New care models

Summary of public engagement on the draft MCP Contract published December 2016

Accountable Care Organisation (ACO) Contract package - supporting document

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

August 2017

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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.

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Introduction

1 The ACO Contract is the latest iteration of a national contract for accountable care models that has been in development since 2016. An earlier version of this contract was referred to as the Multispecialty Community Provider (MCP) Contract. A draft version of the MCP Contract and a number of supporting documents were published on the NHS England website in December 2016 for a period of public engagement and feedback. The series of supporting and explanatory documents published alongside the Contract are similar to those in the current package, and included papers on how GPs can participate in an MCP, the procurement and assurance approach, the financial strategy, and the commissioning system.

2 The engagement period lasted five weeks and concluded on 20th January 2017. This exercise invited feedback on a range of engagement questions covering each document in the contract package. These questions are set out in Annex A. Commissioning and contracting for an integrated care model of this sort inevitably involves a considerable amount of technical detail which some found a challenge to interpret. We will continue to look at ways of presenting the information to help with this. The limited engagement period built on a long period of engagement with MCP Vanguards and local partners. As set out elsewhere in the package, engagement with those who would like to contribute further will continue as the Contract begins to be used and ahead of a formal consultation in during 2018.

3 Responses to the engagement exercise received through NHS England's Citizen Space survey platform and additional emails sent to the MCP Contract mailbox have all been considered. Overall, there were 28 responses received from a wide variety of groups and organisations. These included: GP Federations, CCGs, NHS Trusts, Voluntary Community and Social Enterprise sector, and other stakeholders from across the system.

4 This summary document aims to capture the key feedback themes arising from the responses to the engagement questions and other feedback received. It also includes at a high level, the work being undertaken to address the feedback and incorporate it into the ACO Contract.

Key feedback themes arising from the engagement exercise

5 Some of the key themes arising from the feedback had already been flagged by sites with which we have worked closely to date, however NHS England acknowledges there is a need to do further work across a range of areas over the coming months.

The MCP Contract

6 There was an overall positive reception to the draft MCP Contract; however there are areas that require further development prior to formal consultation. Respondents were generally supportive, with appropriate controls, of contracts of longer duration as an enabler for long-term transformation. Further clarity was requested on the balance between prescription, locally determined content and MCP discretion. We have included additional detail in the explanatory notes to suggest how the roles of the national elements of the contract, the local tailoring by commissioners and the contributions by providers developed during the procurement will together contribute to the development of a clearly specified model of care.

7 Feedback was received on the developing set of controls added into the MCP Contract on areas such as profit distribution, asset locks, and change in control. We are working to strike a balance between the desire for oversight and transparency, and the flexibility to ensure that the contract is commercially and legally deliverable for a broad range of providers. Some amendments have been made to the Contract in this area.

8 Some respondents questioned whether the Contract provides for a mixed economy of GP practices participating in the MCP in different ways. We are clear that the Contract will be able to be used where some practices are partially integrated and some fully. However, as this adds additional drafting complexity which may not be helpful for the majority of readers at this stage, we will work with commissioners using the Contract early to ensure that we can tailor the Contract to allow for these circumstances.

9 Some concerns were expressed around the "levels of financial sanctions which may be imposed under the Contract". We believe there has been some misinterpretation of the Contract in this area, and having adjusted it slightly will be engaging further with commissioners on this point.

10 A number of respondents requested further clarification around insurance/ indemnity arrangements e.g. "21 years of negligence cover needs to be fully costed, as could be expensive for MCPs to secure". This is noted and we will plan to engage with NHSLA, MDUs and specialist advisers to ensure there is clarification on what MCPs will be expected to have in place.

Draft Alliance Agreement and Integration Agreement

11 The emphasis on co-production of these documents was welcomed, as was the inclusion of the template tailored Alliance Agreement to allow CCGs to start putting these types of arrangements in place from 2017/18. It was suggested that refinement of wording would be helpful to reflect adult social care, and we will consider this as part of our engagement with local authority colleagues and will amend to ensure this is addressed. More detail was requested on data sharing and information governance. We have already instigated further work on this to inform further development of these agreements alongside the Contract itself. Finally some queries were raised about the role of the commissioner in alliance arrangements. This may be a misunderstanding of different purposes of the Alliance Agreement and Integration Agreement, but it does highlight the fact that alliance arrangements may be put in place for different purposes in different versions of the models. We will be engaging with vanguards on this point as they develop their models.

Primary Care participation

12 Respondents generally welcomed the clarification on options for GPs to participate in an MCP and thought that the voluntary nature of the Contract was clearly communicated. They also highlighted that the case studies included in the paper were a helpful way of bringing it to life. For example, one respondent stated "The document describes the benefits the MCP model can offer GPs (with useful case studies) and provides some clarity and detail on common technical questions." However, concerns about financial security and the commercial incentive for primary care were raised. We are working to make available further and clearer information on the options and opportunities for GPs working within fully integrated organisations, such as how practices could benefit from a gain / risk share arrangement. We have stressed the option for practices to join in a partially integrated way, leaving current contracting and commercial arrangements in place. This additional suite of information will be accessible and able to be used locally in discussions between CCGs and practices, to clarify how we expect these models to work, building on early experiences, and to highlight the benefits and risks of which it is helpful for GPs to be aware and work through.

13 There were particular concerns about the options available in fully integrated models for use of GP-owned or occupied premises. We will continue to work with leading sites with a view to providing further information about how these premises could be leased or otherwise used within a fully integrated MCP.

