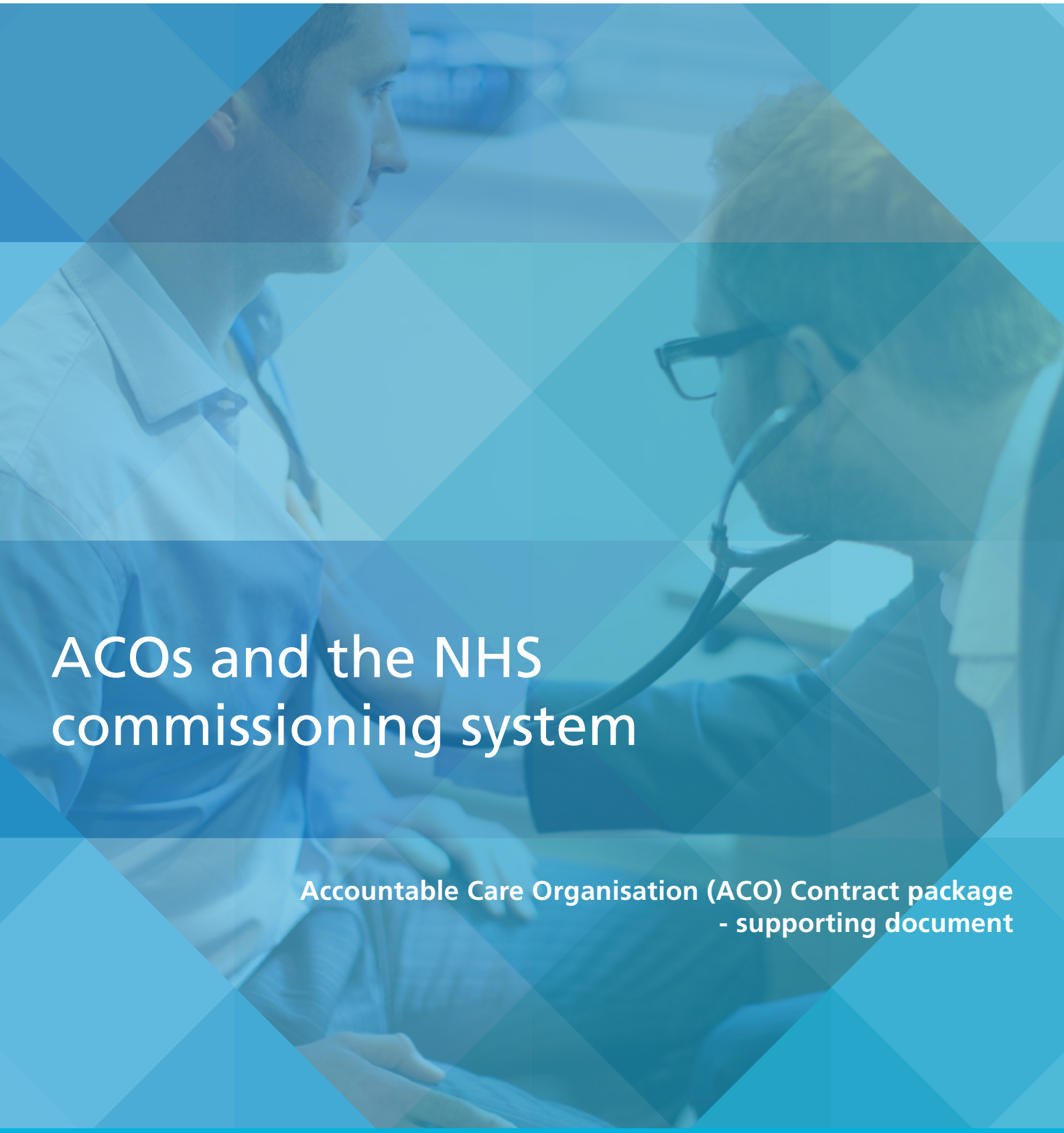
New care models



ACOs and the NHS commissioning system

Accountable Care Organisation (ACO) Contract package - supporting document

Our values:
clinical engagement, patient involvement, local ownership, national support

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Introduction

1 The establishment of Accountable Care Organisations (ACOs) will have implications for CCGs. While some ACOs may lead to a shift in the activities of both providers and commissioners, they will not remove the established boundary between commissioning and provision. CCG statutory functions will not change.

