

Keep Our NHS Public Draft Briefing Paper

Accountable care systems and the National Health Service (NHS)

Summary

This briefing outlines how, as little as five years since the massive restructuring imposed by the Health and Social Care Act (HSC Act) of 2012, the NHS is again undergoing radical change, this time at breakneck speed and without parliamentary consent.

Recent changes by NHS England (NHSE) divided the English NHS into 44 local health systems or 'footprints' (now 'Sustainability and Transformation Partnerships'). Each of these was required to integrate its local health services, and social care services where local authorities were willing, through cross-boundary working and pooled budgets.

These changes, relying on collaboration between healthcare providers within a 'footprint', appeared to run counter to the Health and Social Care Act of 2012, which sought to increase competition.

Now, as a result of further changes in 2017, ST Partnerships are required to deliver 'accountable care' by morphing into Accountable Care Systems (ACSs), with the aim of becoming Accountable Care Organisations (ACOs). ACOs are non-NHS bodies, 'designated' by NHSE, despite the absence of any statutory authority.ⁱ Behind the rhetoric of superseding competition with collaboration, NHSE intends to replace multiple smaller NHS contracts with a single, long-term lead ACO contractor for each region.

NHSE argues that introducing 'accountable care' (a term often and misleadingly replaced by the more politically acceptable 'integrated care') is central to Government aims for the 'financial sustainability' of the NHS. In this context, ***'sustainability' means reducing services to match insufficient funding.*** Despite being one of the richest countries in the EU, the UK currently spends less on healthcare than countries like France and Germany.ⁱⁱ To close the gap between these countries and the UK would require an increase in spending of over 10%.ⁱⁱⁱ

Accountable care systems (i.e. both ACOs and ACSs) need to be opposed for the following reasons:

- They are being ***introduced without adequate public involvement or meaningful consultation, and without Parliamentary scrutiny;***
- They are being imposed in a context where ***NHS and social care services are seriously underfunded;***
- They are ***being implemented beyond any legal framework,*** creating problems of governance and accountability;
- They are being introduced at pace, with ***no robust evidence base*** to support their use in the UK context;
- ***They increase the potential scope of NHS privatisation.*** For example, multiple procurements will be replaced by a single, major, long-term contract to provide health and social care services for an entire area. The draft model contract for ACOs published by NHSE allows for, and may well attract, bids from multinational corporations.^{iv}
- ACOs will ***help strip NHS assets, such as land and buildings,*** so ending the social ownership of much of the NHS estate while allowing private companies to profiteer from it.

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- They will **enforce the unprecedented real terms freeze in spending** (while costs continue to rise by an estimated £22 billion^v by 2020, compared with 2015 levels) and transfer the NHS's funding shortfall to new local, self-contained areas.
- They **incentivise rationing of services and denial of care**, and so are fundamentally at odds with social solidarity and the values of equity and universalism that underpin the NHS;
- They **rely on unrealistic expectations**, for example about collaboration and the sharing of risk and gain between private and NHS service providers.
- They entail 'transforming' the NHS workforce, replacing experienced clinicians such as doctors and nurses with technologies and introducing new, lower skilled roles, such as physician and nurse associates. ACOs are **likely to under-deliver required skill levels and undermine NHS terms and conditions of employment**.

No one can deny that acute, primary care and community NHS services and social care need to be better integrated. However, this does not require commercial contracts and the involvement of corporates.

A truly integrated system of health and social care requires:

- a) Increased funding of the NHS and personal social care;
- b) Personal social care provided on the same terms as health, free at the point of use and paid for from public funding;
- c) Full and public involvement and meaningful consultation;
- d) Robust piloting of future plans for integration and in-depth, independent evaluation; and
- e) New legislation (see, for example, the NHS Bill 2016-17) that protects Bevan's founding principles of the NHS; ends the marketisation and fragmentation of the NHS; and re-establishes public bodies and NHS services that are accountable to Parliament and local communities.

