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Accountable care – the art of the possible



An eight step guide to accountable care



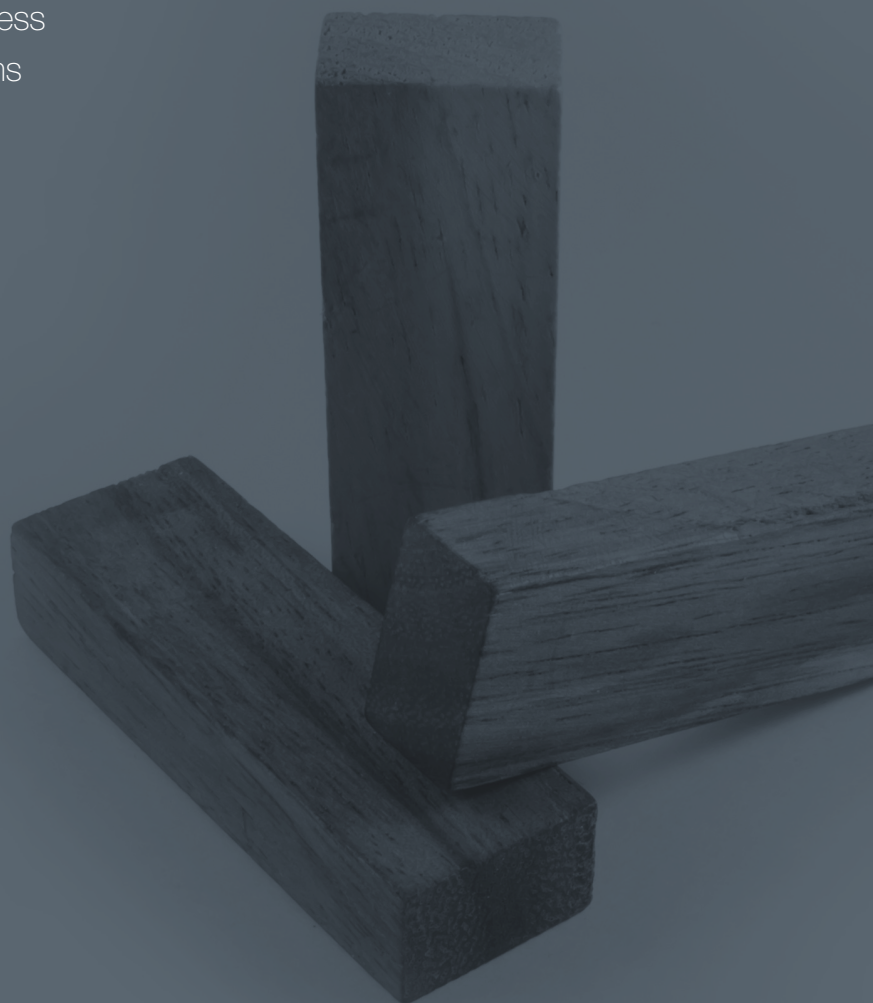
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Introduction

The move from STPs through to accountable care systems responsible for planning and delivering whole population care and onwards to accountable care organisations is now beginning to pick up pace. There are some areas rocketing ahead and others that are just starting to make progress, however all areas will be facing similar governance and legal challenges. Therefore earlier this year Hempsons and NHS Providers hosted a roundtable event to find out what advice you need in order to progress towards accountable care systems and organisations.

This joint publication is based on the discussions at the round table and we hope that it will provide you with useful advice in taking the next steps as you seek to work more closely with partners. We would welcome your feedback and your suggestions on what further advice you will need going forward.



‘A seven step guide to accountable care’, which we published earlier this year, addressed in brief how NHS provider organisations might respond to proposals for the evolution of Sustainability and Transformation Partnerships (STPs) into Accountable Care Systems (ACSs) and in some areas eventually into Accountable Care Organisations (ACOs). This document addresses the same themes, but also expands upon them to reflect the current situation – including an eighth step: competition.