2 While CCGs' role will continue to evolve, there will remain a need for an effective commissioning function in the NHS. This includes acting as funder, setting local priorities and incentives to ensure that the needs of local patients are met, oversight of contracts, ensuring best value for the taxpayer, and ensuring the provision of a comprehensive local NHS within the available resources. CCGs need to ensure that they have the capacity and capability to continue to discharge their functions once an ACO is established.

3 This paper describes some implications for CCGs of setting up an ACO. It:

- **a)** describes how CCGs will continue to be responsible and accountable for the delivery of their statutory duties and powers;
- **b)** defines CCG activities and suggests criteria that CCGs may wish to use in making judgements about the activities that may be passed to providers of ACOs; and
- **c)** sets out the legislative framework for pooling budgets

Statutory functions

4 Legislation sets out:

- **a)** the statutory duties of CCGs – the 'must dos' that they are legally responsible for delivering; and
- **b)** the statutory powers of CCGs – the things that they may do.

5 In this paper we use the term function to describe these statutory duties and powers. In total there are c.215 functions.

6 A list of CCG functions from 2013 is available at: https://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf

Activities

7 CCGs will continue to be responsible and accountable for the delivery of their functions. They have the flexibility to decide how far to carry out activities related to these functions themselves; including in groups (e.g. through lead CCG arrangements); or through external commissioning support. They may also require, through contract provisions, an ACO provider to take action to support the discharge of certain CCG duties (e.g. to reduce inequalities or ensure patient choice). However, in all these instances the CCG will retain responsibility for its functions. These cannot be delegated. As part of the process of establishing aan ACO, CCGs will need to assure themselves and NHS England of their ability to discharge their statutory functions.

8 In making judgements about the activities that may be carried out by providers of ACOs, CCGs may wish to use the following criteria:

i) Consider whether the CCG must carry out the activities related to the discharge of a particular statutory function directly. For example, whilst all providers need to have in place arrangements to deal with complaints, so too must CCGs. Similarly, a CCG has a responsibility to produce an annual plan setting out how it proposes to exercise its functions. It cannot sub-contract this to a provider.

ii) The CCG should be mindful that any activities undertaken by the ACO provider will only relate to services provided by the ACO provider and that if those activities need to be taken in relation to services for other patients or care pathways delivered by another provider, the CCG will need to retain the capacity to carry out or procure elsewhere the activities needed to commission and oversee contracts for these services.

iii) The CCG should ensure that an ACO provider is able to undertake activities necessary to carry out their role and to enable the CCG to fulfil its functions. For example, if a provider is given a whole population budget it will need to have a clearly defined remit within its contract setting the parameters within which it may spend that budget and the flexibilities it has within those parameters.

iv) The CCG should ensure that it has the resourcing capacity and capability to fulfil (i) and (ii) above, particularly where some CCG staff may be transferred to a new provider.

9 CCGs and ACO providers should maximise opportunities for making shared use of administrative resources. For example, creating and operating successful ACOs will require a new set of information management and analytical approaches by both CCGs and providers. These include population-level predictive analysis to monitor care patterns, assess adherence to protocols and best practices, and to anticipate future needs. CCGs and ACO providers should look at how they might work together to develop a shared business intelligence capability rather than invest in potentially more costly separate functions. The same applies to other back-office functions e.g. payroll.

10 The Contract will stipulate some requirements of the ACO which will include:

- the requirement to conduct a population health needs assessment and to develop strategies to improve the health and wellbeing of the population;
- the requirement to seek to address underlying health inequalities;
- the need to put in place information systems and risk stratification; and
- obligations to offer patient choice, including choice of primary care provider.

11 CCGs may want to consider whether the establishment of an ACO means that it would be appropriate to pool functions and management arrangements with neighbouring CCGs. This may be the case where an ACO provider (MCP or PACS) covers the entirety or bulk of the CCG area; and where key CCG staff and capability will transfer to the new provider. In some cases the CCG may want to consider merger with another CCG. The requirements and procedures for CCG mergers are set out in Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution (https://www.england.nhs.uk/wp-content/uploads/2016/11/guidance-constitution-mergers-dissolution-nov16.pdf). However, regardless of transfers, pooling arrangements or constitutional changes, as explained above the CCG will retain responsibility for performance of CCG functions and there must be sufficient CCG resources and systems in place to perform these functions.

