ACCOUNTABLE CARE ORGANISATIONS

Their potential impact on delivery of health & social care to patients in England's NHS

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CONTENTS

PREFACE 2
INTRODUCTION 3
Key points 5
Accountable Care 6
1.1 The Five Year Forward View and Accountable Care 6
1.2 Origins of Accountable Care Organisations (ACOs) 10
1.3 ACOs and their Prototypes in the NHS 13
2. The Role of Local Authorities 17
3. Legislation and Consultation 19
CONCLUSION 21
APPENDIX 1 23
NEW CARE MODELS: TORBAY 23
APPENDIX 2 24
NEW CARE MODELS: CAMBRIDGESHIRE 24
APPENDIX 3 25
Potential Legal Implications of the transition to ACOs 25
APPENDIX 4 29
Consultation and Statutory instruments 29

PREFACE

On 1 April 2018 the first Accountable Care Organisations will be introduced into England's NHS. The NHS and Local Authorities take care of people when they are at their most vulnerable. Changes to the services they need should be the subject of careful scrutiny by parliament and other statutory bodies.

The government is considering bringing forward secondary legislation to make the changes possible. The Chair of the Health Select Committee has called for a pause in implementation subject to her committee reporting on developments to date. An Early Day Motion 660 has also been laid before the House of Commons requesting full scrutiny and debate of these very important issues.

Carillion's collapse tragically underlines the serious consequences that can arise from outsourced contracts for public services.

The history of the development of Accountable Care in England and the documents issued by the Department of Health and NHS England are extensive and complex. We offer this paper as a guide to decision-makers and other interested parties to make sense both of this complexity and of the real challenges that have arisen from the implementation of these changes.

The transition from the structures and statutory responsibility of the Health and Social Care Act 2012 via Sustainability and Transformation Partnerships and other accountable care prototypes have in themselves raised questions. However, Accountable Care Organisations themselves are new corporate entities. It is this final transition which raises questions of scrutiny, transparency and democratic accountability to be the paramount concern before implementation.

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INTRODUCTION

NHS England's Five Year Forward View (5YFV), published in October 2014,[1] seeks to create a new landscape for the NHS. The principle it applies is that safe and secure care in the community with networks of outpatient clinics can reduce the demand for expensive hospital care. The model it applies is derived from US Accountable Care Organisations (ACOs) and involves joining up the NHS with Local Authority social care. It is a cost-led programme although its argument is that savings derive from the improvement in population health and more effective primary care, not from a reduction in care.

In order to test and work towards the development of ACOs, NHS England announced in December 2015 the creation of 44 Sustainability and Transformation Plans[2](STPs).

The only full independent assessment to date has been in North West London[3] prior to the announcement of the STPs when the changes were in their prototype stage. It was led by Michael Mansfield QC. It found that the reductions in NHS services fell in the poorest and most deprived areas of the study. Consideration should be given to whether this is a risk inherent in the organisational structure which is currently being developed.

The plans hinge on cooperation between the NHS and Local Authorities, both currently facing severe resource and operational problems. There are variations between Local Authorities about what their level of engagement with this process should be and is[4]. Local Authorities carry the responsibility of scrutiny of the NHS through Health & Wellbeing Boards but become active participants in NHS delivery through Sustainability and Transformation Partnerships and ACOs. This may be subject to change now that the Secretary of State for Health has responsibility for Social Care.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
[3] https://www.lbhf.gov.uk/sites/default/files/independent-healthcare-commission-report-final-lowres.pdf
[4] https://www.local.gov.uk/sites/default/files/documents/2017-06-28%20STP%20survey%20-%20Full%20findings%20report%20FINAL.pdf

National and local NHS campaign groups have raised questions around the ACOs' fitness for purpose and about risks of the potential increase of private sector involvement. Several campaign groups are also seeking or have sought judicial review both on the ACO contract[5] and on planned hospital closures[6] which are a consequence of this process.

ACOs are a step up for the US which does not have universal healthcare. They are potentially a step down for the NHS in England which does. ACOs are a relatively recent creation in the US and data from the trial period gives a mixed picture of results.

Proponents of ACOs focus on the potential of the system design to deliver high quality care at low cost. They separate out the issue of how it is funded when adopting the system to England's NHS. Any assessment of the implementation of this system in England must be monitored for its impact on equalities in provision, not just for cost saving. But recent studies of the Californian system showed that the rise in insurance premiums is one of their major cost factors, as they increased at a rate five times faster than inflation between 2005-15[7], which is not an issue in England.

In July 2017, NHS England (NHSE) announced eight areas which would become Accountable Care Systems (ACSs), working towards becoming ACOs. This was followed by the publication of a draft contract in August which, it was suggested, could be implemented with local modifications. This was subsequently amended as being subject to a consultation period concerning necessary legislative changes[8].

Secondary legislation amending the Health & Social Care Act 2012 (HSCA 2012) is expected for January/February 2018 and the first ACOs are due to start in April 2018.

This paper explores these issues taking into consideration whether ACOs in the US have succeeded in meeting their own objectives, how they have influenced the

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[5] https://www.crowdjustice.com/case/jr4nhs-round2/ https://www.leighday.co.uk/News/News-2017/November-2017/Campaigners-launch-judicial-review-against-NHS-Eng
[6] http://victoriaprentis.com/horton-general-hospital/
[7] https://jamanetwork.com/journals/jama/article-abstract/2088863?redirect=true
[8] https://consultations.dh.gov.uk/new-care-models/regulations-aco-contract/

NHS in England and the role of UK Local Authorities in the STP/ACO development process. It considers the potential impact on access to health services for rural and deprived areas through the modifications to service delivery implicit in the 5YFV and the Accountable Care model.

