Accountable Care Organisations

What are Accountable care Organisations?

Health care commissioners in all of the new geographical divisions of the NHS - called "Footprints" - have been drawing up plans called Sustainability and Transformation Plans (STPs). The aim of these is firstly to reduce the deficits accruing by CCGs after 7 years of chronic underfunding (sustainability) and secondly to move to new cheaper models of care for the future (transformation).
This transformation requires a move to new integrated models of care where providers - hospitals, community health care providers, GPS and social care - come together as one organisation and work together to provide for the health care needs of a population.
There are many permutations of integrated care but most of the footprint areas are moving towards Accountable Care Organisations (ACOs) or Accountable Care Systems, a less structurally integrated stepping stone towards ACOs.

ACOs are Non NHS organisations.

The formation of ACOs means the dissolution of the NATIONAL Health Service.
Yet they will be given control of the health budget and the power to decide on priorities and standards**.**

Cornwall has plans to move to an ACO system with a shadow system being in place by April 2018 and the system fully working by 2019.

The positive case - integrated care

While the future of the NHS remains a very divisive area there is one thing that almost everyone is in agreement with and that is that integration is a good thing.

Health and social care are so intimately connected that it makes little sense for them to be separate. If social care budgets are cut, as they have been, patients who might otherwise be managed at home end up being admitted and patients who might otherwise be able to be discharged remain in hospital, remain trapped there.
"**Delayed transfers of care"** are widely cited as the most important factor leading to the crisis in NHS capacity with a knock-on effect in A&E waiting times.

This is one of the main but very importantly not the only reason for the crisis of capacity within the NHS.

We must not discount the effect of hospital bed closures.
NHS hospital beds have been cut by more than half in the past 30 years and by a fifth in the last 10 years.
The NHS now has fewer acute hospital beds per person than virtually any other comparable health system.
https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

The capacity problem is particularly acute in Cornwall.
Treliske tops the national league table for the number of times it has been on" black alert" or … OPEL 4 meaning that capacity is overstretched to the point where patient care and safety may be compromised - 99 times in 9 months.
http://www.cornwalllive.com/news/cornwall-news/royal-cornwall-hospital-black-alert-685792

Another major factor affecting capacity and performance is a major recruitment crisis- both in the community and in hospitals.
The staffing crisis is not an act of God but a major failure of health policy, a man-made disaster resulting from cut-backs in training budgets, nurse training and medical school places, a pay cap, stress caused by understaffing, removal of health service bursaries and the exodus of EU nationals from the Service.

It is hoped that the integration of services will deliver efficiency savings.
However a recent report by The National Audit Office says that there is no evidence that integration will work as envisaged .
http://www.nationalhealthexecutive.com/Health-Care-News/nao-no-compelling-evidence-that-health-integration-really-works
In response to the NAO's report influential think tank the Nuffield Trust said the government's plans to save money by shifting care into the community "are built on sand".

It is hoped that money will flow from health to social care allowing patients to be cared for more cheaply within the community.
However when something similar was tried in Torbay money flowed from the Council into the health budget and the project was abandoned.
http://www.bbc.co.uk/news/uk-england-devon-34200313

Concerns - the case against ACOs.

In a nutshell the concerns are :
A lack of accountability.
Changes to the financial basis of health service funding
The danger of private institutions embedded within ACOs gaining control of health budgets,
The erosion of availability and quality of publicly provided health care with the consequent growth of private health insurance.
Whether the benefits claimed for this reorganisation are achievable.
Budgetary risk is transferred from national government to local government.
Responsibility and blame for the curtailment of services is transferred to local government.

ACOs threaten to the core principles of the NHS.
The principle of **free at the point of delivery** is threatened by dissolution of the boundary between health and social care. There will be a transfer of Care from Health Service provision which is free at the point of delivery to means tested Social Care provision mostly provided by private companies. We know that the Conservatives have had plans for this to be funded from the equity in people's homes until they found this to electorally toxic.
Equity of access is sacrificed as soon as there is means testing , co payment or top ups from private health insurance. The inverse Care law is written large- those most in need of care receive the least service.
Comprehensive care is compromised by severe funding restriction, rationing and incentives for providers to provide care on a basis of cost rather than on assessment of need.

