

# HEALTH AND WELLBEING BOARD

6 September 2017

<b>Title:</b>	<b>Response to the East London Health &amp; Care Partnership's Consultation on Payment Mechanisms</b>
<b>Report of the Deputy Chief Executive and Strategic Director for Service Development and Integration</b>	
<b>Open Report</b>	<b>For Information</b>
<b>Wards Affected: All</b>	<b>Key Decision: No</b>
<b>Report Authors:</b> Mark Tyson, Commissioning Director, Adults' Care & Support	<b>Contact Details:</b> 020 8227 2785 mark.tyson@lbbd.gov.uk
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive, and Strategic Director for Service Development & Integration	
<b>Summary:</b> <p>On 11 July 2017, the East London Health &amp; Care Partnership (the new name for the partnership formerly referred to as the Sustainability &amp; Transformation Plan partnership) launched a consultation on future payment mechanisms within the NHS. The document is attached and introduces the need for reform and some of the key considerations. A response is required by 29 September 2017, which is an extended deadline to accommodate this (and other) formal Board meetings.</p> <p>The proposals set out by the ELHCP in their consultation document, whilst quite generalised at this stage, are broadly consistent with the work that has been undertaken across Barking &amp; Dagenham, Havering and Redbridge to scope the development of accountable care approaches. In particular, the Business Case for the development of an Accountable Care Organisation, completed in late 2016, covered much of the same ground in setting out the case for change. Currently organisations in the health and care system are driven by the competing requirements of their commissioners, and therefore new payment arrangement need to drive a focus on the outcomes needed for residents and patients, rather than payments for episodic and unconnected care.</p> <p>The proposed content of a response is included in this report, and the Health &amp; Wellbeing Board is invited to discuss it, make amendments, and ultimately to agree to delegate to the Chair to approve the final text of the submission.</p>	
<b>Recommendation(s)</b> <p>The Health and Wellbeing Board is recommended to:</p> <ul style="list-style-type: none"><li>(i) Note the consultation;</li><li>(ii) Review and amend the outline response, and add in any further matters for</li></ul>	

consideration.

- (iii) Delegate authority to the Chair of the Board to approve the final response on its behalf for submission by the deadline of 29 September 2017.

**Reason(s):**

If we are to improve how well the health and care system prevents ill-health, promotes well-being, and joins up the care received by residents, then we will have to make some changes to how individual organisations are contracted and paid. These payments form incentives to behave in certain ways (attracting episodes of care, rather than responding more fully to the needs of an individual, for example). Working across organisational boundaries can only really happen when financial incentives are aligned to the outcomes that are wanted.

## **1. Introduction and background**

- 1.1. The Strategic Outline Case that was prepared in November 2016 set out a way forward for health and social care in Barking & Dagenham, Havering and Redbridge, and was submitted to inform the London Devolution Agreement, which is still awaited. Amongst the devolution ‘asks’ was a concise summary of the problems which a reform of payment mechanisms are intended to address:

*“Our contracting and commissioning structures are fragmented and do not enable or support integrated working. Currently most of the resource in the system is weighted toward treating people when they become unwell, with significantly lower investment in preventing people from becoming unwell in the first place. Similarly, contracts for services are based on activity rather than outcomes, creating artificial and perverse incentives which pay for services based on the number of people that they treat, as opposed to the experience and outcomes of those that receive them. By changing the way in which we commission and contract for services, and pooling the resources and expertise of commissioners and local authorities, we would be able to utilise greater budgetary flexibility to enable financial incentivisation and prioritisation that more accurately responds to local needs.”*

- 1.2. This is explored in greater detail in the proposals set out by East London Health & Care Partnership. As a local ‘STP’ footprint, the ELHCP has a weight behind it which can carry negotiations with regulators and the NHS centrally, to support the reforms which the local system requires in order to better serve local people. Whilst the shape of local commissioning and payment arrangements will need to be tailored to support the ambitions of the BHR system, it is nonetheless therefore important that ELHCP are part of shaping the options available.
- 1.3. At this stage, the ELHCP is not proposing any specific options for changes to the way services are contracted or how they receive payment for the services that they provide to residents. It is exploring the need for change, and seeking views on how that change might best serve local needs. At this stage, therefore, much of what the BHR system may want to explore has been set out in general terms in the Strategic Outline Case. It is proposed that the response to the consultation from Barking & Dagenham re-emphasises this.