KEY POINTS

- The NHS and Local Authority Social Care take care of people when they are at their most vulnerable. It is essential that any system changes are only made when the process of change itself will not leave gaps in provision.
- It is essential that monitoring bodies provide checks and balances to ensure the integrity of the system. And that they can call a halt to any process which they feel is not producing the stated objectives.
- Local authorities do not appear to be consistently engaged with the process.
- The STP process should not be seen as 'too big to fail' with the investment in it being impossible to retreat from if the evidence is not in its favour.
- Only the Independent Commission in North West London in 2015 has focused in depth on the impact of the current system changes on inequalities.
- There is a mismatch between reporting at system management level and reports of system failure in both health and social care delivery.
- Too much of the literature surrounding the failure of attempts in England to outsource large complex contracts have focused on the management processes, not the impact on populations.
- Evidence from the US does not robustly substantiate the claims made for savings or effectiveness in reducing in-patient care for high-risk groups.

ACCOUNTABLE CARE

1.1 THE FIVE YEAR FORWARD VIEW AND ACCOUNTABLE CARE

The Five Year Forward View (5YFV) is predicated on the assumption that closer co-ordination, based on integrated budgets and management, between the NHS and Local Authorities will lead to a better preventive health approach and enhanced outpatient services. The cumulative impact of these measures is presumed to be a reduction in the number of incidences of hospital care for high-risk patients and an overall reduction in demand for acute and community in-patient care.

The 5YFV provides a blue print for how the NHS in England can create new models of care with a view to developing ACOs[9].

The key feature of the path to Accountable Care is the interface between Local Authority provided social care and public health and NHS provided primary, community and acute care. If Accountable Care is to meet its stated aims then the preventive and health maintenance function of the Local Authorities is the essential underpinning of the NHS' restructured new models of care. One measure of success will be the organisation's ability to stay within tightly constrained funding.

Chapter 4 of the 5YFV makes clear that the existing functions of CCGs may be modified and additional statutory bodies who are not under the remit of NHSE or the Department of Health are to be incorporated in the plan. (Box 1)

[9] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Box 1 extract from Ch 4 of the 5YFV

"This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government. … NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care. We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in Chapter Two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards."

The 5YFV also details how the cost-saving objectives are expected to be met. New systems of healthcare delivery are to be adopted by each health economy.

Publication of the 5YFV was followed early in 2015 by invitations to NHS provider organisations to bid to become Vanguard projects for the development of Primary and Acute Care Systems and Multi-Speciality Community Providers (MCPs), both prototype forms of ACOs and two of the 5YFV's New Models of Care (Box 2). Additional funding was allocated to these projects.[10]

***Box 2** New Models of Care*

The 5YFV introduced seven 'New Care Models' to support better working between traditional healthcare divides. Two of these models, Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) are precursors to the development of ACOs in the NHS.

Both include primary, community, mental health and social care, but a PACS also includes most hospital services.

An MCP will need a population of 100,000 at a minimum, but could be much larger, whereas a PACS will provide care for all the population served by its acute hospital trust, generally at least 250,000.

[10] https://www.england.nhs.uk/new-care-models/vanguards/about-vanguards/

These organisational forms, described as horizontal and vertical integration, share certain assumptions. They consist of groups of NHS providers working closely with Local Authority adult social care with the stated objective of reducing acute hospital admissions by transferring budget share, resources and organisational structures away from the acute care setting into the community.

On 23 December 2015 NHSE published planning guidance detailing the creation of 44 footprints each of which would be responsible for developing a Sustainability and Transformation Plan (STP) in line with the 5YFV[11].

- Acute services will be reconfigured and the total number of Accident and Emergency 'blue light' hospitals reduced in number and centralised into much larger institutions whilst satellite hospitals (previously District Generals) become Urgent Care Centres.
- Health and social care will shift its focus to prevention and improved population health.
- NHS property rendered surplus by this process can be sold off to pay towards the costs of implementation of the new system.
- GPs will enter into accountable care contracts and the family practice model will disappear, either becoming part of the management of the new 'super-clinic' style MCPs or joining into federations.
- New models of working will include different levels of staff, such as Physician Associates or Pharmacists, taking on some of the work of doctors.
- New technologies will be introduced to replace some face-to-face interactions and to create new systems of record sharing.

In July 2017, NHSE announced eight areas which would become ACSs, working towards becoming ACOs. (Box 3)

[11] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Box 3 *Areas due to become ACOs from 1 April 2018*

- *Frimley Health including Slough, Surrey Heath and Aldershot*
- *South Yorkshire & Bassetlaw, covering Barnsley, Bassetlaw, Doncaster, Rotherham, and Sheffield*
- *Nottinghamshire*
- *Blackpool & Fylde Coast*
- *Dorset*
- *Luton, with Milton Keynes and Bedfordshire*
- *Berkshire West, covering Reading, Newbury and Wokingham*
- *Buckinghamshire.*

At each stage of development additional funds have been and will continue to be made available to deliver the changes. The National Audit Office (NAO) has just published its report into the use of this funding[12]. In a statement on 19 January 2018 Amyas Morse, the Head of the NAO said,

"The NHS has received extra funding, but this has mostly been used to cope with current pressures and has not provided the stable platform intended from which to transform services. Repeated short-term funding-boosts could turn into the new normal, when the public purse may be better served by a long-term funding settlement that provides a stable platform for sustained improvements".