There are a number of different definitions for accountable care, a term that is often associated with provider models in the US. The Five Year Forward View Next Steps, published in March 2017, defined these as follows:

Accountable Care System: “An ACS will be an ‘evolved’ version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers)...choose to take on clear collective responsibility for resources and population health ...specifically, ACSs are STPs - or groups of organisations within an STP sub-area... that get far more control and freedom over the total operations of the health system in their area”

Accountable Care Organisation: “In time some ACSs may lead to the establishment of an accountable care organisation. This 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 in the area. A few areas in England are on the road to establishing an ACO, but this takes several years”

Essentially, accountable care models bring together a variety of provider organisations, including primary care, to plan for and meet the care needs for a defined population within a set budget to an agreed level of quality. The difference between an ACS and an ACO is that in an ACS organisationally separate partners work together to integrate care and develop collective responsibility for population health. Whereas it is envisaged that ACOs will be single organisations holding single contracts which are responsible for the planning and delivery of the majority of health and care services in an area.

NHS England rightly acknowledges that one size does not fit all and STPs are therefore continuing to develop at different speeds with different arrangements for STP leadership and accountable care. In some areas there are multiple accountable care models developing within one STP footprint – either an ACS, ACO or even accountable care partnerships (ACPs).

This briefing acknowledges that and builds on our earlier guide. It aims to demonstrate the ‘art of the possible’ by setting out the options and key issues within the existing legislative framework for STPs and their constituent organisations to think about as they take the first steps towards ACSs and ACOs.

Step 1: Phasing

The process of moving from numerous sovereign organisations working together in the current system to collaborative ACS models and single ACOs is complex and challenging. The existing legislative framework is not designed to facilitate this process. Nevertheless, much is possible if partners take a phased approach, starting with the evolution of existing care models and organisational structures towards ACSs and in time, where desirable, ACOs.

How do you start?

Ultimately, the establishment of ACOs or ACSs may require consolidation of some organisations through a series of transactions such as mergers or acquisitions. In most cases the formation of a mature accountable care structure with a single organisation responsible for delivering healthcare to a regional or sub-regional area is likely to involve numerous transactions alongside service reconfiguration over time. The establishment of major lead provider arrangements may be equally complex in terms of contractual arrangements and lines of accountability.

But partners developing accountable care models need to start somewhere and identify some 'quick wins' to help move their model forward. For the vast majority of providers a staged implementation seems to be the preferred option, starting

with the evolution of existing care models and evolving organisational structures towards ACSs and ACOs. In many cases partners are taking incremental steps to improve and streamline service delivery where they can without necessarily yet having a roadmap towards complete system working or becoming a single organisation.

Options for partners to move forwards quickly include setting up partnership boards and putting in place a memorandum of understanding or alliance contract. We explore these options in more detail in steps 3 and 4 of the guide.

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

Key considerations will include:

- commissioners' procurement plans for existing contracts due to expire
- commissioners' plans to put in place an ACO contract 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
- establishment of partnership boards and collaboration arrangements such as a memorandum of understanding or alliance contract.

Step 2: Partners

It is now becoming quite common for there to be more than one proposed ACS/ACO per STP footprint. This reflects the fact that many STP footprints are very large and cover a number of diverse communities with differing perceptions of 'place'.

Early clarity about the key partners in each model will be essential. Some partners will be obvious, such as commissioners, GPs, NHS trusts and foundations trusts and CCGs. Others will be less obvious, such as voluntary sector and private sector partners responsible for delivery of NHS and local authority funded care.

How can primary care engage with accountable care?

Development of locality-based care models led by primary care is at the heart of many STP plans and accountable care models. But the different legislative, regulatory, contracting and payment regime in which primary care operates compared to that of NHS trusts and FTs poses problems when seeking to integrate services in an accountable care model. In light of these problems, there are three main options for integration of primary care with other services:

- **Virtual integration** – GPs and other partners enter into an alliance contract under which they agree to work together to deliver improved outcomes (see step 4 for more information on alliance contracts)
- **Partial integration** – GPs continue to deliver core primary care services but enhanced services are delivered by another partner such as the ACO, with GPs and the ACO agreeing to coordinate services via an Integration Agreement
- **Full integration** – GPs integrate their businesses with the accountable care lead (e.g. the ACO) either by terminating their existing contracts or temporarily suspending them under the 'right to return' mechanism

GPs and their accountable care partners need to consider the implications of each of these models in terms of funding for primary care services, GP influence over decision-making for primary care and consequences for workforce and premises.

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 lead practices or federations
- which model of integration GPs intend to pursue in an accountable care model, initially and as an end goal
- the involvement of private sector and voluntary sector partners
- whether an accountable care model needs to distinguish between 'full' and 'associate' members with differing rights and obligations, for example in relation to decision-making and participation in risk/reward schemes
- how the accountable care model can flex to reflect the exit of existing partners and introduction of new ones over time.