14 Separately, engagement feedback noted that dispensing practices are unable to join fully integrated MCPs whilst keeping their dispensing rights under current regulations. We highlighted that this is currently not possible for legal reasons, although dispensing practices can of course still join a virtual or partially integrated MCP. We are working on this with the Department of Health to find a way to allow full participation by dispensing practices, in order to resolve prior to the first fully integrated contract being awarded.

15 Responses particularly welcomed the use of commissioner spend as a starting point for calculation of Whole Population Budgets, and gain/loss share arrangements to align financial incentives across the system. There was also positive feedback around the development of a dashboard capable of real-time assessment of performance.

16 A number of comments highlighted the need for additional detail on how social care and public health would be incorporated within the Whole Population Budget. This is an area we have addressed in the August 2017 version of the Financial Strategy and on which we have been further engaging local authority partners. Respondents raised the difficulty in providing more comprehensive feedback ahead of the Integrated Budgets Handbook being released. This handbook is now available as part of the August 2017 Contract package.

17 Respondents requested further detail in relation to the metrics against which the MCPs' performance will be measured and more information on gain/loss share, including practical examples. Further to the Integrated Budgets Handbook we are producing an incentives framework for ACOs (detailing a dashboard of indicators and the Improvement Payment Scheme) and a Gain/Loss Framework to support practical implementation. In doing so, we will look to ensure the correct balance of health and social care indicators to drive system change, provide high quality care, and align financial incentives across local health providers.

Local authority, voluntary sector, mental health and broader provider involvement

18 Respondents agreed on the importance of working through how local authorities can participate in the commissioning of an MCP so that social care and public health can be fully integrated. There were a number of suggestions that the contract package was too "NHS centric" and that more engagement is needed with local authorities and the voluntary sector in producing the Contract and supporting documentation.

19 We recognise that there is more we need to do to clarify and describe how the national framework is consistent with the approach and requirements of local government in particular. We also intend further engagement with representatives of the voluntary sector and have set out in the package more clearly the important role it will play in delivering the MCP model.

20 We are working with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) 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 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, ADASS and local authorities will consider areas including how local authority functions could be discharged in and 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. This piece of work has been taking place over the Spring and Summer of 2017.

Next Steps

21 The engagement exercise provided useful feedback to inform the next version of the Contract package which is published alongside this summary for use by early sites. We will do further work over the coming months with commissioners and providers in these most advanced sites to develop the Contract further. This will be an iterative process and we hope that this approach will allow adequate opportunity to receive further feedback and refine the Contract prior to publishing a final version.

ANNEX A

The high-level engagement questions in the Contract covering paper were:

i. We want the MCP Contract to enable commissioners to strike an appropriate balance between contracting for a nationally-mandated care model contracting for services on the basis of locally-determined specifications and standards, and contracting for longer-term health outcomes. Does the current draft offer the right mix of nationally-mandated and locally-specified requirements?

ii. Given the systemic importance any MCP will have in its local health and social care community, we have proposed within the draft Contract a range of financial controls on the MCP provider which are in addition to those within existing commissioning contracts. Will these be effective in minimising the risk of failure, but without stifling local innovation?

iii. The accompanying Finance and payments approach sets out arrangements for calculating payments to the MCP, for the proposed Improvement Payment Scheme and for the underpinning dashboard of core performance indicators. This will be supplemented in due course by a Whole Population Budget Handbook. Is there sufficient detail to support accurate calculation of payments, particularly in terms of identifying existing costs in primary care, social care and public health services? And do you support our intention to develop and publish a dashboard of core performance indicators for MCPs?

iv. NHS England envisages MCP Contracts would be for up to 10 years, allowing time for sustained investment and improvement in population health. We are seeking views on both the opportunities and challenges that longer-term arrangements could present.

v. The long term nature of an MCP Contract requires us to manage how the requirements on the MCP, the associated payment and the level of financial risk can appropriately evolve over time. Have we provided an effective framework for this over the lifetime of the local contract? Does this provide sufficient stability for the provider to encourage long term planning and development? And is the proposed approach to early termination appropriate?

vi. A local MCP Contract may be held by various different types of provider body, in terms of organisational form. Is the draft Contract equally workable from the perspective of each?

vii. The different possible approaches to establishing an MCP all have different implications for general practices and for individual GPs, in terms of their contractual and employment arrangements. In all models general practice will be at the heart of delivering an MCP model. Does our overall package provide sufficiently clear information for practices and GPs?

viii. We have taken national NHS commissioning contracts as our starting point in drafting the MCP Contract with some significant changes to reflect the nature of the MCP model. But how does the draft Contract need to be adapted to better enable integrated commissioning of clinical health services with certain social care and public health services, where this is what local commissioners wish to do? We would welcome any feedback on which terms in the Contract would need to be disapplied in relation to social care and/or public health services, whether any specific, additional terms would be required, or whether some terms would need to change to reflect an integrated service model.

ix. The draft Service Conditions require the MCP, as standard, to carry out some activities directly to support CCGs in delivering aspects of their statutory duties (needs assessment and analysis or public involvement and consultation, for instance). Are there more such activities (whether for CCGs or local authorities) which the Contract should require or enable the MCP to undertake?

x. A key next step for us will be to develop a model commissioning contract for a Primary and Acute Care System (PACS) model including acute hospital services. We envisage that the PACS Contract will share many of the characteristics of the

xi. MCP Contract – but what different elements might we need to include?

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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