Accountable care systems and the National Health Service (NHS)

1. Background

In response to the financial crisis of 2008, global consultancy firm McKinsey & Company was commissioned by the Brown government to propose strategies for cutting NHS expenditure. In 2009, they recommended a combination of provider “efficiency savings”, the ending of “low value-added healthcare interventions”, and “a shift in the management of care away from hospitals towards more cost-effective out-of-hospital alternatives”. They cited Kaiser Permanente as a US model for ‘integrated care’.^{vi} ***This move to integrated or accountable care then developed under the influence of the World Economic Forum (WEF).***^{vii}

The WEF initiated a project in 2012, steered by Simon Stevens (former advisor to Tony Blair, then executive vice president of UnitedHealth Group, a US transnational) and dominated by representatives from multinational corporations ostensibly concerned with the financial sustainability of national health services. Their report,^{viii} co-authored by McKinsey, offered governments a number of strategies to deal with rising pressures on public health services. ***WEF’s preferred option was to lower costs by introducing new payment systems; reducing capacity in higher cost settings such as hospitals; and expecting individuals to provide more ‘self-care’.*** The report also argued that the boundaries of the health industry should be redefined, with corporations taking a greater role as markets became increasingly liberalised and governments cut back on public services.^{ix}

Building on this work, ***the WEF ran a second project in 2013, again concerned with the ‘sustainability’ of health systems,*** and again with the involvement of Simon Stevens and McKinsey, among others. Their report proposed ***new ways of delivering integrated or accountable care*** based on models such as Kaiser Permanente in the US, Bundesknappschaft in Germany, “the NHS in North West London and Torbay”, and the Alzira model in Spain.^x

In late 2013 Simon Stevens was appointed to take over as Chief Executive Officer for NHS England (NHSE) as of April 2014. Just six months after he took office, NHSE published its *Five Year Forward View* (5YFV)^{xi}. This ***echoed many of the WEF’s proposals, including the need for “radical new care delivery options”*** such as ‘Multispeciality Community Providers’ and ‘Primary and Acute Care Systems’ ***that NHSE likened to the Accountable Care Organisations (ACOs) emerging in Spain, the US and elsewhere.***

In Spain, the Alzira model of care originated in 1999 as a private/public partnership (PPP) between Valencia’s regional government and a consortium of banks, construction firms and a private health insurer. The model was then taken up in other Spanish regions, with varying success.^{xii} The Alzira model appears to have been NHSE’s preference for NHS organisations pioneering new care delivery systems.^{xiii} ***(For more information on the Alzira model – the exposure of its downside and its fall from grace -see Appendix One).***

In the US, models of accountable care evolved from Health Maintenance Organisations (HMOs). HMOs, run by medical insurance groups, have been notorious for “routine denial of patients’ access to medically necessary treatment; fighting claims; screening out the sick; paying exorbitant CEO salaries; and undertaking systemic fraud”.^{xiv} ACOs were introduced to reduce spending while improving quality measures. They also shift risk from payers (e.g. insurance companies) to providers who are paid to manage the health of populations, rather than the volume of services provided.^{xv} Although state agencies like Medicare or Medicaid currently account for most ACO contracts, there are an increasing number of commercial ACOs in the USA, many run by insurance companies such as Aetna, UnitedHealth and Humana.^{xvi}

From December 2015, the NHS in England was divided into 44 new local health systems (‘footprints’), each charged to produce a Sustainability and Transformation Plan (STP) showing how it would transform services in its area, in line with the 5YFV.^{xvii} Then, in 2017, each

'footprint' became a Sustainability and Transformation Partnership (ST Partnership). The idea is that eventually ST Partnerships will become full-blown Accountable Care Organisations, but given the complexity of this process, ST Partnerships are initially expected to evolve into Accountable Care Systems (ACSs).^{xviii}

2. What are Accountable Care Systems and Accountable Care Organisations?

The terms ACO and ACS are often used interchangeably but there is a distinction. Both involve a number of service providers working together over a set period to take responsibility for the cost and quality of a specified range of health services for a defined population and for a fixed sum (a 'whole population budget').^{xix} However, beyond this, there are a number of differences.