Accountability

The 2012 Health and Social Care Act has already reduced democratic accountability by removing the Secretary of State for Health's responsibility to provide health services.
Now the Secretary of State directs funds to the Clinical Commissioning Groups (CCGs).
It is then their responsibility to decide how to spend the funds allocated - what to buy and, critically, what services not to buy when the funds being allocated by the government are insufficient.

It means that for example Chris Grayling can be asked, as he was recently on Question Time, whether it's right to deny people operations on the grounds that they have a BMI above 30 or smoke. He can say "I don't agree with this but these are decisions made locally by clinicians" - and get off the hook - it's nothing to do with the government.

Ironically Accountable Care Organisations are the antithesis of accountability.
ACOs are non statutory bodies- there is no Act of Parliament governing their foundation.
Accountable Care Organisations are about balance sheets, accountancy, not accountability or openness to public scrutiny and democratic control.
The legal framework governing the Health Service remains the 2012 Health and Social Care Act.
The development of ACOs is a de facto reorganisation beyond that governed by the 2012 Act which has not been subject to parliamentary debate.
There are no legislative checks and balances governing the activities of ACOs for example regarding the curtailing of services, the extent of involvement of private companies or rules governing the sell-off of NHS land
The 2012 Act separates commissioners (CCGs) and providers. Those controlling expenditure do not buy services from themselves so that there is no conflict of interest.However the formation of ACOs removes this separation. And the formation of ACOs will marginalise or abolish the existing statutory bodies, the CCGs.

Are ACOs legal?

A group of highly influential academics and campaigners including Professor Steven Hawking are mounting a legal challenge to Accountable Care Organisations
https://www.allysonpollock.com/wp-content/uploads/2017/11/PollockEtAl_ACOConsultationResponse_2017.11.02.pdf

The group 999 call for the NHS are also challenging this in court .

Cornwall Council would do well to pause the headlong rush to ACS and allow time for proper public consultation. Instituting a shadow ACS by April does not allow for this.

"All that is needed is for Ministers to clarify that ACOs will be bound by the well-established requirements to engage and consult that apply to single providers."
"..major service changes see CCGs bound by the statutory provisions in the 2012 Act"
"The danger is that a BREXIT-battered Treasury may seize upon the ACOs as a means to accelerate its cost-reduction agenda by sidestepping the expensive and time-consuming processes of dialogue with local communities."
https://www.sochealth.co.uk/2017/12/04/accountable-care-organisations-public-engagement/

What about public consultation?

Those drawing up the plans consider that the consultations already held are sufficient.
That is the STP consultation and plan rejected severely criticised by councillors on 15th March 2017 and the subsequent Shaping our Future consultations open only to a selected few.
Accountable Care Organisations have not been mentioned or explained to staff or the public.
The presentations used by these consultations are flawed and misleading.
See this full analysis of the STP consultation and a more recent analysis of the SoF consultation by Dr Peter Levin.
He taught social policy at the London School of Economics for 25 years, books include Making Social Policy: The Mechanisms of Government and Politics and How to Investigate Them
http://spr4cornwall.net/communications-and-engagement-in-health-and-social-care-a-cautionary-tale-from-cornwall/

Financial

The system of payment governing ACOs is key to understanding why ACOs threaten the very core principles of the NHS.
At present providers are paid for **activity: the more they do the more they earn.**
ACOs are paid by **capitation** i.e. a sum per head to provide all the health care to a population**.**
In this case the LESS they provide the more surplus or profit they make.
An version of this model in the US, Health Maintenance Organisations, involved routine denial of patients' access to medically necessary treatment.
https://m.youtube.com/watch?v=nDHklw6PV3U

Even if they are a not for profit organisation, the less they spend, the more they can pay to their executive board, their private partners and management consultancy companies.
And the possibility of them being handed over in their entirety to private companies is very real.

In the version of ACO believed to be favoured by Cornwall Council and the STP board, the Manchester model, the payment is by capitated budget, there is a long contract (ten years) and the CCG is not part of the (LCO)system.

