

The origins of the idea

The Health and Social Care Act 2012 ordered a split between those commissioning health services and those delivering them. The current Secretary of State for Health and Social Care, Jeremy Hunt, has admitted that this was not a successful change: 'when you're dealing with complex patients who are going in and out of the system a lot those structures prove not to be fit for purpose' (Lintern, 2017).

The creation of STPs (either Sustainability and Transformation Plans or Sustainability and Transformation Partnerships, depending) saw the pendulum swinging back from the 2012 act. England was divided into 44 footprints, within which providers and commissioners – including councillors – were asked to work together to address the challenge set out by the NHS Five Year Forward View. This pendulum swing continues with the UK's government's interest in the type of organisations which are variously known as Accountable Care Organisations (ACO), Accountable Care Systems (ACS) and Integrated Care Systems (ICS). According to NHS England, 'An ACS will be an 'evolved' version of an STP that is working as a locally integrated health system.' (NHS England, 2017)

This approach involves the government paying a group of organisations to work together look after a whole population – the inhabitants of a city, county or footprint – and paying that group of organisations per head. Hospital trusts and general

practices are key organisations within these groups, but voluntary sector organisations could also be included. A phrase used during the adoption of this approach in Canterbury, New Zealand was 'one system, one budget' (Charles, 2017). The UK government hopes that this approach will induce organisations firstly to work more effectively together and secondly to emphasise prevention – rather than cure – of illness. As the national health executive puts it:



the care forum

'The underlying theory is that if you give a population-based budget to a provider organisation or group of organisations and require them to deliver a set of specific health outcomes for their registered population, they will be incentivised to a) keep people as healthy as possible to decrease overall use of healthcare services, and b) minimise the use of high-cost hospital-based care by ensuring effective community-based provision' (National Health Executive, 2016)

It is hoped that this will enable the NHS to cope with the predicted increase in UK population, especially of the elderly and those with long term conditions.

What's in a name?

The models that first inspired the UK government were from the United States,

where groups of providers, including doctors and hospitals - were allowed under the Patient Protection and Affordable Care Act (2010) – sometimes called ‘Obamacare’ – to form Accountable Care Organisations (ACOs) to provide coordinated and joined up care. Even before Obamacare, organisations such as Kaiser Permanente had delivered integrated care in the US, although this was on a private insurance basis. Initially, therefore, the UK government spoke about the creation of ACOs and ACSs across England, with the distinction that an ACS would include the Clinical Commissioning Group (CCG) whereas an ACO would be ‘established when commissioners award a long-term contract to a single [provider] organisation’ (Ham, 2018) (NHS England, 2017).

Immediately, however – and probably because of the US associations - these terms became problematic. Two national campaign groups, including high profile figures such as the late Steven Hawking - attacked ACOs from different angles, leading to NHS England rebranding ACOs and ACSs as Integrated Care Partnerships (ICP) and Integrated Care Systems (ICS). (Bate, 2018) To complicate matters, the ACO brand has been allowed to linger – according to the Health Services Journal - to ‘soak up the political toxicity’ (West, 2018). If you get these terms mixed up you’re not alone: Jeremy Hunt tripped over his terms in a 2014 speech when he said that ‘we are taking the first steps to turn

the 211 clinical commissioning groups into accountable care organisations’ (Bate, 2018).

Successes and concerns

According to The King’s Fund, early evidence suggests that these new approaches may be a step nearer the goal of less people in hospital ‘Some new care models have reported absolute reductions in emergency admissions per capita. Among the eight ICS areas (excluding the Greater Manchester and Surrey Heartlands devolution areas), Frimley Health has also experienced reductions in GP referrals and flat A&E attendances, and the part of the Nottingham and Nottinghamshire area covered by the Mid-Nottinghamshire PACS has seen reductions in emergency admissions’.

But other voices suggest that success thus has been ‘mixed’ (British Medical Association, 2017) and pointed out that changes to organisational structure do not necessarily lead to the key drivers of improved care: ‘clinical leadership, attention to IT and data, development of new clinical processes, establishment of learning culture, and effective patient and community engagement’ (National Health Executive, 2016).

There is agreement that, in order for these structures to be effective, there needs to be heavy investment in technology, especially:

- improvements in population health analytics
- development of new predictive and case management tools

- accelerated implementation of fully electronic care records (National Association of Primary Care, 2017)
This technological investment involves potentially massive upfront costs. Kaiser Permanente's patient record system (the largest civilian electronic medical record system in the world, covering 8.6 million patients) cost \$6 billion - 'a cost exceeding a half million dollars per physician'. (Monegain, 2010)

Further, there are concerns about awarding such sweeping contracts on the basis of what will inevitably be broad estimates about the costs of looking after a given population. The case often mentioned is that of Cambridgeshire and Peterborough's Clinical Commissioning Group (CCG), who awarded a five-year community services contract to the lowest bidder, only for the deal to collapse after six months when the gap between bid and reality became clear (Collins, 2016). According to The King's Fund, memories of this kind of experience will mean that 'the ACO contract is likely to be used sparingly.' (Ham, 2018)

Lastly: just like STPs, these bodies have no legal status. As NHS England writes: 'An ACO is not a new type of legal entity and so would not affect the commissioning structure of the NHS' (NHS England, 2018). CCGs will thus remain responsible in law. The British Medical Association has raised questions about such potentially powerful bodies sitting 'outside legislation' (British Medical Association, 2017). So the word 'accountable' is perhaps misleading.

Implications for the voluntary sector

Possible impact on voluntary sector providers is uncertain. The Kings Fund have stressed the need 'to engage a wide range of stakeholders, patients and citizens in the work that is under way, to listen to their concerns about the ACO contract and other issues, and to involve them in developing new care models and integrated care in a transparent process' (Ham, 2018) But currently footprints have only been asked – but not ordered - to 'consider' the role of voluntary sector providers as well as the amount of 'tactical' commissioning they pass to provider organisations (Hempsons, 2017)

John Rouse - Chief Officer of the Greater Manchester Health and Social Care Partnership – has stated that The Greater Manchester Health and Social Care Partnership 'based our working relationship with the voluntary, community and social enterprise (VCSE) on the recommendations from the Joint VCSE Review' (Fox, 2018), but added that he expected 'to lead the way in using the Social Value Act powers routinely in our health and care contracting, to get the best value possible from public funds'. Making use of local social value policies - see previous TCF info sheet – will perhaps be a key tool for the voluntary sector as it seeks to stay in the conversation.

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