[12] https://www.nao.org.uk/report/sustainability-and-transformation-in-the-nhs/

1.2 Origins of Accountable Care Organisations (ACOs)

Ideas around ‘accountable’ or ‘managed’ care are not new. They have been used in the US since the 1960s. Perhaps the most well-known provider of Accountable Care in the US is Kaiser Permanente whose Health Maintenance Organisation (HMOs) pre-date ACOs. There is little difference between them[13].

The HMO fell into disrepute after a series of lawsuits brought by various Federal and State departments and its ‘managed care’ system became synonymous with denying care and not enrolling expensive patients to save money. In California alone, Kaiser Permanente has had cumulative fines of $1.6million, 63% of all the fines levied by the California Department of Managed Healthcare for cases including failure to protect patient information[14]. They have also been found to have systemically violated its contractual obligations to the California Department of Managed Healthcare’s Mental Healthcare’s services[15]. The consequences for patients were that waiting times for treatments were breached repeatedly and inadequate or inappropriate treatments were given. However, record keeping was managed in such a way as to give a different impression of the care being delivered.

The US does not have a unified system for healthcare delivery, but it has Medicare and Medicaid programmes for certain groups (including retirees and the low paid and unwaged) to be able to access healthcare.

The 2010 US Affordable Care Act introduced a test programme for ACOs, the Pioneer scheme. In a country where healthcare is a byzantine maze of different insurers and delivery models, ACOs ‘integrated’ systems are seen as a means of addressing issues of fragmentation, escalating cost and poor outcomes, especially for state funded programmes. They bring groups of providers together with one or more commissioners and the providers assume the financial risk for the contracted services within a given budget. Any savings are shared between the hospitals, doctors and the commissioning Medicare programme or the private insurers they are contracted to.

[13] http://www.healthleadersmedia.com/health-plans/are-acos-really-different-hmos#
[14] http://www.dmhc.ca.gov/AbouttheDMHC/Newsroom/June20,2005.aspx
[15] http://nuhw.org/wp-content/uploads/2014/01/NUHW-SummryDMHC_FinalReport3-18-13.pdf

The US government's ACO Pioneer scheme above all sought to address the escalating cost. The impact of its integrated care model is designed to be a reduction in the number of incidences of hospital care for high-risk patients and an overall reduction in demand for acute and community in-patient care. The ACO Pioneers failed significantly in these objectives: of the 32 ACOs that started the scheme, only nine completed the test period.

"*Seven pioneer ACOs failed to produce any savings last year and two ACOs abandoned the Medicare Program altogether opting for less risky accountable care models*"[16].

In an ACO system, payments may be 'bundled', that is paying for a particular medical condition or treatment over a specified time or 'capitated', which is a fixed sum per registered patient. This is a move away from 'fee for service' which is a common payment form in the US. The known risk of 'fee for service' is the perverse incentive it gives to doctors to over-test and over-prescribe. Even, in extreme cases, to operate unnecessarily[17].

The evidence of the fixed budget capitated payment system is the opposite, that there may be a tendency to deny treatments in an attempt to contain costs.[18]

The important message to understand from these reorganisations is that real people suffer real harm if the system gets it wrong.

Many US health insurance and health provider organisations have been involved in the development of the NHS in England's new approach. Virginia Mason, a hospital in Seattle, currently holds a five-year contract worth £12.5million to teach five NHS Trusts how to raise standards[19]. The Health Foundation reported in 2014 that the Secretary of State for Health, Jeremy Hunt, had visited Seattle and that:

"*Virginia Mason has given us a route map and that absolutely there are ways of making modern healthcare safe, effective, patient-centred and efficient*."[20]

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[16] http://hitconsultant.net/2014/10/07/pioneer-acos-dropout-providers-leaving/
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1150974/
[18] https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/models-for-paying-providers
[19] https://improvement.nhs.uk/resources/virginia-mason-institute/
[20] http://www.health.org.uk/blog/signing-safety-lessons-virginia-mason

In June 2016 the health regulator in the US found that Virginia Mason was not delivering care safely or correctly and the hospital failed in 29 key areas. It did regain full accreditation by September that year[21].

Virginia Mason uses the 'lean' management system based on Toyota's manufacturing process which is supposed to increase productivity at lower costs. Some studies have suggested that the 'lean' system may be unsuited to delivery of health and personal care services[22]. A comparison made between Virginia Mason's own accounts in 2014 and the accounts of South Tees Foundation Trust show the NHS Trust as providing far more patient care for less money. (Box 4)

Box 4 Comparison of costs between Virginia Mason and South Tees Trust

Virginia Mason Hospital, Seattle, USA
versus
South Tees NHS Trust, Middlesbrough, UK

Virginia Mason (Award winning US hospital)

- Revenue £650m ($1billion)
- 6,000 employees
- 336 Beds
- 16,500 admissions
- 18,000 operations
- 23,000 Emergency Room visits
- 853,000 physician visits including primary care