Step 3: Governance

The corporate governance of STPs and accountable care models through single sovereign bodies corporate is, in theory, no different from the governance of an NHS trust or NHS foundation trust. In fact there is nothing in law to prevent trusts from assuming all of the duties of an ACO or ACS. The difficulty for trusts is in getting there. This can only be achieved under the current legal framework by either a lead provider being the ACO or ACS, with other providers being sub-contractors, or through a series of transactions to create one organisation.

Clearly the creation of ACSs and ACOs will result in the formation of some very large organisations, which in itself presents some governance challenges because the scale of the organisation may be too much for a single board to direct and control. Existing large organisations are meeting these challenges by looking at group structures with a group board, but with each component part of the group having its own CEO and executive directors. Some trusts are considering appointing associate NEDs at this level to ensure that there is appropriate challenge and an independent perspective at all levels.

The question often asked about ACOs and ACSs is 'accountable to whom?': in the current legal framework lines of accountability would be to governors, to patients and the public, to regulators and to commissioners, which in future might be combinations of health bodies and local government.

But overall, the governance arrangements of a single ACO or ACS do have the advantage of simplicity. In contrast, some of the most substantial risks to developing accountable care models lie in transition— in other words, in the establishment of ACSs or ACOs, where multiple health and care body corporates are working together.

For those groups of organisations that are entering into STP and accountable care collaboration or partnership arrangements the most substantial risks relate to the fact

that these arrangements are not bodies corporate and have no decision making powers in themselves. Rather they rely on delegations, to either executive directors or to committees. Delegations are more restrictive for FTs than NHS trusts, because FTs can only delegate to executive directors or to committees of directors. Over-reliance on delegations can mean that decisions are not subjected to rigorous challenge that is the standard way of working at trust board level and constitutes best practice.

Some STP and accountable care collaboration or partnership arrangements 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, that these groups begin to behave as if they were entities with decision-making powers in their own right. In addition some boards have agreed to fetter their own powers so that they will not veto a shared executive without a majority among the other partners. This brings significant risk in terms of holding executive directors to account.

Ultimately the key decision making unit for NHS trusts and foundation trusts remains the trust board. Trust boards will need to increase their efforts to assure themselves that decisions taken on their behalf are made lawfully and that they are properly assured that new and existing risks are identified and properly managed and mitigated.

Regulation also remains an issue for collaborations and partnerships and for those organisations that own or part-own subsidiaries that provide healthcare services. While best practice in governance would lead to the regulation of those who have the legal power to make decisions, NHS Improvement's (NHSI) recent consultation on regulating companies owned by trusts or in shared ownership of trusts as entities in their own right, rather than their owners, for their performance tends to muddy the water in trying to understand if the direction of travel is really towards system regulation.

Can ACS partners set up a partnership board to take decisions?

As this section of the guide indicates, where partners set up an STP or accountable care model through collaboration or partnership arrangements the most substantial governance risks relate to the fact that these arrangements are not bodies corporate and have no decision making powers in themselves. So how can multiple partners make decisions?

- In some limited circumstances, depending on the nature of the partners involved, a partnership board can be set up as a **joint committee**. A joint committee will be able to take decisions on behalf of its members. This option is not available to FTs except in some situations where they are integrating health and social care services
- An alternative is to set up a partnership board as a **committee-in-common**, where each partner sets up a committee of its organisation which makes sovereign decisions at the same time and in the same place as other partners. In some circumstances, committees-in-common can have some or all of the same membership. The aim of a committee-on-common is to facilitate coordinated decision-making
- In all other circumstances, a partnership board effectively operates as a **working group** and will only be able to make decisions which the members appointed to it have the delegated authority to take. An organisation cannot be bound by a decision which the member it appoints to the board does not agree with. So decisions can only be made by consensus.

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

- STP and accountable care models established by collaborations and partnerships currently have no powers to make decisions: their recommendations need to leave partners with real choices on whether to accept the recommendation
- STP and accountable care models established by collaborations and partnerships are not legal entities; this makes it difficult to hold them accountable, so their leaderships need to take care to refer back to partner organisations and respect the unique role of boards as well as the liabilities and duties of directors
- STP and accountable care models established by collaborations and partnerships are not board-led organisations and will not have a NED majority or built in NED challenge. 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 remains 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

Accountable care anticipates a model of service delivery based on integration of different types of health services and integration of health and social care services. At the heart of this is integration of primary care services with other services. The draft ACO contract currently being consulted on by NHS England is designed to facilitate this integration through a single contractual model. This contract is now usable for accountable care models generally, including MCP and PACS models.

