NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING

Meeting Date: 25 November 2015

Title and Author of Paper:
Developing Accountable Care Systems (ACS) / Organisations (ACO)
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Paper for Debate, Decision or Information: Information

Key Points to Note:

This paper seeks to provide background information on the emerging ACS/ACO models. It is primarily for information but also to encourage discussion and consideration of what the individual part Board members may wish to play in helping to ensure that the best interests of people with mental health and disabilities are safeguarded as a minimum and wherever possible, enhanced.

Outcome required:

Board members are asked to discuss this paper and consider what part they may wish to play in helping to ensure that the best interests of people with mental health and disabilities are fully represented in these national and locally developments.

Developing Accountable Care Systems (ACS)/Organisations (ACO)

Introduction

This paper seeks to provide background information on the emerging ACS/ACO models. It is primarily for information but also to encourage discussion and consideration of what individual part Board members may wish to play in helping to ensure that the best interests of people with mental health and disabilities are safeguarded as a minimum and, wherever possible, enhanced.

What is an ACS/ACO?

The term Accountable Care System is used internationally to describe a whole range of managed care options which mean different things to different people. The basic concept of an ACS is that a group of providers agrees to take responsibility for all care for a given population for a defined period of time under a contractual arrangement with a commissioner.

The ACS/ACO approach is new to the UK, has had mixed success internationally (including, for example, early cost containment followed by overheat) and is untested for challenge by other bodies as anticompetitive/monopolistic. It is imperative therefore that risks are fully assessed and mitigated and that early intervention measures are agreed as part of any sign off process with NHS England and NHS Improvement.

In the English NHS, the term used has been Accountable Care Organisation (ACO), rather than an ACS. This is, in my opinion, unhelpful as it risks NHS and LA organisations focusing more on which of the organisations involved should *lead* on the creation and operationalising of the ACO model, rather than a focus on a model that best meets the needs of the people who are going to be using health and care services.

The components of an ACO can be unpacked as follows:

1. **Accountable:** the ACO model is based on the premise that those who are accountable for the cost and quality of care for a whole population will be incentivised to improve care. Accountability refers to both clinical and financial accountability – the ACO is contracted to achieve on a range of quality and outcome measures, typically within a defined budget.

2. **Care:** an ACO delivers care; it doesn't commission it. This is how it can minimise its risk, by taking control of the way care is delivered for a whole population. The ACO is able to develop and deliver preventive interventions for patients with a high-risk profile, as well as reactive interventions to avoid unnecessary hospital admissions.

3. **Organisation**: to organise and deliver this care, accountable providers come together in a formal organisational structure. It is through this structure that the ACO is able to build a leadership team and appropriate governance arrangements to manage risk across diverse providers, holding them to account for their part of the care pathway. If part of the organisation is not performing well, leaders have a range of structures and mechanisms at their disposal to incentivise improvement.

There are alternatives to ACOs that are being tested, including a 'simple' primary and acute care system (PACS), multi-specialty community provider (MCP), prime contracting, appointing a prime system integrator and alliance contracting (not amounting to an ACO). And any or all of these models are likely to be pursued somewhere across the NHS in England, in light of the publication by NHS England last year of the enabling Five Year Forward View (5YFV).

Commissioning and providing responsibilities

The most radical form of an ACO is where the responsibility for the commissioning (specification and payment) of services is vested in a provider organization, in effect similar to how the NHS operated prior to the introduction of the 'Internal Market' in 1991, following the publication of Working for Patients in 1989.

This is the least common of the current models operating across the world, with this distinction maintained relatively well in most models. This may not be the case in the NHS in England. This is for three, largely tactical and immediate reasons:

i. To more speedily require/enable health and care services to operate more closely together at an operational level.

ii. The urgent need to drive out inefficiency in the current health and care system of provision. There is an yet to be proven belief that this will enable the NHS provider sector to regain control of its finances and also contribute significantly to the 5YFV's assertion that the £8bn promised by Government for the NHS over the next five years will be matched by £22bn of a combination of cash-releasing efficiency and productivity improvements.

iii. To tackle at pace the growing problem commissioners face in terms of their finances. This is driven by demand-side and a supply-side issues.

On the demand side, this is largely as a result of the inexorable growth in demand, in particular into acute services linked to the ageing population, new technologies and treatments, as well as a perceived or actual lack of 'joined up' services in the community to prevent people from getting into crisis and needing admission into acute or other institutional models of care.

On the supply side, the issue for commissioners - in the NHS at least - is that for providers of acute hospital provision, payments are linked to activity and so as the number of patients in need of care grows so does the provider's income. This puts

pressure on NHS commissioners' budgets and, with legally- binding contracts in place that require CCGs and NHS England to pay for this activity, a growing number of commissioners are going into financial deficit.

And, more positively, there is also a very important strategic, medium-term reason for pursuing ACO-type models, namely:

iv. The shared policy objective to integrate high quality physical health, mental health and care services with much more person-centred services, designed around the needs of individuals and local communities that are fully joined up and deliverable sustainably within a cash-limited resource envelope.

Key issues about moves to an ACO

The key issues in any such radical ACO models that integrate commissioning and provision are, as I see them, the need to ensure:

i. Robust and transparent governance arrangements around the ACO that bind together all the providers who form part of the ACO

ii. Clear, agreed, quality and outcome measures that are the focus of the work of the ACO and all its partners.

iii. Clear risk sharing and reward arrangements so that when any one of the partners, or any of the quality or outcome measures, are not on track, the whole ACO takes responsibility for ensuring they are recovered as quickly as possible;

iv. Any conflicts of interest are managed on an on-going basis. This will be crucial if the model for the ACO is based on one of the, probably larger, providers takes on responsibility for determining which services they will provide themselves and which they will 'subcontract' to other providers.

And, additionally, for our own service users/carers and our range of services:

v. Safeguards around the commitment to 'parity of esteem', both in terms of levels of relative investment and also in terms of the outcomes for people with mental health and disabilities featuring prominently in the contract agreed with the ACO corporately.

These are some the issues that we have been working hard locally (e.g. with CCGs, other NHS providers, LAs, MPs and Councillors) and nationally (e.g. with NHS England, Department of Health, the Royal College of Psychiatrists, NHS Providers, the NHS Confederation Mental Health Network and other mental health providers) to address.

Recommendation

Board members are asked to discuss this paper and consider what part they may wish to play in helping to ensure that the best interests of people with mental health and disabilities are fully represented in these national and locally developments.

John Lawlor
Chief Executive
November 2015

Accountable Care Organisations – References

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The Kings Fund (2015): Acute hospitals and integrated care

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The Kings Fund (2014): Accountable Care Organisations in The United States and England: Testing, evaluating and learning what works

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Smith and Smith (2015): Away from the past and to a sustainable future