An Accountable Care System is an evolved version of a ST Partnership with responsibility for the health and resources of a defined population. In theory, existing commissioning contracts remain in place. Commissioners, together with a network of providers across different services, enter into an alliance agreement and commit to managing resources together, along with agreeing governance arrangements and the sharing of risk and gain.^{xx} Eight pilot or 'shadow' ACSs were set up across England in 2017. They are not benign, and can affect commissioning contracts, as the Nottingham ACS shows. **(For more information, see Appendix Two.)**

In contrast, with Accountable Care Organisations, a single, long-term contract is held by a single organisation (in some instances a 'care integrator' rather than a provider - see Appendix 2) to take responsibility for providing a bundle of services. This contract holder can decide how to allocate resources and design care for the defined population, as well as change the method or point of service delivery.^{xxi, xxii} Given the aim of integrating health and social care services, there are concerns that the ACO may also decide which services are free and which are to be means tested.^{xxiii}

Not all ACOs have the same structure. **In one version, the lead provider is a single organisation** able to set up a series of sub-contracts with other providers.^{xxiv} **Alternatively, a lead provider (or group of providers) may form a new corporate vehicle (a 'Special Purpose Vehicle' or SPV) to hold the primary contract.** The SPV is a legal entity which, in the case of PFI consortia, have been typically set up by a major bank or insurance company, and which allow the risks faced by providers to be separated out and taken on by investors looking for high financial returns.^{xxv} Already PFI contracts use SPVs for hospital construction and facilities management. Now ACOs can use SPVs to organise the financial administration of clinical services.

2.3 Lessons from elsewhere

2.3.1 In the USA, ACOs mean that the provider (not the commissioner or insurer) takes on the risk of a long-term contract to provide services for a specified population for a fixed budget based on a fee per head of population. It appears that, in the English NHS, adopting the ACO model also means the transfer of financial risk to providers.^{xxvi} **USA providers have struggled to deal with the problem of properly costing the provision of care for a population,** while care coordination and information technology are proving more complicated and expensive to implement than anticipated for bodies like Medicare (See also Section 3.4.3).^{xxvii}

By comparison, in England, funding is nowhere near the US level (nearly 20% of the US gross domestic product is spent on healthcare giving typical per capita spending 3-5 times higher than England levels)^{xxviii} and so there is no margin for organisations to deal with unexpected

additional costs. The more ambitious ACOs in England also extend well beyond health and social care services to encompass public health and other services, and so have little equivalent in the US.^{xxxix}

2.3.2 One of the best-known ACOs outside the United States is the Canterbury Health Board in New Zealand. Recent evidence suggests significant positive outcomes, such as reducing the need for hospital care by supporting more (particularly older) people in their homes and communities.^{xxx} However, in its plans for accountable care systems, NHSE fails to take into account the absence in England of several **important features essential to the success of the Canterbury model.** These include **the maintenance of acute bed numbers alongside increased investment in community-based services, and sustained investment in staff to give them the skills and confidence to innovate.** Significantly, as well as investment, **the Canterbury transformation has taken more than a decade** while still not eradicating a substantial underlying deficit. This highlights the challenge of the tight timescales and limited funding attached to current plans for the transformation of NHS services.

3. What are the issues raised by accountable care systems?

3.1. Human Rights issues

Accountable care systems are based on capitation-based payment systems, including 'integrated' or **whole population budgets** (WPBs) to provide services to a defined population over a specified period for fixed sum.^{xxxi} Even with minimum delivery standards in place, WPBs **provide an inducement to raise treatment thresholds in order to minimise costs, irrespective of the care that is actually needed.**^{xxxii} While capitation funding has been a feature of NHS local allocations since the 1970s and today is the basis for funding of CCGs, the WPB approach – especially in the absence of adequate levels of per capita spending - flouts the duty of government to care for all in society and in this way contravenes the NHS Constitution. It is fundamentally at odds with an NHS based on the principle of social solidarity and the values of equity and universalism.