South Tees NHS Trust, Middlesbrough

- Revenue £578m ($888million)
- 9,000 employees
- 1,046 beds
- 85,780 emergency admissions
- 44,000 operations
- 127,042 Accident and Emergency visits & 28,490 urgent care centre visits
- 187,085 inpatient and daycare patients
- 1,906 seen in community hospitals
- 486,091 Outpatient visits
- 46,000 walk-in-centre visits
- (962,000 patient visits total)

Source: 2014 Annual Reports from both hospitals

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[21] https://www.seattletimes.com/seattle-news/virginia-mason-medical-center-regains-full-accreditation/
[22] Seddon, J: *The Whitehall Effect,* (2014), ISBN 978-1-909470-45-3

1.3 ACOs and their Prototypes in the NHS

In Norman Lamb's *'The NHS: A New Liberal Blueprint'* 2010[23], he quotes Chris Ham, now the Chief Executive of The King's Fund and author of the study into Torbay's Kaiser Beacon programme[24]:

"Chris Ham has proposed a way of implementing some key Kaiser principles in the UK: "Clinical integration would require practices to work closely with hospital based specialists in deciding how to use their resources, especially specialists who work in community settings. General practitioners and specialists would then jointly commission and provide services. As integrated groups evolve, specialists may move out of hospitals to become equity sharing partners in the multi-specialty practices."

This could go hand in hand with introducing effective incentives for preventing ill health and managing those with chronic conditions better: "By giving control over capitated budgets [a total sum of money for the care of each patient] to multi-specialty medical groups, they create strong incentives to keep patients healthy. ... Put another way, they help to promote the maintenance of health rather than the treatment of sickness."

The NHS was running Vanguard and Pioneer[25] test sites from the beginning of 2015, starting just as the US Medicare Pioneer ACOs were coming to an end.

But the NHS has a history of experimentation with similar models of care, based on a long collaboration with Kaiser Permanente.

In 2003 the NHS started a programme in three test areas, Birmingham & Solihull, Northumbria and Torbay, the 'NHS Kaiser Beacon Sites'. There were some areas which showed good results organisationally and in meeting the objectives in reduced admissions for the target group of frail elderly and those with long-term conditions. NHS chief executive, David Nicholson, declared: *"I've seen the future. It's Torbay."*

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[23] http://www.centreforum.org/assets/pubs/nhs-a-liberal-blueprint.pdf
[24] https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/Policy-paper-6.pdf
[25] https://www.england.nhs.uk/integrated-care-pioneers/

In 2011 The King's Fund published a report by Peter Thistlethwaite[26], *Integrating Health and Social Care in Torbay,* in which he notes that the circumstances that allowed Torbay to have a measure of success might not be replicable, but that certain key features were essential. These were:

- it is important to have a clear vision – and one that is based on making a positive difference for service users – and to monitor progress
- work from the bottom up, bringing together frontline teams and align these teams with general practices and their registered populations
- establish joint governance early and be aware that it is possible to overcome cultural, political and organisational differences
- ensure managers and clinical leaders are engaged from the start.

Under the new 5YFV programme in October 2015 the Torbay & South Devon Integrated Care Organisation was set up, a prototype of an ACO. Since then there have been serious problems (Appendix 1).

It is not clear what has caused this dramatic shift from a Beacon site which was considered by some to be leading the way in integrated care to one which has such poor reports. It could be a question of funding, a matter of the system not scaling up, the system no longer meeting the four tests for success outlined by Thistlethwaite, or a combination. But overall, from care for children, care in the home, treatment of the elderly in urgent care settings, and in local community settings the system is failing its patients.

Experiments with new models have taken place in other rural areas. In February 2012, Circle took operational control of Hinchingbrooke Health Care NHS Trust, becoming the first private company to run an NHS hospital. In January 2013, the Public Accounts Committee[27] expressed concerns that Circle's bid to run Hinchingbrooke had not been properly risk assessed and was based on overly optimistic and unachievable savings projections. In January 2015, Circle

[26] https://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay
[27] http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/franchising-hinchingbrooke-peterborough-stamford-hospitals/

announced that it intended to withdraw from the contract, just three years into the 10-year franchise[28].

In addition, Cambridgeshire and Peterborough CCG created a contract to integrate the full range of services to the whole local population of older people. Two local Foundation Trusts (FTs) took it on having formed a limited liability company UnitingCare Partnership. There was a budget of £152 million in the first year. The contract value reduced over the following four years because it was assumed that the new model of working would result in efficiency savings. All the private companies had withdrawn saying the price was too low. The five-year contract started in April 2015 but collapsed after only eight months when it ran into financial difficulties. The predicted savings did not materialise (Appendix 2).

To facilitate the mass development of increased care in the community and to prepare for hospital closure programmes, the Better Care Fund was set up. The Fund is designed to transfer money from the acute hospital budget to Local Authorities to be directed into improving services for frail elderly and high-dependency disability. NHSE's website says,

"Better Care Managers have been recruited in each region to gather learning and coordinate support to local areas. Regions can commission bespoke packages of support to respond to regionally identified needs, generate shared solutions at a regional level and tailor national resources and products to regional needs."

The NAO reported twice on the Fund. In November 2015[29] it said, *"the quality of early preparation and planning did not match the scale of ambition"*. It detailed that it cost more than planned, there was an increase in emergency admissions and delayed transfers from hospital to home or other care. It described the process as based more on optimism than evidence. In its second report in February 2017, it warned:

"that progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities."

