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NHS ENGLAND – BOARD PAPER

Title: Update on draft contract for Accountable Care Organisations (ACOs)

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Purpose of Paper:

This paper invites the Board to note that NHS England will be publishing in due course the draft ACO Contract for public consultation. In the meantime, the attached paper sets out questions that are frequently asked and provides factual answers.

The Board invited to:

To note the paper.

Questions and answers related to the draft ACO Contract

1. What is an ACO?

Accountable Care Organisation (sometimes known as an 'ACO' or 'accountable care provider') is a term we use to describe a provider of general practice, wider NHS and potentially local authority services that enters into an ACO contract with the commissioner¹ of those services. (However, different names are being used for ACOs in different parts of the country – multi-specialty community provider (MCP), or integrated services provider, for example.) The ACO is a 'lead' provider organisation, 'accountable' through clear contractual obligations for the integration of services.

ACOs are not new types of legal entity, but provider organisations awarded ACO Contracts. Under current arrangements, a number of different types of organisations can hold NHS contracts, including the proposed ACO Contract, and these include a statutory NHS body provider (i.e. an existing NHS Trust or Foundation Trust) or a partnership (for example, many GP practices are partnerships).

Neither NHS England nor any other body could designate an organisation as an 'ACO'. An organisation would become an 'ACO' only if and when it is awarded an ACO Contract.

NHS England is committed to consult on an updated version of the draft ACO Contract prior to its potential use in the NHS.

2. Why do we need a new contract for ACOs?

The ACO contract is intended to promote an environment in which different teams and services can come together in a coordinated way, incentivising organisations to focus on delivering better patient care and improving the health of the population as a whole. The contract is designed to allow this to be achieved in a transparent way, ensuring consistency with all national NHS standards and requirements, whilst establishing clear accountability through a lead provider. The long term health and care outcomes for the population are the priority, and the prevention which the contract seeks to incentivise is vital to achieving improvement in those outcomes.

At present, health and care services are bought from and delivered by a range of provider organisations (including GP practices, NHS trusts and foundation trusts, local authorities, voluntary sector and private sector providers), under different contracts on different terms and with different funding and incentive arrangements. Those terms and financial arrangements don't always encourage providers to work together to provide joined-up care for local people, and no one provider has accountability for the health and care of any individual person.

¹ Commissioners are bodies with statutory duties to arrange for the provision of health services. In broad terms, commissioning includes the planning, purchasing and monitoring of health services. In the context of health and social care services, clinical commissioning groups (CCGs) are responsible for commissioning healthcare services for the people they serve; local authorities may commission (or directly provide) public health and social care services.

In many parts of the country, commissioners and providers are working to try to overcome this, by putting in place overlaying agreements (sometimes known as ‘alliance agreements’) which formalise their commitment to work together to integrate the various different services, and together deliver them on a more coherent basis which better meets the needs of local people.

But some local commissioners want to go further: to re-commission packages of services through a single contract to build in integration and ensure that contracts, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for co-ordinating care.

We have therefore developed a prototype contract – a variant of the generic ‘NHS Standard Contract’ which is already used to commission a broad range of NHS services – that is specifically designed to enable integration and sets out:

- a consistent objective to deliver integrated, population care
- consistency in terms and conditions, removing the risk of conflicting priorities or requirements getting in the way of clinicians doing the right thing for patients
- a population based payment approach, allowing flexible redeployment of resources to best meet needs and encourages a stronger focus on overall health, rather than simply paying for tightly defined activities
- aligned incentives across all teams and services.

3. When will the ACO Contract be used?

Subject to the outcome of the forthcoming consultation, NHS England may publish the ACO Contract for commissioners to use to commission services on an integrated basis.

Commissioners in Dudley and Central Manchester have started procurements with a view to awarding contracts for integrated services, and may ultimately use the ACO Contract as the basis for their local contracts if it is made available.

But no commissioner will be able to use ACO Contract unless NHS England makes it available for them to do so following the end of the forthcoming consultation exercise. NHS England will only consider making the contract available after carefully considering consultees’ responses to the consultation. NHS England may make changes to the draft ACO Contract to reflect responses it receives, or it may decide not to publish it for use at all.

4. Why have you decided to consult?

Our intention had always been to consult formally on the draft ACO Contract in accordance with NHS England’s legal duties².