12 The shift in some activities from the CCG to the ACO provider may mean that changes are required to existing CCG governance structures. We will continue to work with the intensive sites to further consider these consequences.

13 NHS England will look for assurance from CCGs that their future arrangements are robust and viable, in line with the CCG Improvement and Assessment Framework. The Integrated Support and Assurance Process (ISAP) for novel and complex contracts will support CCGs to run effective procurements and manage system risk, where new and complex contracts, such as those for ACOs, are used[1].

14 We worked with vanguards to consider how providers of ACOs currently intend to undertake activities that are currently undertaken by CCGs, in order to manage whole pathways of care and a capitated budget. A summary of that exercise is attached at Annex A and is provided as an aid for local judgement. We are extending this work to cover different care models.

15 Separately, we are working with the Local Government Association (LGA) and local authorities in the vanguard sites on how local authorities can participate in the commissioning of a whole population integrated health and care provider. To support this work, NHS England is funding local authorities to obtain generic legal advice which will in part assess how the Contract may need to be adapted when local authority funded services are in scope. Our work with the LGA and local authorities will consider areas including how local authority functions could be discharged through the commissioning of an ACO, how funds can be brought together to provide flexibility for providers, and how local authorities could participate as providers. Our ultimate goal is to ensure the Contract and business model supports the effective delivery of a whole health and care system, and we aim to publish the outputs of this work later in 2017.

1 Further information can be found at: https://www.england.nhs.uk/resources/resources-for-ccgs/#isap.

Pooled budgets

16 The establishment of ACOs will require the provider to deploy its integrated budget flexibly. To enable this, CCGs may need to allocate a single or pooled budget to ACO providers.

17 The current legislation under the NHS Act 2006 enables some NHS bodies to establish pooled budgets across NHS England and CCG functions. In particular circumstances it also allows for the pooling of budgets together with local authorities and/or combined authorities. However the legislative mechanism by which funds may be pooled, and the partners involved in that are different, depending on the specific function and bodies involved. This means that commissioners of ACOs may choose to structure their arrangements in a variety of ways, depending on what they want to achieve. Annex B describes how different commissioning structures can commission different configurations of services.

18 As can be seen from Annex B, the current legislative framework for pooling budgets potentially poses some challenges for the ambitions of ACOs. NHS England has developed evidence to support discussions with the Department of Health about changes to the s.75 arrangements in order to enable the pooling of budgets for all services delivered by an ACO provider.

ANNEX A
Commissioning activities

This list is not a comprehensive statement of CCG functions and activities. It is intended to provide a prompt for local discussions about the split of activities between the CCG and an ACO.

Activity/function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Strategic planning		
Assessing needs		
Population needs assessment	The Joint Strategic Needs Assessment, and other needs analysis and horizon scanning, should be used to provide an understanding of population needs and expectations. Needs assessment should involve clinicians, patients and the publicand should compare population data on outcomes and need against relevant benchmarks and best practice, and include an understanding of environmental and social factors as well as patient preferences.	Yes, the ACO should play a key role in providing evidence/data and in contributing to the final assessment and priorities that emerge. The ACO will also need to conduct its own needs analysis to perform its contractual obligations efficiently and ensure that services are centred around the needs of the patient. This is likely to feed into the CCG's formal strategic needs assessments.
Resource allocation and priority setting		
Commissioning: i.e. arranging for the provision of services to meet the reasonable needs of people for whom the CCG has responsibility; promoting the NHS Constitution in doing so.	Deciding how best to meet the health needs of the population served and what is required e.g. deciding on whether to commission a new model of care, what the new model of care should include, and what flexibilities the provider of the new model of care should have as to the way in which services are delivered.	No The ACO cannot 'commission' but is able to subcontract services to meet the health needs of the population it serves.