- 1.4. Given this, and given the work that is underway in BHR on these issues, it is not proposed that the individual questions posed by the consultation be answered in turn.
- 1.5. It is worth noting, for the sake of clarity, that this is not a consultation about changing how or whether individuals should pay for health and care. It is solely concerned with how the public money to pay for health and care services is packaged up and given to providers in return for the services that they provide to residents.

## **2. Elements of a proposed response**

### **General recognition of the need for change**

- 2.1. The drivers for change set out by the ELHCP are in accord with those set out in the work to develop the case for an Accountable Care Organisation. Currently a programme is being developed to better align commissioning across the BHR system, as well as providers working together on how to take a greater shared responsibility for achieving what residents need from health and care services. This has been subject to a number of updates to the Board over the past year or so, and it is proposed to refer in the response to ELHCP to this emerging work.
- 2.2. Fundamentally, there is no disagreement on the principle that tariff-based payment mechanisms, as currently exist, need to change if we are to increase prevention and move away from fragmented and episodic care delivery.

### **Governance and timing**

- 2.3. The Board may wish to consider taking this opportunity to raise a question about how the consultation has been approached. It is welcome that the borough partners – the Council and CCG – have been invited to respond to the consultation, but this raises a concern that the ‘system’ governance that has been created for BHR has been sidestepped. Given there is a BHR Integrated Care Partnership Board, with democratic and clinical leadership, in time it may be more reasonable to expect partners’ contributions from the BHR patch to be routed through this mechanism. It has been highlighted before that there is a local focus on the BHR system as the means of delivering the shared aims of the ELHCP, and to open up two lines of discussion between individual partners and a level of ‘system governance’ would not be helpful or productive. It is proposed that the consultation response re-emphasises Barking & Dagenham’s commitment to the BHR system for the continuance of these conversations, and encourages ELHCP to engage with the BHR mechanisms accordingly.
- 2.4. Question 10 asks what elements should be in place to ensure current provider relationships support transformation. It is again proposed that Board identify that current plans in BHR are, in principle, for strengthening joint commissioning and for providers to lead collaborations that prioritise outcomes for residents and patients over the current organisational silos. Therefore, ELHCP may be encouraged to ensure their own approaches to provider alliances or new commissioning structures should be created to support, not duplicate or shadow, the emerging BHR systems.

## **Localities**

- 2.5. The backbone of the programme for reforming health and care delivery, in Barking & Dagenham and the BHR system more widely, is the integrated locality arrangements. Currently three localities exist, with a fourth to follow in coming years as the population expands. These are the focus for bringing together a range of social care, community health and primary care services, to meet the needs of both the general population and those with higher levels of health and care need. It is suggested that the localities are referred to as a response to those questions seeking to identify priorities for new payment mechanisms. New 'capitated budget' approaches have been suggested as ways in which locality partnerships might take greater shared responsibility for driving preventive and joined up care, and therefore payment needs to reflect that this is our shared ambition.
- 2.6. In particular, question 7 asks about the geographic footprint for payment systems: a restatement of the longstanding agreement about 'subsidiarity' would again be appropriate. Payment mechanisms should support locality delivery, maintain borough accountability, and be shaped and drive through the BHR system. Where the ELHCP can add specific additional value, they have a role as part of that delivery chain.

## **Services in scope**

- 2.7. It is suggested that, at this stage, the question about services in scope be deferred until the work being undertaken to support joint commissioning and provider collaboration in BHR is at a more advanced stage. As in that work, the Board may simply wish to respond that nothing should be excluded until there is a case identified for excluding it from any new approaches to paying providers for the services that they deliver.
- 2.8. One point that it would no doubt be worth absolutely emphasising in any response, is that a payment mechanism must be able to reward preventive activity, rather than continuing to compensate for reactive care processes. This is the fundamental aim of the programme. This will mean, therefore, that traditional views of 'services' or 'pathways' have to be rethought to identify the opportunities for prevention that are currently missed. Taking it to its furthest conclusion, this may well extend to services that are currently peripheral to the health and care system, but absolutely central to health improvement and the prevention of illness, such as housing, leisure, welfare and employment support.
- 2.9. A further helpful refinement to the approach may also be to consider not only who is paid, but who pays. The starting assumptions read strongly as NHS system payments. Local authorities and other partners also pay for elements of service (weekly price-based contracts for residential care, for example, or hourly homecare contracting) and there is an opportunity think anew about how to contract such services when purchasing for broader service user outcomes together with health commissioners.
- 2.10. The question of 'who pays' is made more transformational still when the resources are given to the service user or patients as a personal budget or personal health budget, and the market is further opened up to what are currently 'non-standard' options. This has the potential to harness or stimulate individuals' willingness to take control of their own health and wellbeing, including with digital health and