3.2 Governance, accountability and legal issues

3.2.1 Simon Stevens has made it clear that he will give **ST Partnerships governance rights over organisations within their local health system, including bodies such as CCGs or local authorities with statutory responsibilities.**^{xxxiii} Currently, ST Partnerships (and the accountable care systems they are evolving into) are, by NHSE's own admission not statutory bodies: they have **no legal power to make decisions without referring these back to partner organisations.**^{xxxiv xxxv} The Conservative Party Manifesto in 2017 proposed to change secondary legislation - without any public consultation – to allow ACOs to operate and there is a danger that they may still proceed along these lines.^{xxxvi} A recent consultation on proposed changes to the ACO model contract envisaged organisations that are neither NHS bodies nor local authorities having a role in both providing **and commissioning** healthcare.^{xxxvii}

3.2.2 ST Partnerships are introducing accountable care systems with **scant public involvement or any meaningful consultation.** This is despite the inevitable changes these systems will involve, and despite current law (HSC Act 2012) and statutory guidance,^{xxxviii} requiring commissioners to directly involve the public in commissioning arrangements, including plans to transform services and proposals to change procurement and contracts.^{xxxix} ACOs and ACSs are presented as local bodies working in partnership with local communities but, **in reality, they will be run as businesses with little accountability to local people. This is in breach of the NHS Constitution,** which commissioners have a duty to promote.^{xl} According to the Constitution, the NHS is accountable to the public, to communities and to the patients that it serves.

3.3 Privatisation

3.3.1 The HSC Act 2012 gave clinical commissioning groups (CCGs) control of most funding for healthcare services at the local level. We have already said that, even though there has been no amendment of legislation so far, ACOs will transfer many of CCGs' responsibilities to potentially new organisations and these may not be NHS or local authority bodies.^{xli} In addition, NHSE's draft contract for ACOs shows that the contract holder could be a consortium of companies or even a Special Purpose Vehicle.^{xlii} This could give the private sector (including multinational companies) **a significant role in the planning and commissioning of services, as well in as their delivery.**^{xliii} There are some indications that ACOs will issue a 'prospectus', suggesting they intend to attract private sector funding.^{xliiv}

3.3.2 Funding to run NHS and social care services is being significantly cut.^{xliv} Yet the Naylor Review, to which the government appears to be committed, estimates that the infrastructure necessary for **new models of care will require around £10 billion of capital investment** in the medium term. The review suggests that **about £2 billion of this can be raised by the sale of NHS assets**, notably land and buildings owned by NHS providers in the acute sector, while facilitating the building of 26,000 new homes.^{xlv} Naylor observes that, currently, even though their assets might be "of greater benefit in another part of the healthcare economy", providers such as NHS Foundation Trusts tend to keep assets to fund their own interests and are unlikely to sell what they own to support others with different statutory responsibilities. However, Naylor sees that the introduction of ACOs will overcome this conflict of interest, persuading acute providers to invest their property assets in primary, community and mental health services as part of a collective responsibility within the ACO. According to the British Medical Association, land or building sales will be conducted through public/private partnerships (Project Phoenix),^{xlvii} effectively **undermining the social ownership of NHS assets, while allowing private companies to profiteer from these.**

3.3.3 Many ST Partnerships have used private consultants (e.g. McKinsey, Deloitte and PwC) to develop plans in order to meet the requirements of NHSE's Five Year Forward View, including plans for new models of care. It has been estimated that by February 2017, at least £17.6 million of NHS money had been spent on consultancy fees.^{xlix}

3.3.4 Some fear that accountable care models will provide a structure that, in future, could help facilitate the replacement of the NHS by private health insurance.^l Whilst the NHS as a whole is far too big to sell in a single transaction, ACOs will offer discrete local systems with budgets big enough to attract investors and potential takeovers, or – if the political circumstances allowed this to be considered - with organisational forms compatible with the US health insurance market.^{li}