Jeremy Hunt is very enthusiastic about the systems run by Kaiser Permanante in the US and he and health service managers have been crossing the Atlantic having talks with them for years. Hunt referenced Kaiser Permanente as a model for the future budgetary arrangements in the NHS at the Commons health select committee in May 2016.
https://m.youtube.com/watch?v=0HyL-riKqqc

This is from The Kings Fund's explanation of ACOs-
"The language of accountable care comes from the United States, where ACOs have taken shape in the wake of Obamacare as an attempt to improve care and reduce growing health care costs. While the term ACOs is relatively new, they represent the most recent manifestation of well-known integrated systems, such as Kaiser Permanente."

Locally driven and developed by clinicians?

This article shows how the Five Year Forward View was derived from a report by McKinsey delivered to the World Finance Organisation.
https://www.sochealth.co.uk/2017/05/25/truth-stps-simon-stevens-imposed-reorganisation-designed-transnational-capitalism-englands-nhs-stewart-player/

This formed the basis of the Five Year Forward View Document , designed by Simon Stevens, now head of NHS England but previously Director of Global Health Operations for the multinational health corporation United Health.
All STP documents are strikingly similar, derived from the 5YFV and have to be approved by NHSE at every step. The ACOs are designed to deliver the service change outlined in the 5YFV and it may be argued the interests of the multinational corporations.

To maximise savings/profits there will be reduction of services, so called "demand reduction" and the forcing down of staff costs.

This means the dismantling of existing services.
There will be closure of minor injury units, community hospitals, acute hospital beds and General Practices.
In Cornwall, minor injury units will be reduced from 12 to 3 or 4 urgent care centres.
Devon has already seen the closures of 4community hospitals.
In Cornwall, Edward Hain Hospital in St Ives, Fowey, St Barnabus in Saltash are "temporarily closed".

Nationally Accident and Emergency depts will be closed or downgraded - the 5YFV anticipates 70 rather than 140 full A&E departments despite the fact that nationally the 4-hour A&E waiting time target has not been met for the past 18 months.
Recently we have seen proposals to deny patients access to A&E without prior vetting.

“Demand reduction”

Some treatments like fertility treatment will become unavailable.
Some groups will be denied treatments, for example denying surgery to people with a BMI over 30 would exclude 1 in 4 people from treatment - effectively categorising people with what are termed “unhealthy behaviours” as undeserving of care. However we know that these behaviours are often linked to complex societal factors.

Independent contractor GP practices are not compatible with the new structure.
General Practice is the entry point to health services and a vital component of a cost efficient Health Service.
GPs have accounted for 90% of patient contact but just 8% of the NHS budget.
As services can be most cheaply provided within the community, integration and control of primary care is a vital part of any ACO.
Nationally the 5 YFV anticipates that from the current number 7,500 GP practices these will be concentrated into 1,500 super hubs.

Primary care will be delivered by “multi speciality community providers” serving 15-40,000 patients.
In Cornwall, 1 practice has closed, others have merged and 10 out of a total of 63 practices are considered “vulnerable”. This is just the start…

Health service administrators have said “GPS won't be forced to give up their GMS contracts” but it is clear that any additional funding will be directed to the federations or merged centralised practices delivering the changes demanded by the 5 YFV. The GP recruitment crisis will mean that practices will be unable to attract new doctors. GPs will be forced to relinquish their independence and become salaried employees. Morale is now so low that many will welcome this change.
There will be 20% less GPs in Cornwall.

To reduce staff costs, there will be a move to a “modern workforce” - a reduced skill mix, with various non doctors in “transitional roles” doing doctors’ work, and carers doing nurses’ work. It would allow the rapid shifting of staff out of the public sector to private companies with altered terms and conditions.
It is worth noting that much vaunted model ACO, the “Alzira model” in Valencia, Spain, failed because the pay terms and conditions were unacceptable to the staff who staged major strikes. They were also subsequently found to have been claiming payments fraudulently.

The NHS will be reduced to a minimal service.

Expansion of private health insurance.

Because the services provided by ACOs will be basic like Medicare in the States, there will be a rapid expansion of private health insurance uptake by those who can afford it. Those who already have illnesses, are old or at high risk will be unable to obtain insurance. The rich will, as in the US, be subject to lots of unnecessary treatments as someone will be making a profit from them
This is the “Inverse Care Law” writ large. The most in need of health services get the least care.

The Health Service will no longer be delivered on the basis of need and not the ability to pay.

A “Trojan horse” for privatisation.