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[28] http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-circle-withdrawal-from-hinchingbrooke-hospital/
[29] https://www.nao.org.uk/report/planning-better-care-fund-2/

"The Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or reduced hospital activity, from the £5.3 billion spent through the Fund in 2015-16."

"The NAO today reiterates its emphasis from its 2014 report on the Better Care Fund that there is a need for robust evidence on how best to improve care and save money through integration and for a co-ordinated approach."[30]

[30] https://www.nao.org.uk/report/health-and-social-care-integration/

2. THE ROLE OF LOCAL AUTHORITIES

The NAO report from February 2017 into the Better Care Fund said:

"local government was not involved in the design and development of the NHS-led sustainability and transformation planning programme. Local authorities' engagement in the planning and decision-making phase has been variable, although four sustainability and transformation planning areas are led by local authority officials.

The Department of Health and the Department for Communities and Local Government have identified barriers to integration, such as misaligned financial incentives, workforce challenges and reticence over information sharing, but are not systematically addressing them. Research commissioned by the government in 2016 concluded that local areas are not on track to achieve the target of integrated health and social care by 2020."[31]

Sustainability and Transformation Partnerships and their developing ACSs will have to rely heavily on the co-operation of all organisations within each partnership. Yet the findings of the NAO are echoed and amplified by Local Authorities themselves. According to a survey published by the Local Government Association in June 2017[32], there is little evidence on the ground of such co-operation and a lack of confidence that it will be developed.

In 2012 the government consulted on proposals to make significant changes to the healthcare economy of North West London, set out under the heading *"Shaping a Healthier Future"*. This involved the downgrading of several hospitals across North West London to "local" hospitals without A&E provision, closure of acute provision and reduction or downgrading of specific services, in line with the 5YFV's objectives. It also promised commitments to investment in capacity of out-of-hospital and community services in order to offset reductions in acute provision. In other words, trialling the Accountable Care Model.

In response, the four Local Authorities whose areas were affected, Brent, Ealing, Hammersmith & Fulham and Hounslow, established an Independent Healthcare

[31] https://www.nao.org.uk/report/health-and-social-care-integration/
[32] https://www.local.gov.uk/sites/default/files/documents/2017-06-28%20STP%20survey%20-%20Full%20findings%20report%20FINAL.

Commission chaired by Michael Mansfield QC, to review the impact on their communities of the changes being implemented.

When the Commission's report was published its recommendations were to reverse the closures and downgrading of the North West London hospitals and goes further to say the programme of changes was eroding the very values of a universal healthcare system.

In its preface it says: "*The findings of the Commission, set out in this report, demonstrate that the reforms, both proposed and implemented thus far, are deeply flawed. As a consequence, there is no realistic prospect of achieving good quality accessible healthcare for all. Therefore, any further implementation is likely to exacerbate a deteriorating situation and should be halted immediately until the measures we recommend are carried out.*

The impact of fragmentation through privatisation is slowly eroding what was a 'national health service '." [33]

These are its key findings:

- Cutbacks are being targeted on the most deprived communities
- The public consultation was inadequate and flawed.
- The escalating cost of the programme (£1bn) does not represent value for money and is a waste of precious public resources.
- There is no business plan to show the reconfiguration is affordable or deliverable.
- NHS facilities have been closed without adequate alternative provision being put in place.
- The plans seriously underestimate the increasing size of the population in North West London and fail to address the increasing need for services.

If the failures in Torbay and Cambridgeshire are reflective of a similar impact on patients, then the evidence with continuing with the implementation of this system must be urgently reviewed.

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[33] https://www.lbhf.gov.uk/sites/default/files/independent-healthcare-commission-report-final-lowres.pdf

3. Legislation and Consultation

In July 2017 NHSE announced eight areas which would become ACSs, working towards becoming ACOs. This was followed by the publication of a draft contract in August which, it was suggested, could be implemented with local modifications. This was subsequently amended as being subject to a consultation period concerning necessary legislative changes[34].

Secondary legislation amending the HSCA 2012 is expected for January/February 2018 and the first ACOs are due to start in April 2018.

Since the publication of the 5YFV in October 2014 steps have been taken to move the organisational structures of the NHS away from the CCG small area model into larger integrated care models. There has been some debate over whether this can be achieved without legislation (Appendix 3).

There have been individual judicial reviews or attempts to hold judicial reviews over individual hospital downgrades, closures and individual GP closures. When judicial review fails in the case of the Horton General Hospital, MPs are appealing directly to the Secretary of State for Health for protection of services[35].

Given that ACOs are potentially responsible for combined budgets in the £billions, it is unsurprising that people wish to ensure that the transition to a new model of care is a fully accountable and transparent process.

An ACO, unlike an ACS or any other prototype systems, requires a corporate entity to be set up. That is to say, a commercial – non-NHS body, even if it includes in its constituent members NHS providers. There is nothing in the current formulation of the ACO that would prevent a private company or global corporation being a constituent member or taking over the contract as a whole.