Activity/ function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Resource allocation and priority setting		
Allocating CCG-level resources	Deciding how to use the CCG budget in order to deliver the best outcomes for the population served. This includes setting the whole population budget for the ACO and allocating resources to services not provided by the ACO and for patients not covered by the ACO.	The ACO will have flexibility to deploy its whole population budget in order to deliver the outcomes detailed in its contract, within the parameters specified in that contract and ensure that its allocation is used in an effective, efficient and economical way to deliver patient-centred services.
Mandated expenses	Responsibility for ensuring that funding is provided for any in-year commitments made by the government or NHS England.	Yes, ACOs could have a role in flowing down mandated expenses to subcontractors.
Procuring services		
Designing services		
Annual commissioning plan	Each CCG must publish an annual plan setting out how it proposes to exercise its functions.	No.
Strategic planning of services across the CCG patch	Taking a holistic view of service provision, incorporating ACO and non-ACO services, developing cross-system plans, vision and accountability centred around the needs of its patients.	Yes, the ACO should decide how best to configure and provide services that it is contracted to deliver, within the parameters set in its contract. It should also use data to stratify risks and target interventions and ensure that services are designed around the needs of patients.
Address underlying health inequalities	Having regard to the need to reduce health inequalities between patients with respect to their ability to access health services, and develop strategies to reduce inequalities between patients with respect to the outcomes achieved for them.	Yes, it should implement patient-centred strategies to address health inequalities in its own population.

Activity/ function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Shaping structure of supply		
Managing and developing the supply chain for services provided across the CCG's area (including across the ACO)	Stimulating the market to ensure there are a number of high quality options for patients available when commissioning services, and that there are alternative providers available in the event of provider failure.	Yes, the ACO should stimulate the market to ensure there are a number of high quality options available when it is sub-contracting services that it is contracted to provide in order to best meet the needs of its patients.
Procurement of health services (as well as the ACO) by the CCG	Decisions relating to the award of clinical and non-clinical contracts across the CCG (including the ACO contract). This activity involves ensuring that all applicable procurement law and guidance is followed.	Yes, the ACO should be responsible for all sub-contracting that it opts to carry out within the parameters set in its contract.
Operational management		
Planning capacity and managing demand		
Demand management across the CCG	Putting in place actions across the CCG to control levels of demand on particular services (e.g. emergency services).	Yes, the ACO should create and manage demand management plans for their populations to enable patients to make appropriate choices.
Service development		
Engagement and consultation on service change proposals	Statutory obligation on CCGs and NHS providers to involve the public in the planning, development, consideration and decisions upon service change proposals.	Yes, it is likely that ACOs will undertake service re-design and potentially change the method or point of delivery for some services within parameters set in its contract. Consultation on such changes should be undertaken by the ACO and the public and patients should be central to decision making. ACOs should develop new ways to involve their population in the design and use of services.
Development of services and quality improvement work across the CCG	Work to improve the quality of services provided across the CCG and the experiences that patients who use these services have.	Yes, the ACO should develop its own services and improve the quality of the services it provides.

Activity/ function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Service delivery		
Integrating the provision of services across the CCG	Putting in place smooth pathways between services provided by a range of providers, including the ACO.	Yes, the ACO should put in place smooth pathways between services provided by (and sub-contracted by) the ACO. The ACO should also work to facilitate integration of services it provides with those of other providers, and to co-operate with other providers in order to put patients at the centre of service provision and improve the overall patient experience.
Ensuring efficient use of funds		
Planning of cost improvement schemes across the CCG	Development of schemes to improve efficiency and reduce cost pressures in the CCG budget.	Yes, the CCG may request information, input or ideas as to how cost improvements could be made. Providers, including the ACO, are well placed to offer these.
Implementation of cost improvement schemes related to health services (including the ACO) commissioned by the CCG	The implementation of cost improvement schemes which relate to services commissioned across the CCG, including the ACO.	Yes, CCG's cost improvement schemes may require changes in behaviour from the ACO in order to be successful e.g. changes in referral behaviour.
Decision making relating to funding routes	Decisions relating to who pays, who the responsible commissioner is and what the most appropriate funding stream for care provided to different patients is e.g. continuing health care assessment.	Yes, where appropriate (i.e. because it covers a pathway delivered by the ACO or involves one of the ACO's patients) the ACO should provide evidence to inform such decisions.

