



## Integrating care: contracting for accountable models NHS England

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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## Summary

- 1** The [NHS Five Year Forward View](#) and the Next Steps update published in March 2017 described a movement towards integrated care, delivered through collaboration across health and care systems.
- 2** Sustainability and Transformation Partnerships (STPs) have been established across England. These partnerships are pragmatic vehicles for health and care organisations to chart their own course for keeping people healthier, improving care and managing taxpayer money in the most optimal way. STPs are a means to an end – a way of facilitating collaboration amongst local leaders and clinicians to improve services and to make the most of every pound of public spending.
- 3** Some areas are ready to go further and more fully integrate their services and funding. The national bodies have designated eight emerging 'Accountable Care Systems' (ACSs), along with two devolution areas (Surrey Heartlands and Greater Manchester), that will lead the way in implementing the priorities set out in Next Steps. An ACS is an evolved version of an STP, potentially covering a sub-set of an STP's geography, in which commissioners and providers, in partnership with Local Authorities, take explicit collective responsibility for resources and population health. In return, they will gain greater freedom and control over the operation of their local health system and how funding is deployed. As more STPs mature, we expect to add to the list of ACSs, laying the foundation for systematic integration of health and care services across the country.
- 4** Some areas also wish to establish Accountable Care Organisations (ACOs). ACOs and ACSs have the same objective of integrating care and having a single, systematic approach to using the resources for a local population to improve quality and health outcomes. They are different in that an ACO is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health. ACO procurements are lengthy and complex, and the development of ACOs relies on a strong underlying approach to care design, engagement and collaboration. For these reasons, most parts of the country are looking to become ACSs before they consider whether to introduce ACOs for some or all of their local population.
- 5** A few areas – particularly some of the MCP and PACS vanguards – are on the road to establishing an ACO. An ACO model simplifies governance and decision making, brings together funding streams and allows a single provider organisation to make most decisions about how to allocate resources and design care for its local population. This creates a more structural solution to accountability for the care and resources for that population. Some ACOs could develop within ACSs, and on a smaller footprint, as part of a wider, collaborative system.

- 6 In the small number of areas that are ready to establish ACOs, we will support their development. Early ACOs will provide valuable learning from which the rest of the system can draw. As ACOs develop, they will need to demonstrate a number of features including the following, described in more detail throughout this package:
- a. A focus on delivering the concrete service improvements set out in Next Steps.
  - b. A compelling vision of the benefits the ACO will deliver, starting with clear outcomes and objectives and a plan for how they will be achieved
  - c. A robust and sustainable financial model with credible plans for managing activity and financial risk within a defined population budget
  - d. Consistency with STP/ACS plans for the future
  - e. High levels of engagement and support amongst health and social care leaders, staff and the public, including the local STP/ACS lead
  - f. In particular, sufficient commitment from primary care providers, who are critical to the success of accountable care, that they are ready to participate
  - g. Robust system plans to commission, procure, fund, establish and oversee the ACO, developing more strategic health and care commissioning arrangements and providing assurance that the new ACO provider is capable of delivering the vision.
  - h. Clear plans to identify, mitigate and manage the risks inherent in the new model. And a robust assessment that the new provider is able to manage them.

In most places, we expect that ACS development will precede the development of ACOs in order to lay the right foundations.

## New models of care

- 7 The Five Year Forward View introduced the concept of a Multispecialty Community Provider (MCP). A detailed description of the MCP care model was then set out in the [Multispecialty Community Provider Emerging Care Model and Contract Framework](#), published in July 2016. The MCP is one type of whole population provider. A second Framework published in September described another: the Primary and Acute Care System (PACS) [Integrated primary and acute care systems – Describing the care model and the business model](#). Where contracted, organisations delivering both the MCP and PACS care models are forms of ACO. In both cases, the Frameworks set out the detail of the care model envisaged.
- 8 In essence, an MCP brings together GPs and other providers of out-of-hospital services to deliver a more integrated model of care. It incorporates a much wider range of services and specialists than traditional models and can encompass mental health services, and social care services where this is agreed by the CCG and local authority. The scope of individual ACOs will vary across a spectrum, with PACS incorporating a wide range of acute services whilst MCPs include fewer, if any, hospital-based services. All accountable models build on strong primary care foundations. In many Vanguards the model is based on local units of integrated primary care provision serving natural communities of 30–50,000 population.