Professor Allyson Pollock, a professor of Public Health at Newcastle University, along with colleagues and with the backing of Professor Stephen Hawking, has

[34] https://consultations.dh.gov.uk/new-care-models/regulations-aco-contract/

[35] http://victoriaprentis.com/wp-content/uploads/2016/07/171221-Victoria-to-DOH-SOS-re-JR-judgment.pdf

launched a judicial review[36] to prevent the creation of ACOs without proper public consultation (Appendix 4) and without the scrutiny of parliament.

There is a second judicial review[37] which is challenging the nature of the ACO contract itself and whether it is unlawful under current NHS legislation.

Denis Campbell, *The Guardian's* health policy editor, reporting on the legal challenges said:

"…the lawsuits also offer the possibility that NHS England will at last be forced to explain and defend in public – and, crucially, prove the legal basis of – its plans.

Now is the time for health bosses to spell out exactly how ACOs are supposed to radically transform the NHS. They must make the case for why the loss of local services is worth it in pursuit of the bigger prize of better care and lower cost through more services outside hospitals, and fewer, regional centres offering specialist care."[38]

Leaving aside the legal questions, Denis Campbell highlights the central question around the 5YFV: are services being restructured in such a way that will be beneficial to the population?

[36] https://www.crowdjustice.com/case/jr4nhs-round2/

[37] https://www.leighday.co.uk/News/News-2017/November-2017/Campaigners-launch-judicial-review-against-NHS-Eng

[38] https://www.theguardian.com/society/2017/nov/07/vital-nhs-account-acos-legal-challenge

CONCLUSION

The NHS in England has a complex organisational landscape with a long and close relationship with US healthcare organisations, particularly though not exclusively with Kaiser Permanente. This paper has sought to examine how that relationship influences current decision-making in the NHS in England and whether the 5YFV, STPs and ACOs are likely to produce their stated aims. The evidence to date from the collapse of services, failures of contracts and the conclusions of both the government's own bodies, the NAO and PAC, and the local independent assessment at the least raise questions about their ability to do so. Those failures contain worrying indicators that within the reconfigurations proposed in the new models of care, such savings may not be possible to derive from an improvement in population health and more effective primary care, but only from a reduction in available services through closures.

When examining the documentation for system change the one thing that is often absent is the patient. Good structures and sound organisational principles are essential in delivering good health and social care, but much of the assessment of success or failure in the new systems hinges on such criteria as whether more people were able to stay in their homes, there were fewer in-patient admissions (a success) or not (a failure) rather than the experience of patients. The example of patients in Kaiser Permanente's Californian programme shows how they could be suffering while the company recorded 'good' results.

NHS and Local Authority Social Care take care of people when they are at their most vulnerable. It is essential that system changes are only made when the process of change itself will not leave gaps in provision. The measurement of success will always be that patients can find the care they need, not that the right boxes have been ticked to show that fewer people have used expensive services.

The results of the North West London Independent Inquiry should cause parliament to take time to reflect on the current changes to England's NHS. The Health Select Committee Chair, Sarah Wollaston, has now requested a pause in the implementation of the ACOs subject to her Committee assessing the stability and effectiveness of the work to date. The Independent Inquiry found that the reductions in NHS services fell in the poorest and most deprived areas of the study. Consideration must be given by parliament, Local Authorities and all other

statutory bodies as to whether this is a risk inherent in the organisational structure which is currently being developed.

Despite the real need for Local Authorities not only to engage with the changes to the NHS but also to develop and provide key primary care services to replace the reducing number of hospital beds and facilities their level of engagement is patchy. This has been reflected both in the NAO report into the Better Care Fund and the LGA's own survey of its members. This has the effect of making the 5YFV a plan for the NHS alone, rather than a collaborative effort with local government.

Secondary legislation amending the HSCA 2012 is expected in January or February 2018 and the first ACOs are expected to be in place by April 2018, but the legal challenges which are being brought by campaigners may yet highlight the need for new primary legislation, rather than amendments to the HSCA 2012.

This paper takes a broad view of STP/ACO development. The potential impact on patient access to health and care services through the modifications to service delivery implicit in the 5YFV and Accountable Care Model is considerable. There is sufficient evidence to highlight the need for greater scrutiny.

The 'accountable' of ACOs does not refer to scrutiny or democratic accountability but to its financial accounting systems.

In conclusion, the evidence throughout this document indicates a lack of democratic accountability.

APPENDIX 1

NEW CARE MODELS: TORBAY

- South Devon and Torbay CCG was rated inadequate (recently moved up a category to ‘requires improvement’)[39].
- England’s Chief Inspector of Hospitals has placed Watcombe Hall Hospital in Torquay into special measures. Watcombe Hall is an independent hospital, providing specialist mental health services for children and adolescents aged 13 to 18 years. Overall, the service has been rated as ‘inadequate’[40].
- Mental health services for young people hit the news when it was reported that a teenager was kept in police cells overnight because of a lack of beds[41].
- In 2017 the Trust closed all four South Devon hospitals in Ashburton, Bovey Tracey, Paignton and Dartmouth with a loss of 71 beds and 32 acute beds at Torbay Hospital.
- The Care Quality Commission’s (CQC) report on Torbay Hospital rates it ‘requires improvement’ – especially end of life care.
- Mears Care, in Torquay, which provides personal care in people’s homes was found ‘Inadequate for being Safe, Effective, Responsive and Well-led and Requires Improvement for being Caring’ by the CQC[42].
- Torbay Council withdrew in December 2016 from the Risk Share Agreement it had with Torbay and South Devon NHS Foundation Trust, warning that it presented a substantial financial risk to the local authority.[43]

