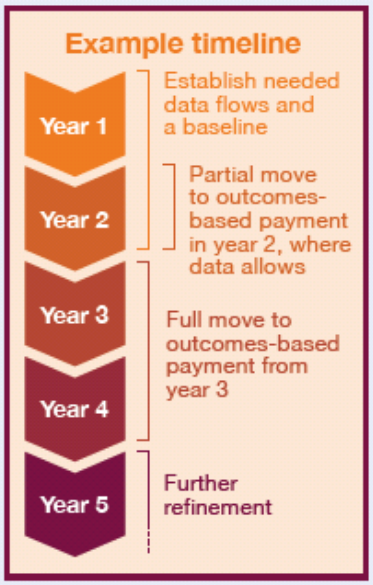
Question 8: What services would be included in a new payment approach?

Considerations for pace of change

4.6. The move to a new way of paying for care does not need to happen via a 'big bang'. Most areas that have introduced changes to payment system have done so via an incremental approach, and taken an evidenced based approach to selecting and testing options. A key first stage will be to get data and information in place – outline what type of data is needed (both the minimum needed to support our objectives, and ideally what data we would like to have).

4.7. System partners work together to understand and improve baseline data, and consider evidence about (i) opportunities for service development and/or improve use of resource within existing services; and (ii) implications on the system of different payment methodologies.

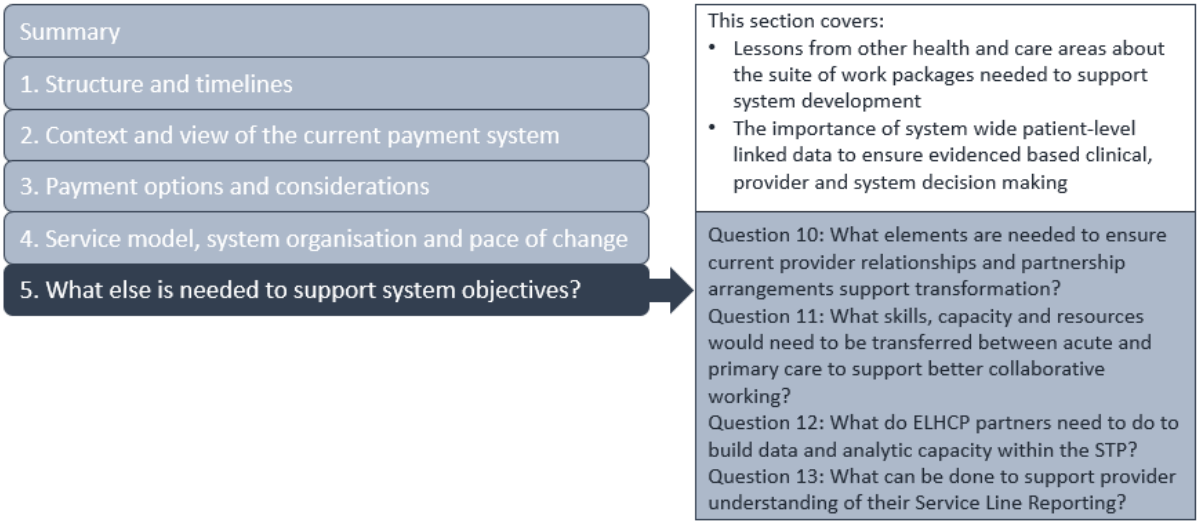
4.8. Experience from other areas shows that this initial stage is a vital step toward achieving transformation. This also shows that the relationships and ways of working established when organisations are committed to the process can be as important a lever for change in local systems as the payment, contracting and governance mechanisms that are developed out of that work. However, that development stage requires real commitment and leadership from all partners as well as continual active cooperation in the development process.



Source: NHSI overview based on Oxfordshire & Cheshire & Wirral

Question 9: What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?

5. What else is needed to support system objectives?



Lessons from other health and care systems

5.1. A number of components are needed to support and enable change within the health and care system. A common vision, good quality data and information (one version of the truth) and structures that allow people in the system to work together to solve collective problems are all essential.

5.2. Experience from other health and care systems show the following elements are needed:

- *An understanding of patient and population needs*. For example, in Somerset the Symphony project Accountable Care Organisation acts as the 'engine room', providing data analytics to inform population segmentation, carry out risk stratification (in terms of need and cost), and inform service redesign.