## A new contractual framework

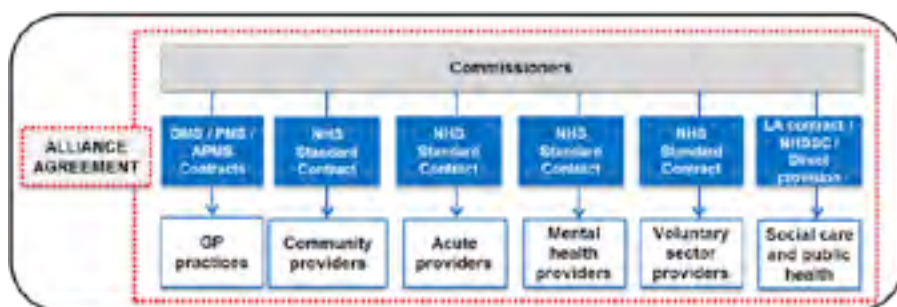
- 9 The [MCP Framework](#) gave an initial outline of a new MCP commissioning contract. Following further engagement and joint working with Vanguard sites, NHS England published a version of this new Contract and a set of supporting documents in December 2016, with the aim that commissioners could start to use these to inform the early stages of their local procurement processes.
- 10 Following engagement on that draft, the contract has been revised for local commissioners and is published here in a state that can be used with substantial elements for local completion. It provides for the delivery of accountable models of care, including the delivery of primary care and other services through a single contractual model. Importantly, the Contract is now usable for accountable care models generally, including MCP and PACS models.
- 11 This package clarifies how accountable models may be contracted for, how local areas would approach procurement questions and the application of the new Integrated Support and Assurance Process, run by NHSE and NHSI in relation to the award of all novel or complex procurements by commissioners. It sets out the funding model including the details of integrated budget approaches, a new Improvement Payment Scheme to replace current incentive schemes and gain/loss sharing across the local health economy to align incentives. Finally, the package describes implications for the commissioning system of new models of whole population provision.
- 12 While the package most often uses MCPs to illustrate the principles of accountable care models, those principles are applicable to all such models

## Establishing the care model in practice

- 13 As described in the MCP and PACS Frameworks, we envisage three main contractual approaches through which accountable models can be established in practice.

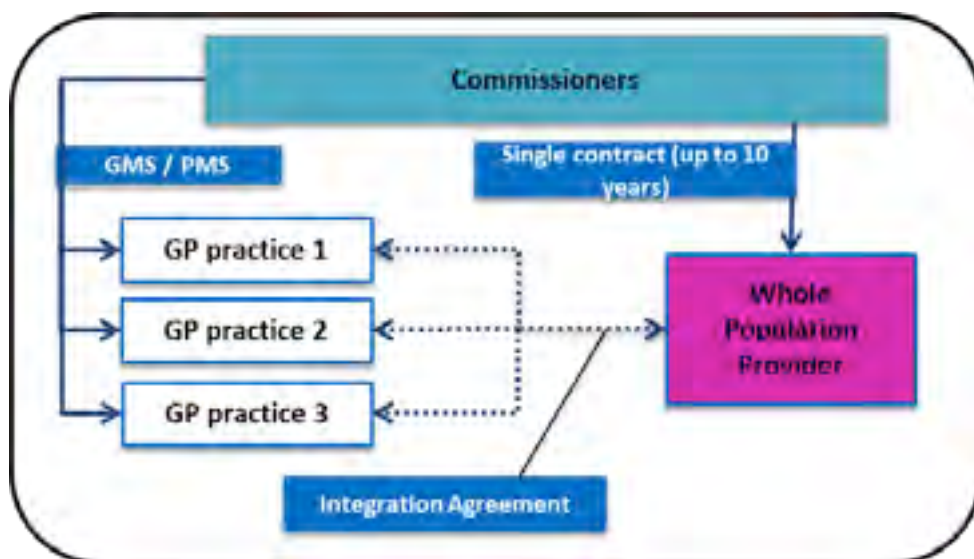
### 14 'Virtual'

- The first approach would see practices, local community services providers and commissioners enter into an "alliance agreement" which would overlay (but not replace) existing commissioning contracts. This agreement could establish a shared vision, a commitment to managing resources together, as well as clear governance and gain/risk sharing arrangements, together with an agreement about how services will be delivered operationally. Many virtual models will usefully include acute providers in the model. Virtual models do not create a single Accountable Care Organisation and in this way are more similar to an ACS.