We want to take the opportunity to explain what the ACO Contract is for and when it might be used, and to dispel misconceptions about what integrated, accountable care models

² Legal duties under Regulation 18 of the Standing Rules Regulations can be found on the Government website: <http://www.legislation.gov.uk/uksi/2012/2996/regulation/18/made> (Information accessed 15 March 2018)

might mean for the NHS and people's care. The consultation will also provide feedback on the specific proposed provisions in the draft ACO Contract.

5. How would the draft ACO Contract protect quality and patient safety?

Although the draft ACO Contract aims to support a new approach to service delivery, the key regulatory and policy requirements which underpin and safeguard the delivery of NHS services remain the same. Any provider of NHS services must comply with the registration and regulatory guidance and standards of the Care Quality Commission (including the [fundamental standards of care](#)), NICE, NHS Improvement and other regulatory and supervisory bodies, and must meet national standards on waiting times and other operational matters, and in respect of quality and safety, including those set out in the NHS Constitution. Any provider which holds an ACO Contract (and indeed any sub-contractors to that provider) will be subject to those same requirements.

6. Who could hold the ACO Contract?

Providers need to be able to demonstrate that they have the capacity and capability to deliver successfully on the requirements set out in the contract, which will include being accountable for the broad range of services which may be included in an ACO model. The organisations emerging from the procurements underway in Dudley and Manchester which may result in the award of an ACO Contract (subject to the outcome of this consultation exercise) are collaborative arrangements between NHS statutory body providers and local GPs.

Through the procurement process and the Integrated Support and Assurance Process (ISAP) bidders will need to demonstrate to commissioners and to NHS England and NHS Improvement that they are capable of holding, and delivering, the proposed local ACO Contract and the wide range of health and care services it covers.

7. Why do commissioners have to run a procurement process before awarding the ACO Contract?

The Public Contracts Regulations (PCR 2015) require that contracts for health and/or care services with a lifetime cost over the current £615,278 threshold generally must be advertised to the market. This does not necessarily mean that there will always be a competitive procurement involving multiple bidders before a contract is awarded; in some local areas, the response to the advertisement may result in the commissioners engaging in dialogue with a single bidder. However, commissioners are required to act fairly and transparently in all cases, and treat all potential providers of the relevant services equally.

8. Is this privatisation of NHS services?

No. The draft ACO Contract does not, promote or encourage privatisation of NHS services or outsourcing of NHS services to private sector organisations.

Furthermore, it would be illegal for commissioners to take steps intended to increase the proportion of NHS-funded services delivered by private providers.

No CCG has yet awarded an ACO Contract but in Dudley and Manchester, the organisations emerging from ongoing procurements to deliver the integrated accountable care contract are local NHS organisations in partnership with local GPs.

9. Will the ACO Contract mean people may have to pay for NHS services?

No. ACOs must by law continue to provide NHS services free at the point of use³, just as providers of NHS services do now.

This is the case regardless of the type of organisation that holds the contract, or whether it is responsible for social care services alongside NHS services or not.

10. Will the holder of an ACO Contract be accountable to the public, if they are not public bodies?

ACOs would be accountable to the public in the same way as other providers of NHS care. ACO providers are not new legal entities – an ACO would simply be a provider organisation which is awarded ACO Contract, and will be subject to the same legal requirements and obligations as any other provider organisations of that type. For example, if the ACO was an NHS foundation trust (FT), it would be under the same duties as other FTs.

The draft ACO Contract requires the ACO to involve and engage the public when it is considering developing and redesigning services, just as the NHS Standard Contract does. ACOs would be subject to NHS England guidance on patient involvement, and to the NHS Constitution.

Commissioners of ACOs must continue to meet their statutory duties to the public, which would not be affected by the award of any ACO contract.

11. Why can the ACO Contract have a duration of up to 10 years?

³ Subject to the statutorily prescribed exceptions, for example in relation to NHS charges for overseas visitors under the NHS (Charges to Overseas Visitors) Regulations 2015.

The duration of any ACO Contract, as for local arrangements under the generic NHS Standard Contract, is not determined nationally, but is for local commissioners to decide, based on the model that they think would work best for their population. Where commissioners use the ACO Contract, we expect them to agree a contract term of up to 10 years.

An important idea behind the draft ACO Contract is that by giving one organisation responsibility for delivering health and care services for the whole local population, it will be able to shape services around what really works best. A longer-term contract offers the stability needed to incentivise the provider to improve longer-term outcomes by investing in services to manage and improve treatment and prevent deteriorations in health, rather than being driven by short-term contracting processes. . It will inevitably take some time for the impact of any new care model to emerge and for the new provider to be able to show improvements in population health outcomes.