Key points to note about the ACO contract are:

- it is based on the NHS standard contract already in use including nationally mandated sections
- it facilitates integration of primary care and other services under the partially integrated and fully integrated models (as described in step 2 of this guide)
- it facilitates a new payment model for accountable care (see step 5 of this guide)
- it is intended to be a 10 year contract
- it provides a population outcomes and incentives framework for ACOs
- it requires providers to give certain undertakings in relation to financial matters, designed to provide assurance in relation to the sustainability of the ACO

The ACO contract may also incorporate terms to allow an ACO provider to support the discharge of certain CCG duties, for example population needs assessment and managing the supply chain. The contract will need to be clear on the split of responsibilities and, in all cases, CCGs will retain responsibility for discharge of their statutory functions.

In time, commissioners may award a single contract to an ACO and indeed the ACO model itself anticipates accountable care being delivered through one contract. But until then partners setting up an ACS will need to operate through a network of different contracting arrangements including existing contracts and new contracts. Alliance contracting may be a useful mechanism to coordinate multiple contracting arrangements in an ACS (see box).



What are the benefits of alliance contracting?

An alliance contract is a contractual arrangement between commissioners and providers who agree to collaborate around a common aspiration for joint working across a system. Alliance contracts include shared objectives and principles, risk/reward sharing mechanisms and governance structures to facilitate decision-making about service delivery. Alliance contracts do not seek to replace or in any way override existing services contracts between commissioners and providers – instead they supplement and overlay those contracts.

There are different types of alliance contract. Traditionally they include both buyers (commissioners) and suppliers (providers) but they can be set up without involving commissioners directly. They can be little more than an extended memorandum of understanding, designed to set out a non-binding commitment to work together for an interim period. Or they can be set up as long-term arrangements with detailed governance and risk/reward sharing arrangements built into them.

Alliance contracting is relatively new to the NHS. As a model, it has its origins in the heavy engineering

and oil industries of the 1990s where it was developed as a response to a range of problems with traditionally contracted service delivery, such as escalating costs, completion delays and litigation. The model has been adapted for use in the NHS but it seeks the same outcome – a collaborative approach to deliver integrated services in a complex environment. Key features of alliance contracting compared to traditional contracting are:

- Commissioners and providers working closely together rather than commissioners operating at arm's length to providers
- A coordinated approach to service delivery by providers rather than each provider delivering its services in isolation
- Adopting a 'best for service' approach to delivery across multiple services rather than an approach based on what is best for each individual organisation
- Risk sharing between parties rather than an approach which seeks to transfer risk from one or more parties to other parties
- A commitment to resolving disputes within the alliance rather than by parties taking action against each other
- Open book accounting and transparency rather than closed book accounting.

Key considerations for contracting will include:

- seeking clarity on if and when commissioners intend to put in place an ACO contract
- how an ACO will sit alongside existing contracts, assuming that it will not be possible for an ACO contract 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

The draft ACO contract and guidance envisages a new payment approach for accountable care models comprising three elements:

- an integrated budget or single payment which will be a budget for the whole of the population served for the services in-scope of its contract. This will only include core primary care funding in a fully integrated model.
- an Improvement Payment Scheme designed to incentivise improved outcomes which will be a top slice of the integrated budget. The quantum of this is intended to replicate existing schemes such as CQUIN.
- a gain / loss share (or risk/reward share) agreement to align financial incentives across health services provided for the population.