Activity/ function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Implementing patient centred care		
Pathway planning, signposting to services and care navigation across the CCG	Supporting patients to access and navigate well planned pathways for health and social care services across the CCG area.	Yes, the ACO should support the CCG in planning smooth pathways built around the needs of patients that incorporate services provided by the ACO and other providers.
Patient choice	Ensuring that patients are offered a choice of providers in line with the NHS constitution.	Yes, the ACO must ensure that, having chosen to access their services, patients are offered appropriate levels of choice if they are referred on e.g. by a GP into elective care services.
Personalisation, person centred care (including self-care and realising the value) and personal health budgets	Ensuring that, where appropriate, patients are offered personal health budgets or integrated personal commissioning. People receiving NHS Continuing Healthcare (or continuing care in the case of children) have the legal right to a personal health budget. Ensuring that people with long term conditions and low knowledge, skills and confidence (activation) are identified and supported to take control of their own health and wellbeing through access to personalised care and support planning and activities such as self-management education, health coaching and peer support.	Yes, the ACO should support patients who wish to have a personal health or integrated personal budgets. Where a ACO is involved in NHS Continuing Healthcare, they should include the option of personal health budgets and make people aware of them. ACOs should identify and support people with long term conditions and low knowledge, skills and confidence to take control of their own health and wellbeing.

Activity/ function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Monitoring and evaluation		
Managing performance		
Development of outputs, outcomes measures and monitoring	Develop, measure and monitor the outcomes against which the performance of the ACO will be assessed and against which decisions on payment will be made.	No.
Contract management for services within and outside of the ACO scope	Using performance data to assess compliance with the terms of the contracts signed by providers (including the ACO). Applying penalties as necessary and agreeing remedial actions where providers are not compliant.	Yes, the ACO will be responsible for managing any contracts it has with sub-contractors.
Quality monitoring / contract management of sub-contracted services	Ensuring that any services that are sub-contracted by the ACO meet the same quality standards as expected of ACO-delivered services.	Yes, quality monitoring of the services being delivered through a sub-contract should be carried out by the ACO as the contract holder.
Oversight and management of system performance	Taking responsibility, as system leader, for the overall performance of the whole local health system, not just the performance of individual providers/ services within the system.	No, the ACO is only responsible for the performance of the services it delivers and sub-contracts.
Oversight of risk and reward mechanisms	Using the contract to put in place mechanisms which spread risk between the CCG and the ACO and which incentivise desired behaviours and performance by using appropriate rewards.	No. While it is not appropriate for the ACO to have oversight of reward mechanisms it may seek to influence them through the contract negotiations (to the extent permitted by public procurement rules). Separately, the ACO may wish to design and implement incentive schemes for its sub-contractors.

Activity/ function that the CCG is responsible for	Description	Can the ACO undertake activities to support delivery? If yes, how?
Seeking public and patient views		
Management of FOI requests and provision of data for responses	Responding to Freedom of Information requests and/ or providing the necessary information for others to respond jointly.	Yes, the ACO should provide data/ respond as appropriate.
Complaint handling	Receiving, distributing and responding to complaints received about services commissioned by the CCG, including ACO services.	Yes, as a provider of services, the ACO should respond to patient complaints in the same way that other providers have a responsibility to respond (or should provide the necessary information for the CCG to respond).

ANNEX B

How different commissioning structures can commission different configurations of services