12. What would this mean for GPs; will participation be voluntary?

GPs are at the heart of the NHS, and their participation is absolutely vital to deliver integrated care. Without it, we will not be able to deliver the full potential of the population-based models developed through the New Care Models programme.

The draft ACO Contract is specifically designed to aid the integration of primary medical services with other local health and care services. Along with improving people's care, this is intended to ensure the sustainability of general practice, support a future of strengthened relationships between GPs and the rest of the system, and offer the scale and infrastructure to underpin the ongoing delivery of primary medical services.

In order to achieve this different options have been created for GPs to work in partnership with ACOs, however no GP will be required to select one of these options; participation is entirely voluntary. Locally, there should be broad engagement, including with GPs, on the appropriate model for integrated care, which should inform a decision to award an ACO Contract. GP practices holding General Medical Services (GMS) or Personal Medical Services (PMS) contracts would always retain the option to continue to deliver services under these arrangements. Practices which continue to operate under GMS or PMS contracts may enter into contractual arrangements to integrate their services with those provided by the ACO.

GPs can suspend their GMS/PMS contracts, and return to those contracts later if they wish to.

13. Why has NHS England created different participation options for GPs?

General practice is fundamental to integrated accountable models of care, but GP participation in an ACO is voluntary. To support GPs to take a more central role in the health and care system, we have developed the draft ACO Contract to provide for two distinct means by which general practitioners can participate in an ACO model and

therefore work more closely with other teams to join up pathways and deliver an improved service for patients.

In the ‘partially integrated’ ACO model, the commissioner would award an ACO Contract for a package of services excluding core general practice. The contract requires the ACO to integrate its services with services delivered by local GPs. Practices keep their active GMS / PMS contracts and form an agreement with the ACO (the ‘Integration Agreement’), setting out how they will work more closely together.

In the ‘fully integrated’ ACO model, the commissioner would award an ACO Contract for a package of services including core general practice. This would happen when GP practices choose to suspend their GMS/PMS contracts, which allows them to work either in the ACO directly as an employee, or become a subcontractor to the ACO, which will become responsible for the overall delivery of services. This option has been developed to give GPs more opportunity to join up care pathways and offer a more coordinated service to patients. Where GPs decide to become employees, the draft ACO Contract requires salaried GPs to be employed on terms and conditions no less favourable than those in the BMA model terms and conditions for salaried GPs.

14. Will patient choice be maintained under the ACO Contract?

Yes. The draft ACO Contract has been designed to make sure that bundling services into a single contract does not restrict the choices people have about how and where they receive care. The draft ACO Contract not only requires the ACO to ensure that the rights to choice people have under the NHS Constitution are respected, but also to offer further choices as to when, where and how people can receive the services they need wherever practicable.

15. Will ACOs serve everyone in their areas?

The draft ACO Contract makes clear that the ACO must provide healthcare services for everyone registered with the ACO (or with practices integrated with it) and everyone else permanently or temporarily resident in the relevant geographical area – unless they are registered with a GP practice which is not the ACO or a practice integrated with it. That is the ACO’s “population” for healthcare services.

Where the ACO is commissioned to provide core primary medical services, it must accept onto its registered list all permanent and temporary residents of the area, and may accept people who are not permanently or temporarily resident. So anyone registered with a practice which isn’t integrated with the ACO has the option to register with the ACO (or an integrated practice) and so be served by it.

The ACO must make available to everyone within its population all healthcare services which are within the scope of the contract, to meet individual needs.

16. How do social care and public health fit into the ACO Contract?

The importance of integration between health and social care services is widely recognised. The potential benefits of the accountable care model will be greater if social care and public health can be commissioned under an ACO contract alongside NHS services.

Local authorities (LAs) have legal responsibility to arrange or provide public health and social care services. We are working with a number of LAs in areas in which an ACO is being considered, and with the Local Government Association (LGA), to consider how we can make sure the draft ACO Contract is fit-for-purpose for commissioning public health and/or social care services alongside NHS services. As part of this, we are considering the different statutory duties and powers of LAs and the potential impact on providers of, particularly, social care services. The draft ACO Contract on which we intend to consult will include feedback we have received from LAs and the LGA to date – and we will continue to work with local government to consider this further.