Private companies will be embedded within these organisations from the start either as partners, advisers, of providers of PFI capital or to manage the administration of the organisation. In Cornwall the STP plans are being designed with advice from PriceWaterhouseCooper and Finnamore.

One of the first wave ACOs in Nottingham has awarded a £2.7m contract brokered by Capita (responsible for the loss of thousands of NHS Documents) to Centene (responsible for the failed Alzira model in Spain which led to huge Health Service workers strikes and has been accused of fraud) to help turn the STP into an ACO because it said it doesn’t have the expertise to manage this in-house.
The private health company Circle Health (responsible for the failure of Hinchinbrooke hospital) is also embedded as a partner in the organisation.
The Frimley ACO lists Virgin Health as a partner.
With “friends” and advisers like these who needs enemies?

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Practical - will this system of care work as envisaged?

There is **no evidence** whatsoever that these models will work in the way they envisage - it hasn’t been trialled.
No other country in the world has reduced the number of hospital beds per head to the levels envisaged by these plans relying instead on care in the community.
The Kings Fund says there is no evidence it will be cheaper.

This important article questions whether the claims made for ACOs are sound.
The author is an NHS-trained accountant, Ex Director of Finance, Ex Chief Executive Officer with 20 years management consultancy experience.
He considers that “that ACSs/ACOs are not new and they don’t work. They promise 20-30% savings but they cost at least an extra 15-20%. There are better ways of saving money and improving quality. It’s the wrong solution. The NHS spends far less, with fewer inputs, and delivers less, not surprisingly, than other countries. Looking to trim output further will be counterproductive.
In the UK it makes little sense to integrate health and social care. The NAO couldn’t find the evidence for it and the DH has still to provide it. The real problem is the inadequate funding of both health and social care. Expecting both to support the other is like asking two drunks to help each other stand up. It is not practical.”
https://www.sochealth.co.uk/2017/12/03/accountable-care-systems/

I reference again the National Audit Commission
http://www.nationalhealthexecutive.com/Health-Care-News/nao-no-compelling-evidence-that-health-integration-really-works

EVIDENCE THAT ACCOUNTABLE CARE IS UNLIKELY TO WORK IN CORNWALL.
(from the Kings fund)
The Canterbury model of integrated care has been successful but:
"changes in Canterbury required investment....
they have not cut beds or taken resources from hospitals....
transformation of this kind takes time, with progress still under way a decade into the journey..

This raises questions over the feasibility of ambitions around NHS transformation. Vanguards and sustainability and transformation partnerships are being asked to make significant service changes with little or no additional funding, and services are already under immense financial strain; it is hard to see how the kind of progress made in Canterbury can be achieved in this austere context. Canterbury's experience also casts doubt over expectations that that new models of care will enable disinvestment in acute hospitals in the NHS. "
Cornwall are expecting to implement this in haste , against a background of severely restricted budgets both NHS and social care and to close hospital beds at the same time !
https://www.kingsfund.org.uk/publications/developing-accountable-care-systems?utm_source=facebook&utm_medium=social&utm_term=socialshare

The Alzira model has been on the back foot in Spain since 2013, when mass health workers' strikes combined with a High Court injunction forced the resignation of Madrid's health minister and the Madrid government's abandonment of its plan to impose the Alzira system on six public hospitals. A new law passed by the Green/Socialist/Podemos regional government in Valencia w brings the health service back into direct public management and provision, and there has been the recent police investigation into Ribera Salud corruption.
https://calderdaleandkirklees999callforthenhs.wordpress.com/2017/09/01/buyer-beware-centene-corporation-contract-with-nottingham-nhs-organisations-is-2-7m-can-of-worms/

Despite this the Alzira model is that being adopted in Nottinghamshire.

There are **not enough staff** to provide existing community services, far less to provide for the increased community provision.

Substantial capital investment is needed to deliver service transformation in STP plans
- £10bn, according to the **Naylor report**, and it will come from property disposals and private ACOs will be bound by the well-established requirements to engage and consult that apply to single providers."
"..major service changes see CCGs bound by the statutory provisions in the 2012 Act"
capital from **new PFI projects** - the so-called **Project Phoenix.**
https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

Footprint organisations will not receive any capital funds from the Treasury unless they sell off property deemed to be 'surplus' but if they do the Treasury will match their receipts in a " 2 for 1" offer. Some of the property deemed surplus may be properties still providing clinical services and community hospitals which have been "temporarily" closed will be in danger.
The sell-off is being planned in haste and secrecy.
In Cornwall the CCGs annual assessment by NHS England states that they have "in place" a "local strategic estates plan."
However when a formal question was submitted to their annual general meeting about this they declined to reveal any details.