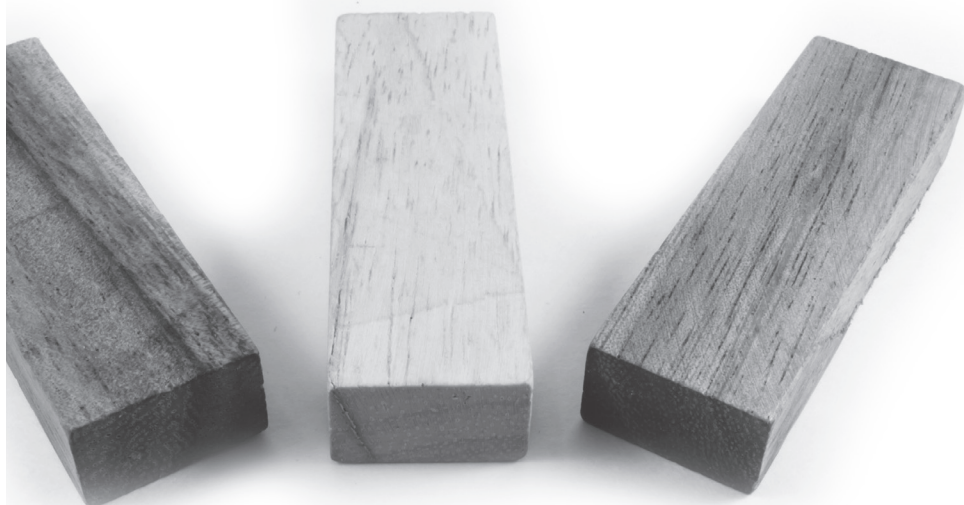
Putting in place this new payment approach under ACO contracts is likely to take time. In the meantime, partners in STPs and ACSs need to consider how to build on existing payment regimes to support the development of their model.

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 STP or accountable care model will need the ability to move finances around the system with the agreement of those involved.

On this basis, particular attention may be paid in the early stages of an ACS to development of a gain / loss share agreement which, for example, can be incorporated into an alliance agreement or lead/sub-contractor arrangements.

Key considerations for partners in developing funding arrangements will be:

- commissioners' plans to pool funding for health and care
- pending the introduction of whole population budgets, whether arrangements can be put in place in the short term to permit ACS-wide gain/loss sharing within existing payment regimes
- requirements for financial sustainability of providers under the regulators' Integrated Support and Assurance Process <http://bit.ly/isap-nhs>
- VAT consequences of setting up new vehicles (see step 6).



Step 6: Organisational form

One of the characteristics of recent debate about organisational form has been a lack of clarity about what this means. The most important thing by far is that there exist board-led bodies corporate which are responsible for directing and controlling the planning and delivery of healthcare. Only bodies corporate can properly be held to account and regulated.

An ACO is likely to involve one body corporate with responsibility for delivery of the ACO contract, albeit with other bodies corporate in a supply chain. In contrast, an ACS is likely to involve a number of different bodies corporate operating under collaboration arrangements.

So which types of bodies corporate are most suited to leading accountable care models? Some have explored

setting up new jointly owned corporate vehicles, while others have explored existing organisations such as NHS trusts and foundation trusts as well as primary care and community services providers. The preferred choice of organisation will depend on a number of factors. For new vehicles in particular, tax, VAT, workforce and pensions implications need careful investigation. And in most cases the organisation must be able to satisfy the requirements of the regulators' Integrated Support and Assurance Process (<http://bit.ly/isap-nhs>).

In terms of the shape of the organisation itself – something that is often described as organisational form – 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. But early discussions between partners about organisational form can help to move development of the accountable care model forward.

Organisational form options

The main options being explored for accountable care models are:

- Memorandum of Understanding – a loose collaboration between partners
- Alliance Agreement
- New corporate vehicles
- Lead provider model – one provider takes overall responsibility for the delivery of care in a locale and other partners act as contributors to the planning process and delivery sub-contractors

Any of these models may also include:

- Integration arrangements with primary care providers, including via an Integration Agreement
- Establishment of a partnership board
- Consolidation through a series of transactions, normally acquisitions or mergers

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.

Step 7: Enablers

Partners need to make sure that key enablers for accountable care are built into the programme from an early stage. Enablers must support the model and not hinder it.

The most important enabler is workforce. For accountable care models to be effective, organisations will need to embrace new cultures and ensure their workforce has the right skills, values and behaviours to work effectively. The ability for individuals and multi-disciplinary teams to adapt to provide care in different settings, at different times and in different organisational and team structures will be essential.

Key issues for consideration will be improving staff health and wellbeing, reducing obstacles to better performance, providing training and looking at whether terms and conditions support high performance and redesigned service provision. Organisations might also need a different skills mix to achieve their objectives, including utilising extended, advanced and new hybrid roles. Significantly, if a new care model results in changes to an organisation's structure and working arrangements then complex employment law issues may arise and need to be managed carefully.

Digital transformation and innovation is also crucial for developing accountable care, with benefits including:

- Better collation of patient data and an easier means of keeping that data accurate and up to date in 'real time'

- Improved access to data for both clinician and patient
- Greater efficiencies, enabling clinicians to work more effectively, generating a better patient experience and improved outcomes.