Closer integration of NHS and LA services can be achieved through means other than a single ACO contract for both sets of services. For example, an ACO commissioned to provide healthcare services only may be required by the contract to work closely with the LA and other providers of public health and/or social care services, and may sign integration agreements to set out how they will work together.

17. What does the ACO Contract mean for the voluntary sector?

The voluntary sector plays a key role in delivering a population-based model of care, focused on the needs and wishes of individuals, which the ACO Contract is designed to support. The vanguards in the New Care Models programme have worked closely with local voluntary organisations to shape local services that support both health and wellbeing for local people.

Any organisation can partner with others to bid for an ACO Contract or to provide services as a sub-contractor to the ACO, and this includes voluntary organisations. We expect that commissioners will require bidders for any ACO Contract to demonstrate how it will involve and work closely with local voluntary sector organisations to deliver choice and person-centred care.

18. Does the ACO model blur the so-called 'commissioner-provider' split?

ACOs will not change the established boundary between commissioning and provision of health care.

The ACO Contract does not contravene a CCG's statutory duties to 'arrange for the provision of' health care services. Any provider of NHS services will make decisions about how its resources are spent and how care is delivered. This would be the case for example where an FT holds an ACO Contract as where that FT held a contract to deliver acute services out of a hospital, or for the GPs running a practice. The draft ACO contract clearly prohibits the

ACO from doing anything which would constitute an unlawful delegation of a CCG's statutory powers, or place the CCG in breach of a statutory duty.

However, the award of an ACO Contract – which places responsibility for all or most health services in an area with one provider – may mean the balance of activities carried out by the commissioner and provider could change. For example, the ACO may carry out more population analytics to understand future health needs.

19. Is primary legislation required to create ACOs?

Primary legislation is not required to create ACOs using the draft ACO Contract.

An ACO will not be a new type of legal entity. 'ACO' is a term we use to describe a provider of health and care services which enters into an ACO Contract with a commissioner.

The draft ACO Contract does not contain any provisions that are contrary to existing primary legislation and so does not require primary legislation before it can be used. There will be no 'designation' of ACOs by NHS England or the Secretary of State (or any other body).

20. The ACO Contract will have a wider scope and higher value than many current contracts – will there be an inappropriate transfer of risk to the ACO?

The scale of an ACO Contract and the systemic importance of an ACO locally make it particularly important that the ACO budget will be used appropriately, that necessary services will continue to be delivered, and that the ACO will remain on a sound financial footing. An ACO would hold the risk associated with any increases in people's demand for services it delivers, as the ACO itself would be responsible for delivering the extra services required.

We will include a number of new and existing safeguards in the draft ACO Contract, to ensure that it is always used as intended to improve the overall health and care of the population in the short and longer term.

These are in addition to safeguards already included from the generic NHS Standard Contract, including rights to terminate the ACO Contract if it does not meet quality or financial requirements, and rights to terminate individual services or sub-contracts.

In addition, NHS England and NHS Improvement have introduced the Integrated Support and Assurance Process (ISAP) to support commissioners to make a robust assessment of the ability of any organisation to hold and deliver the ACO Contract.

21. What's the difference between an ACO and an ICS?

Across England, areas are working to achieve integrate services through greater collaboration between commissioners and their existing providers. In some areas, referred to as an ICS (or “integrated care system”), commissioners and providers are intending to go further to discuss how they can each play their part in improving services and health outcomes for local people within their collective local budget. Those discussions will inform the decisions local commissioners then make about how current and future contracts may need to change. ICSs vary in size, but in general, an ICS will operate across a larger population than that covered by any individual provider (ACO or otherwise).

An ACO is different approach, because under this arrangement the intention is for a lead provider to holds a single contract for the delivery of integrated services for a whole population, and is given an annual budget to do so. It is the accountable provider under the contract, but is likely to sub-contract with other providers to deliver particular services. Instead of there being many contracts between local commissioners and providers, all or most health services for local people are covered by a single contract between the commissioners and the ACO.

22. Why have only two areas of the country been able to develop plans to use an ACO model to integrate health and care services?

A number of local areas have considered ACO models or continue to do so. In many cases, commissioners have decided that an ACO model is not right for their area, or not yet, and so are exploring other means of achieving the integration and more population-focused service delivery they are looking for.

Dudley and Manchester happen to be two areas in which local commissioners are procuring an ACO model. Those commissioners, and local providers, have already developed their proposals sufficiently to suggest that they will be in a position to award contracts to implement their models.