This table (which aims to simplify a complex legislative structure) should be used as a guide only and local commissioners should seek their own advice when entering into local arrangements. In order to use this table, commissioners will need to identify what functions they wish to include (for example, is it a function capable of being part of a s75 Arrangement?),who owns that function and whether there are any restrictions on the ability to pool funds with prospective partners,at an early stage.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
A: ACO providing primary medical services and community health services	• Under s3 and s3A of the NHS Act 2006, a single CCG is under a duty to commission community health services. • NHS England's functions relating to commissioning of primary medical services can be delegated to single CCGs under s13Z. • A single CCG could commission this new care model under existing legislation and in accordance with the existing Delegation Agreement.	• Primary medical services is a function of NHS England and responsibility for this cannot be delegated to multiple CCGs under s13Z as NHS England can only delegate to a single CCG. • There is no mechanism to enable a group of CCGs to commission the entirety of this care model as described. (The alternative approach is set out in column 1.)	• Integrated commissioning would not be necessary for this care model as no LA commissioned services are included.	• Integrated commissioning would not be necessary for this care model as no LA commissioned services are included.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
B: ACO providing primary medical services, community health services and social care	• Responsibility for any local authority health-related functions, including social care and public health, cannot be delegated to a single CCG. • There is no mechanism to enable a single CCG to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See row A. • Also, responsibility for any local authority health-related functions, including social care and public health, cannot be delegated to a group of CCGs. • There is no mechanism to enable a group of CCGs to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• CCGs can exercise their functions (i) jointly with NHS England under s14Z9 or (ii) jointly with a combined authority (under s143ZA) following changes brought about by the 2016 Devolution Act. • s3 and s3A CCG functions can be included in a s75 Partnership Arrangement. There are services that cannot be included in Partnership Arrangements. • Specified local authority health related functions, including some social care and public health, can be included within the s75 Partnership Arrangement.	• CCGs can exercise their functions (i) jointly with NHS England under s14Z9 or (ii) jointly with a combined authority (under s143ZA) following changes brought about by the 2016 Devolution Act. • s3 and s3A CCG functions can be included in a s75 Partnership Arrangement. There are services that cannot be included in Partnership Arrangements. • Specified local authority health related functions, including some social care and public health, can be included within the s75 Partnership Arrangement.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
B: ACO providing primary medical services, community health services and social care			• Where NHS England has delegated primary medical services to a CCG, the CCG can enter into Partnership Arrangements as part of a s75 Partnership Arrangement. **Pooled budgets** • CCGs may pool funds under an agreement under s14Z3A, and subject to the terms of that agreement, the CCGs could pool those funds under a s75 Partnership Arrangement in respect of their own CCG functions. • CCGs may pool funds when jointly exercising functions with a combined authority (where the combined authority is not exercising delegated NHS functions) under s14Z3A.	• Primary medical services can be included as part of a s75 Partnership Arrangement. **Pooled budgets** • CCGs may pool funds under an agreement under s14Z3A, and subject to the terms of that agreement, the CCGs could pool those funds under a s75 Partnership Arrangement in respect of their own CCG functions. • CCGs may pool funds when jointly exercising functions with a combined authority (where the combined authority is not exercising delegated NHS functions) under s14Z3A.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
B: ACO providing primary medical services, community health services and social care			• Primary medical services funds could be pooled with other funds by the CCG(s)/ CA/ LA, subject to amendments being made to the Delegation Agreement and NHS England being satisfied that there is sufficient information and evidence as to the benefits of partnership arrangements. • In a Partnership Arrangement where NHS England's functions are to be included (e.g primary medical services) it is good practice for NHS England to be party to the agreement. • It is also possible to have parallel budgets as an alternative.	• Primary medical services funds could be pooled with other funds by the CCG(s)/ CA/ LA, subject to amendments being made to the Delegation Agreement and NHS England being satisfied that there is sufficient information and evidence as to the benefits of partnership arrangements. • It is also possible to have parallel budgets as an alternative. • It would be possible for one or more CCGs and a LA and/or CA to commission the entire new care model as described in conjunction with NHS England. • The care model described, however, does