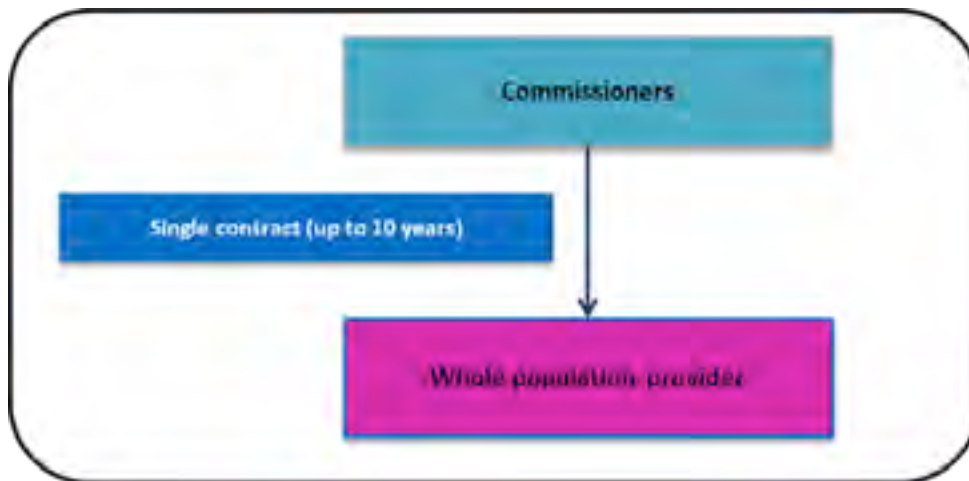
## 15 'Partially-integrated'

- The second approach would be for commissioners to re-procure, under a single contract, all services that would be in scope of a fully-integrated model except for core general practice. The organisation holding the contract would be required to integrate these services directly with core primary medical services (and, would enter into an "integration agreement" with the practices delivering those services to support its integration obligations). It may not provide all services directly, and may arrange for a series of subcontracts to be in place with other providers to capitalise on specific skills and capabilities available elsewhere in the system. The entity awarded the contract could be a new organisation (perhaps a joint venture vehicle) or an existing organisation taking a lead role across the system. Under this model, practices would continue to be commissioned to provide primary medical services under their GMS/PMS contracts; GPs would still be able to take a management, leadership or ownership position in the ACO itself.



## 16 'Fully-integrated'

- The third approach would be for commissioners to re-procure, under a single contract, all of the 'in scope' services, including core general practice. This will establish a single organisation as lead provider for the full range of community and primary medical services (and, in the case of PACS and some other accountable care models, acute services), with full responsibility for provision and integration of care. A GP or practice could relate to the ACO as one or more of co-owner, director, employee or sub-contractor. Because essential primary care services would be commissioned under the new contract, the fully-integrated model requires GPs to be released from their current contractual obligations (under a GMS, PMS or APMS contract). This can either be effected by terminating current contracts or through temporary 'suspension' of those contracts. NHS England has engaged with the BMA on how such a suspension mechanism could be introduced, and we are working with the Department of Health to consult on changes to regulations to create this option as soon as possible over the coming months. As with the partially integrated option, the contract holder could agree with other providers to subcontract a range of services rather than provide these directly. This may include primary care services, where practices choose during the procurement to become subcontractors.



17 In principle, each of these three approaches could deliver the outcomes envisaged. Local areas will need to work through the trade-offs between:

- the degree of formal integration they want to achieve and the strength of governance and decision making required for implementation of the model; and
- their appetite for change and the pace at which they are able to proceed.

Some areas may choose a virtual or partially integrated model as an endpoint or transitional step. Others may decide this doesn't enable them to secure enough of the benefits of the fully integrated model. Mixed economies, in which some GPs take part in a fully integrated sense and others in a partially integrated relationship, are also possible. This will require us to work through the detail with sites.

18 The Contract is designed to act as the commissioning contract for the partially-integrated and fully-integrated approaches. Under the virtual approach, existing commissioning contracts remain in place – but augmented by an alliance agreement between the parties, a model version of which we have published as part of this package of materials.

19 An effective local health and care system should provide NHS, public health and social care services in a joined-up way for its population, but it is for local commissioners to decide how to achieve this integration. Accountable models can therefore include public health and social care services where this is agreed by the CCG and local authority – and this is the intention in a number of vanguards, if not initially then at a later point.

## Supporting documents

20 Alongside this Contract, and to assist those likely to use the Contract early, NHS England has also published a series of supporting documents, covering the following:

- Summary of engagement feedback.** This summarises the key themes of the feedback we received during the engagement process and the work being undertaken to address the feedback.