- *Good quality data and information* to inform system-wide decision-making as well as provider actions and the activity of front line staff. Practical examples of where this has worked include Northumberland Tyne and Wear NHS Foundation Trust and Group Health, who operate a closed insurer and provider system in the USA. In both cases, they invested in developing data over time and used this to inform services and care, understand their impact on patients and support continuous improvement using data in an active dialogue led by clinicians.

- *Patient and public feeding into goal-setting and decision-making*. For example, commissioners and providers in Oxfordshire developed an outcomes based commissioning model for adult mental health, which was co-developed with experts-by-experience and third party sector partners. The framework is based on a capitated payment approach linked to outcome measures.

- *Governance assurance tools for cross-boundary working* for safe, high quality care. These give public and providers assurance that safety and quality will not be compromised, and could include:
    - monitoring progress of system goals;
    - monitoring performance of organisations within the accountable care system;
    - infrastructure and planning to raise issues early to deliver services more effectively;
    - aligning assurance across health and social care; and
    - links with others outside the local system (e.g. London Borough Councils, voluntary sector, housing authorities and the education sector if they are not formally part of the accountable care system).

- *Professional working arrangements* across organisational boundaries. This includes setting out routes to develop innovations in care pathways using new technology, skill mix and care delivery.

- *Escalation and dispute resolution routes.* Lessons from Hudson Headwaters Health Network in the US suggest it is important to acknowledge that partnership working is challenging. This includes identifying issues that may arise in a partnership environment, and having mechanisms set up in advance to manage quality issues and disputes.

- *Funding flows that reduce barriers* to front line staff being able to deliver efficient care in a person-centred way. This needs to be supported by complementary organisational structures. It means avoiding overcomplicated management and payment forms. Supporting teams and giving permission to be more innovative and have a greater degree of ownership and using mechanisms that reduce patterns of behaviour that add limited value.

Question 10: What elements are needed to ensure current provider relationships and partnership arrangements support transformation?

Question 11: What skills, capacity and resources would need to be transferred between acute and primary care to support better collaborative working?

Getting the infrastructure right, whatever option is chosen for payment

5.3. Based on the evidence above, it is clear that further investment and development is needed to support a system-wide data and analytic function in ELHCP. The aim of this function is to:

a. *Support clinical decision making* - enable continual improvement and best use of resource from front line staff (e.g. adoption of a learning system approach)

b. *Support providers* to manage and monitor performance and resource-use as well as identify (and act on) opportunities to improve care. To do this, providers need to understand outcomes for people in their care, their activity and costs at a granular level and how these relate to resource utilisation.

c. *Enable system management* and improved strategic commissioning to support health and wellbeing across health and care systems - including constructive, evidenced-based discussions on care and quality improvement

5.4. Learning from successful transformation work shows these elements are needed to support analytics and system intelligence:

- *Patient level data* is key to supporting sophisticated system intelligence and clinical decision making. It enables us to track people through care pathways and understand the impact of their interactions with the health and care system.

- *One version of the truth*, where all organisations have access to consistent data and analytic outputs and have the same understanding of where issues and opportunities lie.

- *Use of advanced statistics and analytics* help us understand patterns and correlations. Retail and other sectors have used this for years and it is time for health organisations to make better use of the information we have. NHS England has kicked off a tender process for common specifications and procurement of business intelligence and analytics across London. Data and analytics is a critical part of the work to develop payments and support system development. Therefore, comments on analytic needs are sought as part of this engagement process, which will help inform ELHCP analytic development as well as any London-wide efforts.

- *Patient and population engagement at scale.* As commissioners and providers, we need to complement the data and information within the health and care system with patient and population voices via the appropriate forums and representative groups. This will add depth and understanding to data outputs and offer input to shape analysis undertaken.

- *Patients and carers able to readily access and enter their own details*, to support public engagement and people's ownership of their care. People are used to this with other services and will increasingly demand this from health and care, it also provides valuable information to inform diagnosis and care[13].

Question 12: What do ELHCP partners need to do to build data and analytic capacity within the STP?

Question 13: What can be done to support provider understanding of their Service Line Reporting?

[13] Example: Salford, where partners are working on a new integrated care model with personal health data. http://www.cbrgovernment.com/healthcare/salford-nhs-trust-improve-services-data-analytics-control-centre/

Annex: ELHCP Payment Development Consultation - questions

Below are the thirteen questions asked in this consultation document. This list allows easy access to all questions in a single place and can be copied into another document to help frame your organisation's written response to this consultation. **The deadline for written responses is 18:00 Friday 29 September 2017**. This has been extended from the original deadline of 4 September.