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[39] http://www.southdevonandtorbayccg.nhs.uk/get-involved/Documents/participation-update/participation-update-28.pdf
[40] https://www.cqc.org.uk/news/releases/cqc-inspectors-place-children%E2%80%99s-mental-health-service-special-measures
http://www.bbc.co.uk/news/uk-england-devon-30261980[41]
[42] http://www.cqc.org.uk/news/releases/mears-care-limited-rate-inadequate-care-quality-commission
[43]
http://www.torbay.gov.uk/DemocraticServices/documents/s36762/Annual%20Strategic%20Agreement.pdf

APPENDIX 2

NEW CARE MODELS: CAMBRIDGESHIRE

Cambridgeshire and Peterborough CCG launched a tendering process for a lead provider contract to integrate the full range of services to the whole local population of older people, with a budget of £0.8bn. The private bids withdrew because the price was so low and two local FTs took on the contract having formed a limited liability company UnitingCare Partnership. There was a budget of £152million in the first year. The contract value reduced over the following four years because it was assumed that the new model of working would result in efficiency savings. They did not materialise.

The five-year contract started in April 2015 but collapsed after only eight months when it ran into financial difficulties. The NAO reported on the contract collapse[44] with a focus on the system management, poor contract specifications and negotiation and low price. It paints a picture of organisations used to public service rather than commercial contracting.

The Public Accounts Committee (PAC) also investigated the collapse[45]. Meg Hillier MP, Chair of the PAC, said:

"It beggars belief that a contract of such vital importance to patients should be handled with such incompetence. The deal went ahead without parties agreeing on what would be provided and at what price—a failure of business acumen that would embarrass a child in a sweet shop, and one with far more serious consequences. Services for patients are likely to suffer and we will be expecting the clinical commissioning group to come clean about precisely how much damage has been done in terms of future service provision and finances. …it is understandable that those responsible for providing services will explore new ways of doing so. What is not acceptable is for services to be farmed out to the lowest bidder without due regard for the interests of patients."

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[44]https://www.nao.org.uk/wp-content/uploads/2016/07/The-collapse-of-the-UnitingCare-Partnership-contract-in-Cambridgeshire-and-Peterborough.pdf

[45] https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news-parliament-2015/unitingcare-partnership-contract-report-published-16-17/

APPENDIX 3

POTENTIAL LEGAL IMPLICATIONS OF THE TRANSITION TO ACOS

The 2012 Act took the NHS into full market status but did not transition it to the ACO model.

From January 2015 NHSE CEO Simon Stevens put out a series of offers for bids from interested parties to trial 'Vanguards' and other forms of new models of care outlined in the 5YFV. But, by December 2015, it was clear that these were not moving at the 'scale and pace' required to make the necessary changes within the 5-year framework.

That is with the exception of Northumbria, whose plans to hand over to an ACO were announced in the trade magazine *HSJ* (Health Service Journal) in July 2015.

On 23 December 2015 the next phase was announced, the Sustainability and Transformation Plans (STPs). All NHS services, whether commissioner or provider, were grouped to form 44 geographical 'footprints' where collaboration would theoretically take precedence over competition (in direct contrast to the directives of the HSCA 2012). The footprints would be given financial 'control totals' over the whole footprint, obliging them to meet the restrictions of their allocated budgets. The new models of care of the 5YFV are the STP's instruments by which the necessary savings are to be made: reducing the number of A&Es, closing and selling off as many assets as possible, etc.

It is possibly without precedent that the head of a public service should propose, or implement, changes on such a scale without enabling legislation. This could be argued to be a substantial service alteration, in which case it should have been subject to a major public consultation. There must also be transparency about where the authority to make these changes derives from.

In June 2016 the Life Sciences Minister was reported as follows in the National Health Executive[46] :

[46] http://www.nationalhealthexecutive.com/News/final-june-stp-deadline-watered-down-to-work-in-progress/142862

"Depending on the level of local and national agreement, [STPs] may form the basis for further plans and actions that will be subject to the same legal and best practice requirements that govern the NHS," "The June STP submissions will be work-in-progress, and as such we do not anticipate the requirement for formal approval from boards and/or consultation at this early stage. Plans have no status until they are agreed. When plans are ready, normal rules around engagement and public consultation will apply."

But a month later in July 2016, two documents were published which remove any possibility that the STPs were merely advisory.

First was *Strengthening Financial Performance and Accountability in 2016-17*[47]. In this document are sets of figures which are used to put financial reins on hospital trusts, CCGs and other NHS bodies to ensure that they conform to the new models of care. *'Doing nothing'* as it says throughout all STP and NHSE statements *'is not an option'*. If there is any doubt about the obligatory nature of these proposals they:

"*introduce new programmes of financial special measures for providers and commissioners that are unable to ensure sufficient financial discipline*".

That includes removing the leadership and imposing turnaround directors as had already been the case with three 'failing health economies' in Cumbria, Devon and Essex whose running had been taken over by NHSE to ensure compliance.

CCGs were put into special measures too, and could be required to implement an improvement plan under legal directions from NHSE, stop particular functions, or have their accountable officer replaced. They could also be disbanded entirely, required to share management, or become part of an ACO.

The second document was *NHS Improvement Business Plan 2016/17*[48]. This business plan lists as a priority:

'*to facilitate independent sector providers to form NHS partnerships'*.