- b) Explanatory notes to the Contract.** These give a high-level explanation of the function of each main section or schedule of the Contract.
- c) Model Integration Agreement.** This is a model document for local adaptation, for use with the 'partially-integrated' model described in paragraph 15 above; it sets out how an accountable provider and local GP practices will work together to integrate the ACO's services with core primary medical care to deliver the accountable care model.
- d) Procurement and assurance approach.** This sets out:
- relevant procurement legislation relating to the use of the Contract;
  - how the national Integrated Support and Assurance (ISAP) process will interact with the procurement;
  - key steps and considerations for CCGs;
  - GP engagement considerations during the procurement process; and
  - annexes on potential considerations in relation to workforce and estates
- e) GP participation in an MCP.** This sets out:
- how the model fits in with the broader strategy for primary care as set out in the General Practice Forward View;
  - what an MCP means for patients, the GP's role and the practice; and
  - implications for existing GP contracts.
- f) ACOs and the NHS commissioning system.** This covers:
- advice on CCG duties; and
  - current rules around pooling of budgets
- g) Finance and payment approach for ACOs.** This covers:
- the payment approach, comprised of three main elements;
    - the 'integrated budget' or single payment made to the new entity;
    - a 'gain / loss share agreement' to align financial incentives across health services provided for the population; and
    - the 'Improvement Payment Scheme' designed to incentivise improved outcomes
  - the structure of these three elements, and how they can be contracted for.
- h) Whole population models of provision: Establishing integrated budgets.** This provides detailed guidance on the construction and operation of the population-based payment to an ACO, including details of how a gain / loss share agreement can be constructed. We are seeking feedback on this document via the following survey link: <https://www.engage.england.nhs.uk/survey/whole-population-model/>
- i) Incentives framework for ACOs.** This sets out a description of the emerging framework that will be used to assess performance in these models, and a pay for performance scheme, the Improvement Payment Scheme. We are seeking feedback on this document via the following survey link. <https://www.engage.england.nhs.uk/survey/498133f0>

**j) Accountable models and NHS Pensions.** This covers:

- the current rules for NHS pensions access and how they apply to accountable models.
- a summary of changes to pensions regulations to protect access to the NHS Pension Scheme.

In addition to the supporting documents to the Contract outlined above NHS England has also published the following document for use with the 'virtual model'."

The Model Alliance Agreement is a model document for local adaptation, for use with the 'virtual' model described in paragraph 14 above. At this stage this agreement is focused on the development of new governance arrangements to bring providers and commissioners together, but does not reference specific detail related to the care model. We will work with sites to develop this further over the coming months.

## Key changes made in the Contract and supporting documents

**21** We have made a number of changes to the Contract and supporting documents, compared to the versions published in December 2016. Those made directly in response to feedback during the engagement process are summarised in the separate document referred to in paragraph 20a) above. Importantly:

- The Contract published in December 2016 reflected the existing mandatory requirements for contracts for primary medical care set out in the DH APMS Directions. These Directions were designed to operate in the context of much lower-value, primary-care-only contracts and were, in some respects, not fit for purpose for use in this new context. DH has now drafted a revised set of Directions relating to contracts for accountable care, which are expected to be published in final form later in the year. We have updated the Contract to refer to the new Directions as currently drafted by DH, but further iteration will be required to reflect the final version when published.
- Our original thinking in drafting the Contract was that an MCP would not be responsible for running acute services based in hospitals. It has become clear that commissioners in some vanguard sites intend to include a range of acute hospital-based services within scope of their MCP. It has also become apparent that, with minimal tailoring, the Contract – with inclusion of provisions from the current NHS Standard Contract which apply specifically to acute services – should be fit-for-purpose for use for ACO models more generally. We have therefore imported those provisions into the Service Conditions of the Contract only. The 'tailoring' functionality which we have now built into the Contract means that these provisions need only apply where relevant.

MCPs and PACS models are points on a spectrum of integrated, population-based provision in an accountable model. Although we will wish to engage further with those using the contract to tailor it for their purposes, we believe that, with the inclusion of the acute-specific provisions described above, the Contract is now broadly suitable for adaptation and use for all accountable models, including those which feature the full range of CCG-commissioned acute services.