Whether through the Global Digital Exemplar programme, the NHS and industry 'test bed' partnerships, vanguard projects or local programmes, partners must access knowledge from across the NHS and build it into an accountable care-wide transformation programme.

Key considerations for putting in place enablers to support delivery of accountable care models will be:

- strategies for developing a shared workforce with the right skills, values and behaviours including a shared culture (see box)
- 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
- ensuring compliant information governance systems are in place for sharing of data
- strategies for accessing a shared estate and, in time, developing a fit for purpose estate across each accountable care model.

Developing a shared culture

Peter Drucker's remark that culture eats strategy for breakfast still holds true. It is well-established that a healthy, safe and open culture in health sector organisations is crucial to the successful delivery of high-quality, compassionate and continually improving patient care. Culture is the engine of any establishment because it has a direct impact on key operational areas such as:

- the effective provision of services
- the organisation's values/goals
- the organisation's strategy/direction
- effective collaboration/partnership arrangements
- staff morale
- high levels of performance from staff
- good staff retention rates/reduced turnover

Culture can only be shaped and influenced at a local level, which means that work on culture needs to be done locally. However culture needs to be based on a shared vision and shared principles at ACS / ACO level and lived out in the behaviours of leaders at all levels. Key criteria for partners to factor in will be:

- Openness and transparency
- A commitment to consultation from now onwards which is demonstrated by actions
- Cultures led locally, but based on a shared vision
- A desire to make up for lost time and bad press in some areas.



Step 8: Competition

Competition and procurement rules continue to apply to the NHS, even those designed for a less competitive and more collaborative NHS, and seem likely to do so for the foreseeable future. This means care must be taken in establishing and operating an ACO or ACS to ensure compliance with these rules. Challenges under these rules can emerge even from unlikely places (as can be seen with the challenge to ACO contracts by pressure group 999 Call for the NHS).

Where commissioners and providers are focused on delivering the best possible service to patients, and can show that their decisions have been taken with this in mind, they will minimise the risk of breaching competition rules.

Key considerations relating to competition and procurement rules include:

- **Merger control:** moves to establish fully integrated ACOs are subject to potential review by the Competition and Markets Authority (CMA) under merger control rules where a new single organisation is created. Most integration to establish an ACO involves organisations offering different services (e.g. acute and community providers), which raises few concerns under merger control rules, and is unlikely to require notification to the CMA.

Where a merger does bring together two providers of the same services (e.g. two acute trusts), this may well require formal notification to the CMA and a review by it. Similarly, bringing together multiple GP practices

may bring about a CMA review if concerns are raised about a loss of choice for patients in relation to either primary or acute care. The CMA will allow mergers that reduce patient choice and competition, provided that it can be satisfied that the benefit to patients arising from the merger outweighs any adverse effect arising from a loss of competition.

- **Prohibition on anticompetitive agreements:** agreements between providers to establish an ACS are subject to the general competition law prohibition on anticompetitive agreements. Parties to these agreements need to take care that they do not deliberately or inadvertently restrict the ability of other providers outside the ACS to provide services (e.g. by collectively refusing to cooperate with, or refer patients to, these providers) in a way that cannot be justified in terms of ensuring the best possible service to patients.
- **Prohibition on abuse of a dominant position:** once an ACO is established, it may be regarded under competition law as having a dominant position in the services that it provides. This has the potential to place additional obligations on the ACO when considering how it interacts with other healthcare providers and, additionally, has the potential to constrain how it carries out its tactical commissioning responsibilities. Those ACOs that can clearly demonstrate that their decision-making is in the best interests of patients will be most secure against complaints of abuse of dominance.

About Hempsons

Hempsons is a leading national health and social care law firm. We advise the NHS on a wide range of strategic and legal issues to help them meet the complex and ever changing challenges they face.

Our clients are public/private healthcare organisations, charities and social enterprises who plan, commission, regulate or provide health and social care services, or operate within the supply chain, as well as organisations in the life sciences sector. Our strong NHS client base includes many foundation trusts, NHS trusts, COGs and CSUs, NHS Improvement, NHS England and other health related bodies.

About NHS Providers

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.

About Aldwych Partners

Aldwych Partners is a consultancy that advises on mergers and competition in the NHS and broader health and care sector. Aldwych Partners recently advised Central Manchester University Hospitals NHS Foundation trust and University Hospital of South Manchester NHS Foundation trust on their Competition & Markets Authority merger review. This was the first merger cleared by the CMA on patient benefit grounds.



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