3.4 Evidence

3.4.1 There is little robust evidence from pioneer programmes in the UK to support the introduction of accountable care systems to the NHS: by NHSE's own admission, these programmes have been of short duration and provided only small sample sizes.^{lii}

3.4.2 Ribera Salud hospitals using the **Alzira model in Valencia** (see Appendix One) claim to have higher patient satisfaction rates, lower staff absenteeism numbers, shorter average lengths of stay, lower waiting times and lower capitation costs than competitors. However, **robust evidence is hard to find:** reliable financial and contract information is limited,^{liii} and there are concerns about the objectivity of data from Ribera Salud.^{liv} Notably, in 2013, after analysing data from a wide variety of public records covering 2000 – 2009, the union UGT-FSP blamed Alzira model management failures for thousands of premature deaths in one year alone.^{lv}

3.4.3 **In the US, ACOs are still at an early stage of development but, so far, there is mixed evidence about performance.**^{lvi} For example, research shows that while the majority of ACOs are able to make quality improvements, reducing costs has been more difficult.^{lviii} The majority

of ACOs are in the Medicare Shared Savings Programme (MSSP), run by the Centres for Medicare and Medicaid (CMS). Claims to save money are contentious: the ACOs are in a one-sided risk-sharing scheme with the CMS, which means that ACOs can keep the savings they make, but any losses are covered by the CMS and ultimately by the US tax payer.^{lix}

Finally, the very different contexts in which the NHS and US health care system operate (not least the different levels of funding), and the lack of a standard model of care makes it difficult to extrapolate from the US experience or learn from cross-national experience more generally. As researchers from Manchester Business School put it, “Care is needed to avoid unwarranted inferences that this [ACO] policy will deliver the claimed benefits of lower costs whilst maintaining sustainable quality.”^{lx}

3.5 Unrealistic expectations

3.5.1 ST

3.5.1 Partnerships (or subsequently accountable care systems) will have to rely heavily on the co-operation of all organisations within each partnership. Yet in Sept 2017, a survey showed that **only one of 56 organisations involved in ST Partnerships believed that full joint working would be achieved in the next five years.**^{lxi}

3.5.2 ST Partnerships and their successors also have to introduce a new form of financial control (a shared control total),^{lxii} in which financial risk is shared across the whole local health system: individual providers within the system must set aside their own interests and allow any surpluses they make to be used to offset losses elsewhere within the system. In effect, **each provider will police the spending of its partners. As, increasingly, many providers within an accountable care system could be private companies whose first priority must be to make profit, they are unlikely to put aside their own interests for the good of the whole, especially as some NHS providers will be in deficit.**^{lxiii} Alternatively, this system runs the risk that public funding will support private companies operating at a loss.

3.6 Workforce issues

There are indications that one of the ways in which an ACO will reduce costs will be through ‘transforming’ its workforce. As in the McKinsey (200) report and current STP plans, “provider efficiencies” are the biggest source of cost cutting. **ACOs are likely to have reduced numbers of doctors and nurses who will be replaced by new technologies, and new roles - such as lower paid, lower skilled physician and nurse associates. It is feared that nationally agreed pay levels and NHS terms and conditions of work will be undermined** as members of staff are transferred to employment by ACOs and offered locally negotiated employment contracts.^{lxiv}

4. Conclusion

Accountable care systems (especially ACSs) are being introduced at breakneck speed, without robust evidence, and in the absence of meaningful public involvement and consultation, parliamentary scrutiny or appropriate legislation. In addition, they are already beginning to give private corporations new roles and powers to shape the NHS in their interests.

