NHS Improvement

To: The Board

For meeting on: 29 September 2016

Agenda item: 8

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Report on: New Care Model Update: NHS Improvement's role in establishing and overseeing Accountable Care Organisation

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1. The purpose of this paper is to provide an update to the Board.

Background

2. In this paper, the term Accountable Care Organisation (ACO) is used as a shorthand for multispecialty community providers (MCPs) or primary and acute care systems (PACS) that involve a single provider taking responsibility for population health and for managing resources across multiple services (as a minimum, community health services and general practice services) that have previously been commissioned and provided separately. This would involve a single contract, underpinned by a single capitated budget.

3. Many of the activities traditionally undertaken by commissioners, eg resource allocation, risk stratification and pathway design, will be carried out instead by the ACO. The new arrangements therefore will shift the boundary between commissioners and providers, although NHS commissioners (CCGs and NHS England) still need to assure themselves, both in the initial contract award and in subsequent contract monitoring, that the ACO arrangement enables the commissioner to meet its statutory duties, for instance in relation to quality improvement, resource management, health inequalities, NHS Constitution standards, public and patient involvement etc. Notwithstanding those continuing CCG duties, it is expected that CCGs will need to pass some portion of their running costs on to ACOs to recognise the activities they are now carrying out instead of the commissioner.

Who are the Vanguard sites in the process of tendering a new contract for an ACO?

4. 14 MCPs and 9 PACS Vanguards are working with the NCM programme to fully develop their care models. Some are closer than others to being ready to move towards new contractual arrangements: the New Care Models team are working intensively with six MCPs to co-develop a new MCP contract for use in 2017-18. Of these, Dudley has made most rapid progress on the path to awarding a MCP contract. Of the PACS Vanguards, Northumberland, and South Somerset have each initiated processes to award a new contract. All of these Vanguards will need to take part in a joint assurance process with NHS England and NHS Improvement prior to contract award.

How will we know if they are succeeding?

5. Evaluation is an important part of the New Care Models programme. The evaluation workstream is tracking the development of Vanguard sites and aims to detect the impact the sites are having. A core set of metrics has been established that are being tracked across all sites, covering each of the triple aims: health and wellbeing, care and quality, and efficiency (emergency admissions per capita and total bed days per capita). A dashboard is shared with Vanguards each quarter, which tracks these metrics against the rest of the MCP and PACS cohorts, and the rest of England (as the counterfactual). Through the national support package, Vanguards have been funded and supported to commission comprehensive local evaluations, which will provide a much richer source of intelligence and data on impact.

6. We do not expect to be able to detect statistically significant change for several quarters, given the natural levels of variation in the data. In advance of that, we can increase our confidence in the likelihood of impact by tracking and supporting the implementation of Vanguards' agreed delivery plans, which are linked to expected outcomes through their logic models. We can also identify specific 'green shoots' – examples of progress from particular initiatives, sometimes covering specific populations or geographic locations. For example:
    - The 'My Life A Full Life' (Isle of Wight) (PACS) Crisis Teams provide wrap around care for people at risk of hospital admission. In a nine month period, the crisis team saw 489 people and spent an estimated £725,000 less than it would have done with a more traditional approach. Of those 489 people, just 58 were admitted to hospital.
    - Stockport Together (MCP) 'Consultant Connect' connects GPs to a 'rota' of hospital consultants. It has reduced GP to consultant referral time from 3-4 weeks, to receiving advice in less than 1 minute. It has prevented hospital referrals in 70% of recorded cases since launching for haematology and endocrinology.
    - Better Care Together Morecambe Bay (PACS) has worked with Millom to improve local healthcare services. The Millom Alliance is a partnership between GPs, the community trust, the acute trust, social care, the

ambulance trust. Analysis of local data indicates that between 2014/15 and 2015/16 there was a 29% reduction in the number of emergency occupied bed days in Millom and Duddon Valley.

7. Despite these emergent examples of initial impact, identifying the specific NCM contribution to overall CCG-wide demand numbers is complex, given the range of other active programmes, system pressures and changes. Over the coming months, the NCM evaluation and metrics team will subject a series of these examples to an agreed and consistent 'impact study' process, testing in more detail the extent to which we can identify the specific contribution of NCM interventions to the observed outcome.

NHS Improvement's role

8. NHS Improvement is working with NHS England and other ALBs to support the development of ACOs, from the planning phase, through transition, to the delivery phase when the model is up and running. This paper addresses the key issues relating to NHS Improvement's role in helping approve and oversee ACOs.

Who agrees that an ACO can be set up?