## Planned changes to regulations to support the development of ACOs

- 22 We have been working closely with the Department of Health (DH) to ensure that relevant regulations are updated where necessary to reflect the development of a new contract. There are a number of ongoing discussions which may lead to regulations changes being made later in the year, in advance of the first contract being signed. The substantial potential changes are listed below:
- **Pensions:** We have agreed with the DH and HMT, following formal consultation in late 2016, that clinical subcontractors to accountable providers will be able to pension this subcontracting income in line with the current Independent Provider (IP) regulations. This recognises the fact that funding for these services would previously have been eligible for the NHS Pension Scheme where it was provided directly by NHS Standard Contract holders, and will continue to be on the condition of the use of an approved standard sub-contract. An amendment to regulations has already been made to allow IP subcontractors to an NHS Standard Contract to pension this income from April 2017, and further changes are planned to incorporate approved subcontracts to accountable models contracts on the same basis later in 2017
  - **GMS / PMS suspension:** We are working with DH to make changes to the GMS and PMS Regulations in order to allow for suspension of these contracts which will allow practices the option of joining a fully integrated model. For more information please see the GP Participation in an MCP document.
  - **Section 75 Partnership Regulations:** NHS England has developed evidence to support discussions with the Department of Health about changes to the s.75 arrangements in order to enable the pooling of budgets for all services delivered by a new care model provider. We expect changes to be made to regulations in support of this in 2018, and will work with commissioners in the meantime to ensure the current exclusions to s. 75 agreements are not a barrier to taking forward these models.

## Further development of the Contract – and its use in practice

- 23 It remains our intention that, following formal consultation in due course, the Contract for accountable models will become – like the generic NHS Standard Contract – a model commissioning contract, mandated by NHS England under our Standing Rules regulations for use by commissioners in specific circumstances.
- 24 In the meantime, however, the revised Contract which we have now published is not the finished article. We remain committed to working closely with vanguards and other stakeholders to develop and improve the Contract further in the light of their practical experience on the ground. Further work remains to be done in order, for instance, to
- clarify the final arrangements for the Improvement Payment Scheme and incentives framework for ACOs;

- ensure that the Contract is workable for, and reflects the specific needs of, local authorities as commissioners of social care and public health services (we have agreed a programme of work on this with the Local Government Association and local authorities involved in vanguards, with the aim of establishing whether further amendments are needed to the Contract by late summer); and
- reflect in the Contract the precise content of final revised DH regulations and directions.

We will also develop further supporting materials, including a model subcontract which we expect to make available later this year.

## 25 So what does this mean for commissioners who are now ready to take forward procurement of an ACO model?

- The current version of the Contract is not intended, at this stage, as a final contract suitable for signature at local level. Further development at national level and in discussion with sites will be required before this becomes the case for each transaction.
- However, CCGs may use this Contract in the early stages of their local procurement process. They may, for instance, start to populate local schedules of the Contract on a provisional basis, so that – through a proper, transparent process – potential providers can see the commissioner’s emerging detailed intentions.
- In doing this, CCGs must ensure that they make clear to potential providers the nature of the current Contract – and that the contract to be signed locally will be in a revised form mandated or approved by NHS England in due course.
- For early procurements, NHS England will operate a process of ‘approved derogations’ to address situations where a CCG believes that a specific element of the current Contract is not suitable for its particular local circumstances. In such a situation, the CCG may approach NHS England (via [england.newbusinessmodels@nhs.net](mailto:england.newbusinessmodels@nhs.net)), with details of the aspect of the Contract which it would wish to vary and its rationale for doing so. NHS England will consider such approaches on a case-by-case basis. Where a derogation is approved in principle, NHS England will work with the relevant commissioner (and its legal advisors where appropriate) to agree and sign off revised wording for use in the local contract.
- We will do further work over the coming months to develop the Contract so that by the time we formally consult we have a single, final document which, with the addition of appropriate local content, works for all forms of integrated, accountable commissioning. Commissioners who are now at the stage of needing a contract to use in the early stages of their procurement process may use this version, working with us.
- Local areas pursuing an ACO using the Contract will be required to go through the Integrated Support and Assurance Process (ISAP) to ensure (amongst other things) that the Contract is indeed fit for their purposes. In advance of ISAP, commissioners are of course welcome to approach NHS England (via [england.newbusinessmodels@nhs.net](mailto:england.newbusinessmodels@nhs.net) for early, informal advice).

- 26 This updated version of the Contract, and the majority of the revised package of supporting materials, are not being published for a specific period of engagement or consultation – they are being made available for use locally, on the basis set out above. We are requesting feedback on the two new documents in the package (the integrated budgets handbook and incentives framework for ACOs) at the following links <https://www.engage.england.nhs.uk/survey/whole-population-model/> and <https://www.engage.england.nhs.uk/survey/498133f0>. However, we will continue to welcome feedback from stakeholders on ways in which we can continue to improve the Contract and full wider package; feedback can be sent at any point to [england.newbusinessmodels@nhs.net](mailto:england.newbusinessmodels@nhs.net)

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