No one can deny the need for acute, primary care and community NHS services and social care to be more coordinated. However, this does not require commercial contracts and the involvement of corporates. **These new models of care must be opposed.**

Instead, the success of **a truly integrated system of health and social care** requires:

- **Increased funding** of the NHS and personal social care to ensure that integration can deliver improved patient services rather than be the disguise for ‘efficiency savings’ and cuts;
- **Personal social care provided on the same terms as health**, free at the point of use and paid for from public funding, as in Scotland;

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- ***Full public involvement and meaningful consultation;***
- ***Robust piloting*** of future plans for integration with in-depth, independent evaluation;
- ***Clarity on the governance and accountability of decision making bodies;***
- ***New legislation*** that protects Bevan's founding principles of the NHS; ends the marketisation and fragmentation of the NHS; and re-establishes public bodies and NHS services that are accountable to Parliament and local communities – legislation such as that drafted in the NHS Bill 2016-17.

Acknowledgements

Many thanks to members of Keep Our NHS Public for information and comments.

Appendix One: The Alzira model

The Alzira model is a form of public-private partnership (PPP), similar to the contentious Private Finance Initiative (PFI). However, with the Alzira model, not only does the private sector finance, construct and operate new infrastructure (such as a new hospital building), but it also delivers the clinical services as well.

The original Alzira PPP marked the first time that the private sector in Spain could enter into contracts to self-manage hospitals. In the late 1990s the regional government of Valencia awarded a ten-year contract to UTE-Ribera – a Special Purchase Vehicle (SPV) comprised of savings banks and Ribera Salud^{lxv} to provide the finance, plus construction firms and a medical insurance company - to build and run a new public hospital (the La Ribera in the town of Alzira).

The UTE-Ribera's tender was based on an annually adjusted capitation fee, initially set at 204 euros per resident. Health officials noted at the time that this figure was very tight. It had to cover all the expenses needed to provide the service (including payroll, drugs and other medical consumables, utilities, depreciation of assets and the cost of loans) whilst elsewhere in Valencia capitation fees were between 301 and 362 euros.^{lxvi} UTE- Ribera's profits were capped at 7.5%.^{lxvii}

The La Ribera hospital opened in 1999. As a privately-run hospital, it introduced a new contract of employment terms and conditions considerably worse than those found in the public sector: pay scales were lower, hours were longer and there was less job security. In addition, working practices were changed to 'boost productivity'.^{lxviii}

The contract with Ute-Ribera was terminated in 2003 following financial losses. Subsequently, the SPV was refinanced, and a new contract put in place, this time giving UTE-Ribera responsibility for all health care – both primary and secondary - for the local population. The capitation fee was raised to 379 euros.

Use of the Alzira model was extended to other regions, including Madrid, but only for 'specialist' or hospital-based care. However, following mass health workers' strikes and other difficulties, the regional government abandoned its plan to use the Alzira system for six public hospitals.

Some research suggests that in 2008, compared to public health care, the Alzira model offered a saving of around 28%. This figure is highly questionable. Researchers^{lxix} have noted that comparisons between PPPs and public health systems are impossible because of variation in healthcare models; lack of reliable information from the private sector; and because some PPP costs are still borne by the public sector (such as outpatient costs for pharmacy, prosthetics and transport). Some savings have been attributed to reduced quality of care and lower wages. Medical salaries had a fixed component of 80% (90% for general practitioners) and a variable element (up to 20%) dependent, for example, on shifts or how staff responded to incentives.^{lxx}

NHSE appears to favour the Alzira model but there are concerns about importing it to UK.^{lxxi} For example, it would transfer significant power from Clinical Commissioning Groups to private providers. In the Spanish context, commissioners used contracts to state the outcomes they wanted, but with little detail and direction about how to do this. There have also been concerns about the closeness noted between the contract holder and their suppliers, meaning less than rigorous oversight of sub-contractors. In the English context, this model could squeeze out other types of providers, like social enterprises or charitable providers. In addition, research^{lxxii} suggests that the Alzira model has built-in 'perverse' incentives, such as encouraging managers to 'cherry pick' the most lucrative specialties or inducing clinicians to choose cheaper treatments that may not be in patients' interest.