wellbeing self-management tools and other alternatives to dependence on current service models.

### **Questions about data and analytical capacity**

- 2.11. A set of questions at the end of the consultation explore issues of data flows and the capacity to manage any new system of payment.
- 2.12. In terms of system development, the Local Digital Roadmap has been in on-going development for some time, to shape the data and record management system needs for a more integrated and responsive health and care system. The questions which are raised about data capacity ought to be resolved through that workstream. The Board's response may be to suggest that this be referred back to the respective leads in each of the health and care systems for their consideration, and for each of them to raise common issues which the ELHCP may be in a position to help resolve.
- 2.13. On a specific point, it has been noted in a number of forums locally that the East London Information Sharing Agreement is now quite old (dating back to around 2004-2007). Whilst it remains serviceable, and there continues to be Service Specific Information Sharing Arrangements created under its terms, general good practice would suggest that it may be opportune to review it and ensure that it supports the information governance arrangements of the work that all of the health and care systems are doing or planning. That would seem to be a clear example of a piece of work that could usefully be led across ELHCP.
- 2.14. On the subject of analytical capacity, again the Board may wish to consider whether the response should be to draw the ELHCP into supporting the development of shared analytical capacity within the BHR (and neighbouring) health and care systems, rather than planning the creation of capacity at ELHCP level. The complexities of planning for population health improvement and more outcomes-focused payment mechanisms will require considerable resource, and if it is to be assumed that there is not the available resource to double this up at both BHR and ELHCP level, then the points made above would all suggest that the priority should be on supporting the ambitions laid out in BHR.

## **3. Mandatory implications**

### **Joint Strategic Needs Assessment**

- 3.1. Currently organisations in the health and care system are driven by the competing requirements of their commissioners. New payment arrangements need to drive a focus on the outcomes needed for residents and patients, rather than payments for episodic and unconnected care. The Board's response to this consultation can capture this.

### **Health and Wellbeing Strategy**

- 3.2. Barking and Dagenham's Joint Health and Wellbeing Strategy identifies 'improvement and integration of services' as a priority theme. The creation of new, effective payment arrangements may forward this priority, and the wider agenda of health and social care integration in Barking and Dagenham.

## **Integration**

- 3.3. The creation of new payment arrangements could unify the driving motivations behind services, forwarding the ambition of the ELHCP, and delivering further health and social care integration.

## **Financial Implications – completed by Katherine Heffernan: Group Manager, Service Finance**

- 3.4. There are no financial implications directly arising from this report.

## **Legal Implications – completed by Dr. Paul Feild Senior Lawyer**

- 3.5. The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. In addition as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The Health and Well-Being Board terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated manner. As part of that role it has an expectation that it is consulted on potential changes to health provision within the Council's area.
- 3.6. The function of this report is to seek observations on a consultation document on payment mechanisms the East London Health & Care Partnership may adopt for its accountable area. The consultation document is detailed with some complex and interlinked issues. These will need to be fully considered and reflected upon. Furthermore the timescale is short. It is important that the Boards voice is heard and so this report therefore recommends that the Board delegate to the Chair of the Board informed by professional advisors and practitioners, making the Boards response to the consultation.

## **Safeguarding**

- 3.7. n/a

## **List of Appendices:**

**Appendix A:** Payment Development Consultation – 11 July 2017

**Appendix B:** ELHCP General Update – September 2017

**Appendix C:** Transformation Priorities July 2017

**Appendix D:** What ELHCP is doing and what it means

**Appendix E:** ELHCP STP Governance Structure