[47] https://improvement.nhs.uk/resources/strengthening-financial-performance-and-accountability-201617/
[48] https://www.england.nhs.uk/wp-content/uploads/2016/03/bus-plan-16.pdf

There is an FAQ page on STPs[49] on the NHSE website. It says:

"… from April 2017, STPs will become the single application and approval point for local organisations to access NHS transformation funding. One of the original aims of STPs was to develop new care models, blueprints for future care introduced initially under the 'vanguard' and 'pioneer' programmes

*… Ultimately, the NHS must turn STPs into delivery partnerships focused on implementing the proposals. Most will be forums for shared decision-making, supplementing the role of individual boards and organisations. A small number of STP partnerships may evolve into integrated or 'accountable' care systems. In these areas, providers and commissioners could come together, with a combined budget and fully shared resources, **to serve a defined population**."*

(NB Not a geographical area, but a registered 'defined' population).

Page 35 of *Next Steps on the NHS 5 Year Forward View*[50] published on 31 March 2017 listed the likely first contenders to start to work towards ACO status. But when Simon Stevens was presenting an advance indication of the intentions of his *Next Steps* to the House of Commons PAC on 27 February 2017 he said:

*"We are going to formally appoint leads to the 44 STPs. We are going to give them a range of governance rights over the organisations that are within their geographical areas, including the ability to marshal the forces of the CCGs and the local NHS England staff. We will probably get about 6-10 of them going as accountable care organisations or systems. … We will nevertheless, within the letter of the law, act according to the spirit of what I have just described and push as hard as we can **without parliament itself having to legislate. If at some point down the line you choose to do so, that will no doubt be a welcome recognition of where the health service will have moved to in the meantime**."*

Despite the insertion of 'within the letter of the law', it is clear that Simon Stevens is saying that he is going ahead anyway with the changes and that parliament can catch up later. The Conservative Manifesto of 2017[51] indicates that changes would be necessary but implied that this might be done without formal

[49] https://www.england.nhs.uk/systemchange/faqs/
[50] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
[51] https://www.conservatives.com/manifesto

legislation. There should be concern when a service CEO can fundamentally reshape a public service with an open acknowledgement that there isn’t the law to allow him to do it.

APPENDIX 4

CONSULTATION AND STATUTORY INSTRUMENTS

In December 2016, NHSE launched a consultation on the MCP Contract. The engagement is described as lasting five weeks. It concluded on the 20 January 2017. In the introduction to the *Summary of Public Engagement* on the draft MCP contract which was published in a second version in August 2017 it describes the ACO contract then out for consultation as the:

"*latest iteration of a national contract for accountable care models that has been in development since 2016. An earlier version of this contract was referred to as the Multispeciality Community Provider (MCP) contract.*"[52]

It acknowledges that *'commissioning and contracting for an integrated care model of this sort inevitably involves a considerable amount of technical detail which some found a challenge to interpret"* and goes on to say that the consultation will continue *'as the Contract begins to be used'*.

Implementation will come before full consultation. Engagement with the consultation from December 2016 - January 2017 was very limited (as might indeed have been anticipated from the holiday period and time frame) although the summary describes them as, *'a wide variety of groups and organisations'*. There were 28 responses in all, including *"GP Federations, CCGs, NHS Trusts, Voluntary Community and Social enterprise sector, and other stakeholders from across the system."*

This consultation affects GP working across England. To put those numbers in context there are: 207 CCGs; 135 Acute Non-Specialist Trusts (including 84 FTs); 17 Acute Specialist Trusts (including 16 FTs); 54 Mental Health Trusts (including 42 FTs); 35 Community Providers (11 NHS Trusts, 6 FTs, 17 Social Enterprises and 1 Limited Company); 10 ambulance trusts (including 5 foundation trusts); 7,454 GP practices and 853 for-profit and not-for-profit independent sector organisations, all of whom will be affected by the new models of care.

[52] https://www.england.nhs.uk/wp-content/uploads/2017/08/1693_DraftMCP-1d_A.pdf

Add to that the Royal Colleges, especially the RCGP, and the BMA and it is reasonable to have expected a somewhat higher level of interest, or even to have extended the consultation period with a higher level of publicity.

The Summary document uses the previous public engagements over the Vanguard models (January 2015 – to date) as reason for not needing an extensive or formal initial consultation prior to drafting the amendments to the regulations.

In September 2017, the Department of Health announced it had identified some necessary changes to its regulations concerning the development of the ACOs contract[53]. It stated:

"this is largely to ensure that current rules continue to apply to the new contract, and the organisations using it. It also increases flexibility in some cases, for example for GPs who wish to enter into ACO arrangements without terminating their existing contracts. NHS England will continue to develop this contract further over the next year, with a view to consulting on a final version in 2018."

They published the draft regulations and an online survey. The survey was largely limited to asking whether the proposed amendments to the National Health Service (General Medical Services contract &c) Regulations deliver the policy objectives as set out in the consultation document.

Therefore, at this stage these are high-level technical questions about policy delivery, rather than questions over the policy itself.

The consultation ran from 11 September to 3 November. As yet there has been no response to the consultation but the Government has stated it would like to implement the regulatory changes by February 2018[54].

[53] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643714/ACO-contract-reg-changes-consultation-1.pdf
[54] http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-10-12/107452/