Interestingly Naylor does not envisage that the NHS will be able to reduce the number of hospital beds further.

Integration is widely held to be a laudable goal.
But are Accountable Care Organisations are necessary to deliver this objective?

The social care deficit is 2.6 billion.
Local authority spending on adult social care in England fell 8% in real terms between 2009–10 and 2016–17, but was protected relative to spending on other local authority services.

The population has been growing, so spending on adult social services per adult fell by 13.5% in England over the same period. This doesn't take into account that the population is ageing, which will have put additional pressure on adult social care services.
https://www.ifs.org.uk/uploads/publications/bns/BN200.pdf

If this money were made available directly to councils and social care was adequately funded would the drive to ACO be compelling?

Since 2009/10 the number of older **people aged 85 and over rose by almost 9 per cent**
It has become much more difficult for people to get **publicly funded social care; numbers have fallen by 25 per cent since 2009** (from 1.7 million to 1.3 million) and in 90 per cent of local authorities only those with 'substantial' or 'critical' needs will get publicly funded services.

Councillors will be able to access the figures for Cornwall.
I have been told that spending on social care has risen over the past year.
Is it back to 2010 levels in real terms?

There is no money available to help KCCG in their current financial difficulties but there is apparently an offer of writing off existing debt (maybe of the order of £100 million) conditional on the move to ACO .
Why is the offer to write off debts incurred by the underfunding of Cornwall's health service being https://www.ifs.org.uk/uploads/publications/bns/BN200.pdf used as a bribe to achieve an ideologically driven reorganisation in this way?
More money has been pledged by government for social care in 2019/20 but this will be after the transition to Accountable Care Organisations has been done.

Are Accountable Care Organisations necessary to deliver a radical upgrade in prevention?
Again this could simply be solved by funding Public Health properly.
While paying lip-service to improving preventive medicine the public health budget has been repeatedly raided to prop up the inadequately funded acute care sector.

An analysis, based on Department of Communities and Local Government data, shows that public health spending is more than 5 per cent less in 2017/18 than it was in 2013/14 [1].
https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets

The Council are responsible for the Public Health budget.
A recent news story reveals Cornwall Council is cutting £400,000 from health visitors.
This hardly shows commitment to preventive health. It also reveals tensions between the council and it's prospective partners.
https://cornwallreports.co.uk/cornwall-council-is-a-risk-to-future-generations-as-county-hall-cuts-400000-from-health-visitors/

Are Accountable Care Organisations necessary to encourage social prescribing and small scale voluntary organisations?
Social prescribing is not new . Subsidised gym memberships, subsidised membership of Weightwatchers and small scale financial support for patient groups have been around for a while and are perfectly feasible under other structures.
These organisations will be partners in name only- they will not have any decision making input.

Budgetary risk to Cornwall Council.

Andrew George released a statement on 31/12/16 on behalf of the Lib Dems saying that
"Cornwall's STP merely rearranges the diminishing deckchairs of the NHS....The STPs are

fundamentally budget driven and are about forcing local communities to decide how to cut their own services."
The same is true for ACOs.

Even if the historic debt of KCCG is written off , KCCG's Expenditure is set to exceed income by £ 37.6 million.

From KCCG AGM 5/9/17 :
" What we can achieve is not what NHS England needs us to achieve " Simon Bell
Chris Blong said that the CCG have struggled to identify where any further savings could be made
"We have looked down the back of the sofa, checked supermarket trolleys for change"

Dr Rob White asked" Is the problem too big to solve? We are all shying away from the fact that this is going to affect patient care . We can't say that out loud"
He also gave instances where he thought patient care had suffered because of patients being kept out of hospital too long.
Dr Francis Olds concurred that " Anything more drastic would compromise patient care."

With ACOs budgetary risk is transferred from national government to local government. Responsibility and blame for the curtailment of services is transferred to local government. The evidence cited above points to a strong risk that the projected savings of the ACO will not be achieved.

Jan Macfarlane, December 2017