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As noted above (Section 3.4.2), in 2013, after analysing data from a wide variety of public records covering the years 2000 – 2009, the union UGT-FSP blamed Alzira model management failures for thousands of premature deaths in one year alone.^{lxxiii}

Notably, in June 2017 the new coalition government in Valencia passed new legislation to return the Alzira health concession to direct public management. At around the same time the Ribera Salud Group, a main player in the Alzira PPP (and increasingly involved in the NHS in England), came under police investigation for embezzlement and corruption.^{lxxiv}

Also of note, Ribera Salud manages the Vinalopó University Hospital, near Alicante, via its wholly owned subsidiary, the SPV Elche Crevillente Salud SA. In Oct 2017, the Valencia regional government imposed a €150,000 fine on the SPV for exposing workers in the Pathology Department to formaldehyde, classed as “carcinogenic to humans” by the authoritative IARC.^{lxxv}

Ribera Salud is 50% owned by the US transnational health insurance company Centene Corporation.^{lxxvi} Centene is currently keen to expand in the UK, where they already own 75% of The Practice Group, a private company involved in providing an expanding range of NHS services, primarily in primary and community care, across a number of regions.^{lxxvii} Their involvement in the Greater Nottingham ACS is detailed in Appendix 2.

Appendix Two

The eight shadow Accountable Care Systems

Eight 'shadow' Accountable Care Systems were set up in early 2017. These are Frimley Health (including Slough, Surrey Heath and Aldershot), South Yorkshire & Bassetlaw (covering Barnsley, Bassetlaw, Doncaster, Rotherham, and Sheffield), Nottinghamshire (with an early focus on Greater Nottingham and Rushcliffe), Blackpool & Fylde Coast (with the potential to spread to other parts of the Lancashire and South Cumbria at a later stage), Dorset, Luton (with Milton Keynes and Bedfordshire), Berkshire West (covering Reading, Newbury and Wokingham), and Buckinghamshire.

These shadow ACSs have been offered certain freedoms by NHSE, provided they sign up to a number of new measures, including agreeing to regional performance contracts, "assertively" reducing growth in service use, and delivering NHSE's 5YFV plans faster than other regions. Between them they have the potential to control £450 million of transformation funding over the next four years.

The example of Greater Nottingham 'shadow' Accountable Care System

The ST Partnership across South Nottinghamshire (the "Greater Nottingham Health and Care Partnership") is made up of four Clinical Commissioning Groups, the City and County Council, Nottingham University Hospital, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham Citycare Partnership, Circle (the private hospital group that took over and then abandoned Hinchingbrooke),^{lxxviii} East Midlands Ambulance Service and Nottingham Emergency Medical Services.

In 2016, this Partnership began to develop a strategy for an ACS in collaboration with McKinsey and Co^{lxxix} and by drawing on the experience of three local Vanguards (i.e. pilot schemes supported by NHSE to test its proposals for new models of care). The Partnership was also working with the discredited Ribera Salud^{lxxx} associated with delivering the Alzira model (See Appendix One).

By the end of 2016, the ST Partnership had submitted a proposal to NHSE concluding that three elements were required to enable integration within the ACS: a single process for commissioning health and social care services across CCGs and local authorities; joined-up delivery of health and social care services; and new partnerships to support integration, using expertise from across the UK, or internationally.

The early focus for the ACS was on Greater Nottingham and the southern part of the STP, focusing on out-of-hospital care, hospital care (including referrals and discharge processes) and urgent and emergency care.

In 2017 the Nottingham and Nottinghamshire ST Partnership used £2.7 million of its £5.7 million transformation funding to buy in interim support and advice on developing an Accountable Care System (ACS).^{lxxx} The ST Partnership procured commissioning support from Capita – a company infamous for what NHSE has described as an "unacceptable level of performance"^{lxxxii} in fulfilling a £700m contract to provide back-up services for GP practices across England that led to shortages in basic equipment and delays in the transfer of medical notes.^{lxxxiii}