Consultation questions

1. What are your top five priority areas relating to the payment system to support better outcomes for patients across the system?

2. In your organisation's view, how does the current payment system support and inhibit attainment of system objectives?

3. What does your organisation want out of the payment system?

4. What payment elements do you consider are most important to meet agreed ELHCP objectives?

5. What payment options do you, as partners in ELHCP, want to explore further?

6. Is it best for payment to cover populations based on a person-centred approach or disease/condition specific approach?

7. What geographic footprint is appropriate for payment: CCG level; City and Hackney/Waltham Forest, Newham and Tower Hamlets/Barking and Dagenham, Havering and Redbridge; or across the ELHCP footprint?

8. What services would be included in a new payment approach?

9. What steps are needed to secure this type of buy-in and practical engagement among all ELHCP member organisations?

10. What elements are needed to ensure current provider relationships and partnership arrangements support transformation?

11. What skills, capacity and resources would need to be transferred between acute and primary care to support better collaborative working?

12. What do ELHCP partners need to do to build data and analytic capacity within the STP?

13. What can be done to support provider understanding of their Service Line Reporting?

ELHCP Payment Development Work

September 2017

Ian Tompkins, Director of Communications & Engagement ELHCP

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Background

- ELHCP wants to enable more collaborative working across the system, with providers, commissioners and other partners working more jointly to deliver system wide benefits for our populations.

- To do this it must address cultural and structural barriers to achieving this (including the way funding currently flows around the system).

- This requires a different approach to contracting and a move away from the traditional commercial objectives of organisational bottom-line to more effective system wide resource use.

- The April ELHCP Board commissioned the Financial Strategy Committee (FSC) to develop a consultation on payment development, with a sub-group established to develop the materials, consider the technical aspects and drive the process at an operational level, reporting back to the FSC.

Consultation and engagement process

- The initial consultation and engagement period began on 11 July and will close on 29 September.

- We are inviting written responses from all organisations in the ELHCP as well as clinicians, other health and care professionals and front line staff, finance managers, councils, patients and the public.

- The following workshops have taken place:
  - Patients, carers and public (20 July)
  - Clinical, care professional and front line staff (25 July)
  - Senior executives and directors (27 July)

- Further workshops are planned in September
  - Contracting professionals (12 Sept)
  - Clinical, care professional and front line staff (20 Sept)
  - Senior executives and directors (21 Sept)

Overview of consultation paper


East London Health and Care Partnership:
Consultation on payment development and drivers for change
Page 48

- Provides an overview of different payment approaches, and notes how payment development has been used in other areas to support improved patient care and development of Accountable Care Systems.
- Highlights other work and process that are needed to complement successful payment development.
- It also
  - Notes challenges, system objectives and the wider context the health and care system is working in
  - Outlines pros and cons of current payment system
  - Offers examples of service models, system organisation and pace of change

Proposed milestones for consultation process

	Milestone	Timing
1	Publish consultation paper	11 July
2	Series of workshops to kick off discussion and gather input	Late July
3	Discuss payment approach with boards, committees and steering groups across ELHCP (including Health and Wellbeing Boards)	July- end September
4	Hold further set of workshops	Mid/late September
5	Closing date for written feedback from organisations and individuals	29 September
6	Review responses and share themes and messages with ELHCP committees and partner forums	October-November
7	Agree timelines for next stages of work and develop options for payment and contracting based on written feedback, verbal feedback and ELHCP governance group discussions	November
8	Begin testing new approaches to payment	April 2018
9	New payment system in place	April 2019

Page 49

d TBC

Proposed TBC

These are milestones and not an exhaustive list of tasks...

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Inner North East London (INEL) **Joint Health Overview and Scrutiny Committee** 6th September 2017 **Single Accountable Officer for East London Health and Care Partnership**	Item No **5**

OUTLINE

The East London Health Care Partnership (ELHCP) is proposing to create a Single Accountable Officer (SAO) for the 7 CCGs in the North East London STP area.

This paper sets out the details of these proposals for consultation with the INEL JHOSC.

Reasons for Urgency

The ELHCP were not able to provide the reports for this agenda item in time for publication as they are waiting on them to be agreed by the CCG Chairs. This item will still be heard at the INEL JHOSC meeting as a decision on whether to accept the proposal to create a SAO will be taken by the CCG governing bodies on the 13th September, and the Committee needs to be consulted on these proposals before this date. The papers will be published as soon as they are available.

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

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