

# A seven step guide to accountable care

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# Introduction

*Next Steps of the Five Year Forward View* (March 2017) sets out plans for the transition of the NHS to population-based integrated health systems. This will be achieved by the evolution of Sustainability and Transformation Partnerships (STPs) into Accountable Care Systems (ACSs) and in some areas eventually into Accountable Care Organisations (ACOs).

Accountable care is more easily defined by a series of common characteristics than by a fixed definition. A commonly held definition of accountable care is a model which brings together a variety of provider organisations to take responsibility for the cost and quality of care for a defined population within an agreed budget (for example, a whole population budget).

NHS England distinguishes between ACSs and ACOs. An ACS will allow STP partners to work together to integrate care and develop collective responsibility for resources and population health. An STP that develops into an ACS is also expected to get greater control and freedom over the health system in their area, working closely with local government. Becoming an ACO will be the end objective in the evolution of STPs in some areas, where commissioners will contract with a single organisation for the great majority of health and care services in an area.

NHS England rightly acknowledges that one size does not fit all and STPs are continuing to develop at different speeds with different arrangements for STP leadership and accountable care.

This briefing identifies seven key steps STPs and their partner organisations should consider to support the evolution to accountable care.

## Step 1: Phasing

NHS England recognises that the transition to accountable care is complex and requires careful management of risk. In particular, ACOs are likely to take time to establish, given they will be dependent on the award of whole population budgets under long term contracts. Staged implementation will be necessary, starting with the evolution of existing care models and organisational structures towards ACSs.

Partners will need to identify the roadmap towards delivering accountable care over the coming years.

### Key issues to consider will include:

- commissioners' procurement plans for existing contracts due to expire
- commissioners' plans to put in place MCP or PACS contracts and whether competitive procurement processes will be required by procurement law
- a phased approach to primary care integration recognising that it may take some time for GPs to move to fully integrated models and that GPs may want to move at different speeds.

## Step 2: Partners

STPs may decide that their area is suited to one accountable care model or a number of different models. Early clarity about the key partners in each model will be essential. Some partners will be obvious, such as commissioners, GPs, acute and mental health trusts. Others will be less obvious, such as voluntary sector and private sector partners responsible for delivery of NHS and local authority funded care.

In considering how partners will work together to deliver accountable care, **key considerations will include:**

- the role of commissioners in an accountable care model and the extent to which they will transfer 'tactical' commissioning responsibilities to provider organisations
- whether GPs engage with other partners as individual practices or via one or more federations
- which model of integration GPs intend to pursue, initially and as an end goal (for example, virtual, partial or full as described in the MCP and PACS frameworks)
- the involvement of private sector and voluntary sector partners
- how the accountable care model can flex to reflect the exit of existing partners and introduction of new ones over time.

## Step 3: Governance

Some of the most substantial risks to developing accountable care models lie in transition. Corporate governance in the UK is based on the body corporate – an entity in law that can be held answerable for what it does and how it performs. That presents a challenge to the successful delivery of accountable care given the multiple health and care body corporates operating in each STP area.

Some STPs have seconded chief executives and other executive directors and are looking to recruit panels of lay members to take on a quasi-NED role in order to facilitate coordinated decision-making. But there will be some risks, as they seek to lead change in their locale, for STPs to begin to behave as if they were entities with decision-making powers in their own right. And in due course the same will be true of developing accountable care models comprising multiple organisations.

For this reason partners should start to consider whether leadership by a single organisation will make decision-making easier and reduce governance risks. If that is the case, then partners need to consider whether mergers, acquisitions and lead/sub-contractor models should be explored earlier rather than later.

Within an ACO, the governance challenge becomes one of delivering good governance within one large scale organisation. A group structure with intra-group boards, probably with NED input, may well be the way forward.