Capita is one of eight organisations accredited by NHSE to deliver support services to CCGs and other commissioners of health and social care services,^{lxxxiv} and the only one to bid for the contract to acquire the expertise that the Greater Nottingham STP Partnership claimed was not available internally. As a prime provider, Capita supported the tender process and acted as a link between the ST Partnership and Centene UK (part of the major US healthcare insurer Centene Corporation). It is understood that Capita is to remain involved in 'assurance' work

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while Centene UK will be ‘the boots on the ground’, developing the ACS and establishing work streams concerned with patient pathways, population health, social care, provider payment mechanisms, information management and technology and what has been described as ‘ACO design’: Centene will not be a healthcare provider but an “integrator of care”.^{lxxxv}

A subsequent £210 million, 7-year contract for out-of-hospital care makes clear that the ACS will be a single, risk-bearing entity that manages the entire care continuum. It will hold the budget for, as well as provide, a wide range of services including Public Health, Primary Care, Community Services, Social Care, secondary Acute Care, prescribing, Mental Health and Continuing Care. Whoever wins that contract will be expected to work with the Care Integrator responsible for providing support and the successful delivery of the ACS.

Implementation of the ACS is planned for early 2018/19. The CCGs involved have already agreed to move to one contract for the ACS partnership, suggesting the system is already evolving into an ACO. From Autumn 2017 they expect to have formed a joint committee, with a single accountable officer, to oversee the work of providers and ensure value for money.

The small print of a contract notice^{lxxxvi} appearing in the Official Journal of the EU (OJEU) indicates how the role of CCGs could change with accountable care systems. If this contract notice is anything to go on, CCGs will remain responsible for ensuring that accountable care systems are commissioned so as to provide maximum value; that CCGs will set the required population-level outcomes; and will hold accountable care systems to account for delivery. In turn, providers will enable the delivery of, or contracting for, provision of all NHS and local authority funded health and care services. Providers will also be responsible for integrating primary, community and hospital services. But not only this, the evolution to an accountable care system will involve modification of existing providers’ contracts, and require the provider to consent to the transfer of the supervision of their contract to another provider or to the system’s Care Integrator “*in the place of the CCG*”.

Endnotes

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- i <http://blogs.bmj.com/bmj/2017/11/14/jeremy-hunt-must-consult-properly-on-accountable-care-organisations/>
- ii A new definition of 'health spending' adopted by the Organisation for Economic Co-operation and Development (OECD) now includes spending on social care and preventative health. This definition suggests that, in 2014, the UK spent 9.8% of its GDP on healthcare compared with the average of 9.7% for the EU-15 (EU members prior to 2004). However, spending per person in the UK is below EU-15 averages. <http://www.bmj.com/content/358/bmj.j3568>
- iii <http://www.health.org.uk/blog/accounting-care-0>
- iv <https://www.england.nhs.uk/wp-content/uploads/2017/08/1bi-170804-ACO-Contract-Particulars.pdf>
- v There have not been actual cuts in total NHS funding since 2010 - funding has risen very slightly in cash terms. However, the rise has been far slower than the growth of population need and cost pressures. £22bn is the gap between the virtually frozen funding for 2015-2020 and the steadily rising costs and pressures, and that implies "savings" which must amount to cuts.
- vi <http://www.nhshistory.net/mckinsey%20report.pdf>
- vii The World Economic Forum describes itself as the International Organisation for Public-Private Cooperation, "providing a platform for the world's leading 1,000 companies to shape a better future."
- viii http://www3.weforum.org/docs/WEF_HE_SustainabilityHealthSystems_Report_2012.pdf
- ix For a fuller analysis of the World Economic Forum's healthcare group, and its influence on redesigning the NHS, see <https://www.sohealth.co.uk/2017/05/25/truth-stps-simon-stevens-imposed-reorganisation-designed-transnational-capitalism-englands-nhs-stewart-player/>
- x http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf
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- xviii <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> p31
- xix <https://improvement.nhs.uk/resources/whole-population-budgets/>
- xx https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf
- xxi <https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/nhs%20structure%20and%20delivery/stp/accountable-care-systems-briefing.pdf?la=en>
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