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
B: ACO providing primary medical services, community health services and social care			• It would be possible for one or more CCGs and a LA and/or CA to commission the services provided under the new care model as described.	not incorporate any non-delegable NHS England functions, so the CCG(s) and LA/CA should not be reliant upon NHS England in order to commission effectively.
C: ACO providing primary medical services, community health services, social care and LA	• See row B. • There is no mechanism to enable a single CCG to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See rows A and B. • There is no mechanism to enable a group of CCGs to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See row B. • It would be possible for one or more CCGs and a LA and/or CA to commission the services provided under the new care model as described.	• See row B. • It would be possible for one or more CCGs and a LA and/or CA to commission the entire new care model as described in conjunction with NHS England. • The care model described, however, does not incorporate any non-delegable NHS England functions, so the CCG(s) and LA/CA should not be reliant upon NHS England in order to commission effectively.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
D: ACO providing primary medical services, community health services, social care, LA	• See row B. • There is no mechanism to enable a single CCG to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See rows A and B. • There is no mechanism to enable a group of CCGs to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See row B. • It would be possible for one or more CCGs and a LA and/or CA to commission the services provided under the new care model as described. (The alternative approach is set out in column 3.)	• See row B. • It would be possible for one or more CCGs and a LA and/or CA to commission the entire new care model as described in conjunction with NHS England. • The care model described, however, does not incorporate any non-delegable NHS England functions, so the CCG(s) and LA/CA should not be reliant upon NHS England in order to commission effectively.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
E: ACO providing primary medical services, community health services, social care, LA	• See row B. • There is no mechanism to enable a single CCG to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See rows A and B. • There is no mechanism to enable a group of CCGs to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See row B. • The Secretary of State could delegate the commissioning of s2A public health services under s7A to NHS England, combined authorities/local authorities or CCGs. • If NHS England has been asked to exercise the s2A public health function, it could then delegate this, subject to Secretary of State agreement, to CCGs or combined authorities, but the s7A public health services are currently not included in the specified functions in the s75 Partnership Arrangements Regulations. **Pooled budgets:** • See row B.	• See row B. • The Secretary of State could delegate the commissioning of s2A public health services under s7A to NHS England, combined authority/local authorities or CCGs. **Pooled budgets:** • See row B. • Funding is ring-fenced for s7A public health services programmes/ specifications and cannot be used for other purposes. • It would be possible for one or more CCGs and a LA and/or CA to enter into arrangements in conjunction with NHS England in respect of the commissioning of services under the new care model as described.

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
E: ACO providing primary medical services, community health services, social care, LA			• Funding is ring-fenced for s7A public health services programmes/ specifications and cannot be used for other purposes. • It would be possible for one or more CCGs and a LA and/or CA to enter into arrangements in respect of the commissioning of services under the new care model as described. • It would be possible for all of these services except s7A public health to be included in a pooled budget (subject to the requirements described in row B).	• It would be possible for all of these services except for s7A public health to be included in a pooled budget (subject to the requirements described in row B).

	1: Individual CCG	2: Multiple CCGs	3: One or more CCGs and LA and/or CA	4: NHS England and one or more CCGs and LA and/or CA
F: ACO providing primary medical services, community health services, social care, LA	• See row B. • Specialised services cannot be delegated to single CCGs under s13Z and s13ZA and s13ZB apply. • There is no mechanism to enable a single CCG to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See rows A and B. • Specialised services cannot be delegated to multiple CCGs under S13Z and s13ZA and s13ZB apply. • There is no mechanism to enable a group of CCGs to commission the entirety of this care model as described. (The alternative approach is set out in column 3.)	• See rows B and E. • Note in particular the 's75 exclusions' that relate to specialised services. • It would be possible for one or more CCGs and a LA and/or CA to enter into arrangements in respect of the commissioning of services under the new care model as described. • It would be possible for all of these services except for s7A public health, some specialised services and excluded CCG services to be included in a pooled budget (subject to the requirements described in row B).	• See rows B and E. • It would be possible for one or more CCGs and a LA and/or CA to enter into arrangements in conjunction with NHS England in respect of the commissioning of services under the new care model as described. • It would be possible for all of these services except for s7A public health, some specialised services and excluded CCG services to be included in a pooled budget (subject to the requirements described in row B).

(i) Exclusions from section 75

Functions that currently cannot be part of a s75 partnership arrangement:

- surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments
- s7A public health services (see endnote ii)
- primary dental services
- pharmaceutical services
- primary ophthalmic services
- emergency ambulance services.

(ii) Section 7A public health functions

NHS England commissions s7A public health services on behalf of the Secretary of State through an annual agreement. The scope of services included in the agreement is determined by the Department of Health, and in 2016/17 include:

- National population screening programmes
- National immunisation programmes
- Child Health Information Services (CHIS), including Child Health Records Department (CHRDs) and IT Systems
- Public health services for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate
- Sexual Assault and Referral Centre (SARC) Services.

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support

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