### **Key considerations that should be taken into account by STP partners leading on the evolution to accountable care are:**

- STPs currently have no powers to make decisions: their recommendations need to leave partners with real choices on whether to accept the recommendation
- they are not legal entities; this makes it difficult to hold them accountable, so STP leaderships need to take care to refer back to partner organisations and respect the unique role of boards and well as the liabilities and duties of directors
- STPs are not board-led organisations and will not have a NED majority or built in NED challenge. STP leaderships need to consider how real challenge can be built in to the way they operate and will also need to deal with challenge from partner organisations
- leaderships need to acknowledge that while lay member committees are useful, they have no powers and are not a substitute for NEDs
- there is a system-wide imperative to make swift progress and a seeming unanimity as to the way forward; in these circumstances leaderships need to guard against group-think
- the transition from STP to ACS to ACO is clearly difficult to achieve in the current legislative framework. Clarity and simplicity in decision-making are therefore preferable to complexity.

## Step 4: Contracting

NHS England anticipates that accountable care models will operate under accountable performance contracts. These contracts are likely to be based on the existing and evolving suite of contracts produced by NHS England for new care models. They will be long term contracts which incorporate new payment models, such as whole population budgets, improvement schemes and gain/loss share agreements.

In time, commissioners may be able to award a single accountable care contract to an ACO, but until then partners will need to operate through a network of different contracting arrangements including existing contracts and new contracts.

### **Key considerations will include:**

- which new care model contracts commissioners intend to put in place, for example MCP or PACS contracts
- how these contracts will sit alongside existing contracts, assuming that it will not be possible for MCP/PACS contracts to replace them entirely in the short to medium term
- whether an alliance contract may be a helpful interim step on the road to accountable care
- how contracting arrangements continue to facilitate requirements for patient choice.

## Step 5: Funding

Delivering integrated services for an accountable care footprint will ultimately require whole population based funding. NHS England has indicated its intention to put in place such arrangements and indeed whole population based funding is already in place in a small number of locations.

In this regard it is worth noting that system control totals that simply represent the aggregate of the control totals of the constituent organisations of a footprint are not meaningful. The partners within an accountable care system will need the ability to move finances around the system with the agreement of those involved. This would seem to militate against control totals for individual organisations in favour of footprint-wide control totals.

### **Key considerations for partners in developing funding arrangements will be:**

- commissioners' plans to pool funding for health and care
- whether arrangements can be put in place in the short term to permit system-wide gain/loss sharing within existing payment regimes
- the transition process to whole population budgets.





## Step 6: Organisational form    Step 7: Enablers

An accountable care model can take many different organisational forms ranging from loose alliances or partnerships in which organisations retain their own autonomy but agree to collaborate, to fully integrated networks of hospitals and other providers. An ACO is likely to involve a greater degree of organisational integration than an ACS.

There is no 'right answer' to the question of which organisational form best suits a particular model – the much-quoted 'form follows function' really is true here.

### Key considerations for partners in developing their organisational form will be:

- undertaking robust options appraisals to identify the end goal in terms of organisational form together with any interim models that may support evolution to that end goal
- demonstrating how provider organisations will operate on a vertically and horizontally integrated basis to deliver accountable care
- regulatory, tax, funding and contracting implications of different organisational forms
- whether partners have the resources and skills to implement their preferred organisational form.

Partners need to consider the key enablers that will be required to deliver accountable care, as identified by *Next Steps* – workforce, safer care, technology and innovation.

### Key considerations will include ensuring that developing accountable care models factor in:

- strategies for developing a shared workforce with the right skills, values and behaviours
- ensuring continued improvement in patient safety to meet the aim of making the NHS one of the safest healthcare systems in the world
- harnessing technology and innovation to improve patient access to care, including by ensuring accountable care partners operate under single or aligned systems
- strategies for accessing a shared estate and, in time, developing a fit for purpose estate across each local economy.

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NHS Providers is the membership organisation and trade association for NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those foundation trusts and trusts to deliver high quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

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