9. Existing providers can go a long way towards setting up an ACO through collaboration and joint ventures across organisations. If, however, they want to have a single contract and single budget for an integrated set of services and outcomes, the relevant commissioners need to award such a contract. Where new contracts of this kind will have significant implications for the scope of services provided by an NHS trust or NHS foundation trust, NHS Improvement will need to review, as with any other major transaction, the impact on quality and financial sustainability. The key question, however, for both NHS England and NHS Improvement is whether the proposed ACO is likely to improve quality, health outcomes and financial sustainability for the health economy as a whole. NHS Improvement is, therefore, jointly with NHS England and CQC, developing an assurance process for the setup of ACOs (PACS and MCPs). We plan to have agreement across the ALBs by October.

10. The joint assurance process will provide assurance that the proposed model is strategically sound in the context of the local Sustainability and Transformation Plan and is likely deliver net benefits to the local health economy. The joint assurance process will incorporate NHS Improvement's transaction review process which evaluates the risk on the provider organisation taking on the contract. It will also ensure there is a clear plan to effectively manage any short and long term consequences on affected organisations. Existing processes will,

where possible, be aligned behind a 'united shop front' with, for instance, information requests and site visits being planned according to a 'tell us once' principle.

Is there a preferred organisational model or legal form?

11. Procurement rules do not allow for commissioners to specify a preferred provider organisational form. The Organisational Form support workstream has analysed a number of options and their implications, such as whether the given organisational form can hold a contract for primary medical services. This work is helping potential providers evaluate different potential forms and make an informed choice about how they would wish to bid for a contract, taking into account technical differences in relation to VAT recovery, access to the Clinical Negligence Scheme for Trusts and eligibility for the NHS Pension Scheme. It is also supporting commissioners to consider how they would evaluate these bids.

What procurement processes do commissioners have to use?

12. The Public Contract Regulations 2015 came into effect on 18 April 2016 for health services and require a 'light touch' regime. This requires a commissioner to publish a PIN (Prior Information Notice) or a contract notice in the Official Journal of the European Union (OJEU) when it intends to award a contract valued at more than 750,000 euros. The PIN invites expressions of interest from potential providers. Based on the responses, the commissioner can design a process to fairly and transparently select from those providers expressing interest. It need not be a formal competitive tender, as there is only one bidder, the commissioner can proceed without designing such a process.

What are the implications of competition law on collaboration?

13. Competition law is not a barrier to the development of an ACO. In fact, many of the efforts to integrate services are unlikely to be affected by competition rules at all where the service providers are not existing competitors. For example, integrating services along a vertical care pathway (e.g. bringing together acute care, community services, mental health services and general practice) is unlikely to raise competition issues as the service providers are not competitors. Where providers are providing similar services (such as two local hospital trusts) then different considerations come into play. This includes ensuring that plans to collaborate are based around the benefit to patients. NHS Improvement supports trusts that are considering closer collaboration including, where necessary,

advising on the merger review process and ensuring speedy clearance of mergers that benefit patients.

How will the payment system work for ACOs?

14. Capitation combined with payment for quality and outcomes is the proposed approach best suited for mature ACOs. NHS Improvement and NHS England, through working with a number of Vanguard sites, have developed a method for calculating and implementing a simplified version of capitation called Whole Population Budget. The constraints on activity and cost data, particularly outside of acute care, and constraints on ability to link data across care settings at patient level, limit the ability to implement a person level capitated payment mechanism at this time. NHS Improvement will continue to provide support for the sector in developing payment systems.

Who provides oversight and how?

15. The degree and type of NHS Improvement oversight of ACOs will vary by organisational form. ACOs will need to hold a Monitor provider licence, and NHS Improvement is responsible for making sure they meet the terms of that licence. Under the new Single Oversight Framework, if the ACO was an NHS trust the same licence conditions would be applied.

16. If the ACO is an NHS trust or foundation trust, those licence conditions will be the same as for any other trust. If the ACO is a non-NHS provider, there are choices as to how far NHS Improvement adapts its licence conditions to apply similar requirements to those for NHS providers. This is currently under consideration.

17. ACOs will be providing a broad spectrum of health and care services, potentially including primary care and adult social care. This will require NHS Improvement to work with NHS England, CQC and local government to ensure coordinated arrangements for provider oversight. NHS Improvement is working with partners to ensure that ACOs experience what feels like a single form of oversight, while allowing respective bodies to fulfil their distinct statutory duties.

Public Sector Equality Duty:

NHS Improvement has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. We have thought about how the issues dealt with in this paper might affect protected groups. We believe the paper will not have any adverse impact upon these groups and that NHS Improvement has fulfilled its duty under the Act.