

Writtne Evidnce from Evidence of Professor Allyson Pollock and Mr Peter Roderick**Institute of Health and Society, Newcastle University****Summary**

Neither the Department of Health nor NHS England have consulted on the principle of accountable care organisations (ACOs), which will not be subject to the checks and balances of statutory commissioners. There are many uncertainties, but as presently understood ACOs will not lead to a return to area-based planning, will degrade public involvement and accountability, will replace the internal market with the external market, will not end the purchaser-provider split and are likely to lead to more fragmentation and loss of public control. The Private Finance Initiative has been described as a 'fraud on the people' and ACOs must not be the same. We urge the Committee to recommend that they are not introduced until and unless their intended form, membership, governance and operation has been publically explained, consulted on and provided for in primary legislation.

Introduction

1. Professor Pollock is a Professor of Public Health at Newcastle University, and Director of its Institute of Health and Society. She trained in medicine and public health and worked as a consultant in public health medicine in district health authorities for eight years on planning, needs assessment and community care. She worked with local authorities and a regional health authority on community care plans in the 1990s and published on this. Over a period of 15 years she has also analysed and published widely into the planning and financial basis of more than 30 PFI business cases for hospitals. Mr Roderick is a barrister and Principal Research Associate in the same Institute. They have researched and written extensively on the Health and Social Care Act 2012, during its passage through Parliament and since, and are co-authors of the proposed NHS Reinstatement Bill,¹ last tabled in the House of Commons by Margaret Greenwood MP as the NHS Bill 2016-17.²

2. Professor Pollock is one of five claimants in a judicial review being brought against the Secretary of State for Health and NHS England in relation to their plans for ACOs. Mr Roderick has assisted the claimants.

3. The Department of Health (DH) are planning to make regulations in February to allow ACOs to operate from 1st April 2018. They would be non-statutory bodies receiving billions of pounds of public money under lengthy contracts but without statutory accountability or governance obligations. The government has said that their form and ownership would be up to the ACO to decide,³ and can include, for example, NHS trusts and foundation trusts, GPs and private companies, including insurers, banks and property companies. They can be established as off-shore companies, or as 'special purpose vehicles', as used for PFI – which Sir Howard Davies, chairman of the Royal

¹ www.nhsbillnow.org

² <https://services.parliament.uk/bills/2016-17/nationalhealthservice.html>

³ Hansard. Health Services: Contracts: Written question 105277, 11 October 2017, available at: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-09-14/105277/>

Bank of Scotland, has described recently as a “fraud on the people”.⁴ According to PWC, a special purpose vehicle is:

“an off-balance sheet vehicle (OBSV) comprised of a legal entity created by the sponsor or originator, typically a major investment bank or insurance company, to fulfil a temporary objective of the sponsoring firm. SPVs can be viewed as a method of disaggregating the risks of an underlying pool of exposures held by the SPV and reallocating them to investors willing to take on those risks. This allows investors access to investment opportunities which would not otherwise exist, and provides a new source of revenue generation for the sponsoring firm.”⁵

4. ACOs would need contracts with trusts, GPs, private health companies and voluntary organisations to provide services to or for it, and the definition of an ACO in the draft regulations would allow them to sub-contract all ‘their’ services.⁶ This outsourcing will lead to further fragmentation, loss of public control, more bureaucracy and unnecessary expenditure. Moreover, it is not clear how pooling budgets will work when social services are means-tested and charged for, and health services are not.⁷

5. This is happening without any consultation having been undertaken on the principle of ACOs or primary legislation having been proposed. Indeed, legislation has been said by NHSE Chief Executive, Simon Stevens, as something to “workaround”.⁸

6. Our evidence covers four points which are relevant to the final three bullet points of the inquiry’s terms of reference: area-based planning; public involvement and accountability; ending the internal market and purchaser-provider split; and integration. We also pose some questions for the Committee to consider.

1. Area-based planning

7. One of the common misunderstandings that seems to have arisen is that sustainability and transformation plans (STPs) and accountable care systems (ACSs) would be a return to area-based planning. Unfortunately, this is not the case.

8. Contiguous geographic area populations are the normal basis for the resourcing, planning and provision of services in universal public health care systems which are premised on equity, and services free at the point of delivery.

9. Until 2012 in the NHS in England, the population denominator for needs assessment and resource allocation was the number of residents living in an area using ONS population estimates derived

⁴ <http://www.bbc.co.uk/news/av/uk-politics-42741079/rbs-chairman-pfi-has-been-a-fraud>

⁵ <https://www.pwc.com/gx/en/banking-capital-markets/publications/assets/pdf/next-chapter-creating-understanding-of-spvs.pdf>

⁶ “ ‘ACO’ means a body known as an accountable care organisation, having been so designated by [NHSE] because it is providing or arranging the provision of services under the 2006 Act under contractual arrangements...”: the draft Local Authority Social Services and NHS Complaints (England) (Amendment) Regulations 2017 (*sic*), emphasis added, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643470/Annex_IV-Draft_Complaints_Regulations.pdf

⁷ Sutaria S, Roderick P, Pollock, AM. Are radical changes to health and social care paving the way for fewer services and new user charges? *BMJ* 2017;358:j4279 doi: 10.1136/bmj.j4279

⁸ <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/integrated-health-and-social-care/oral/48009.html>

from the census and updated annually using birth and death registration and other data. There were inevitable criticisms of the formula, which was periodically reviewed and changed,⁹ but the use of these estimates reflected the systemic objective of *covering everybody*; and this systemic objective flowed from the Secretary of State's legal duty to provide services "*throughout England*", delegated to health authorities and primary care trusts.

10. Since 2012, census data are no longer the basis for resource allocation and have been replaced by GP practice lists. This would appear to reflect a systemic objective of *covering individuals on lists*, which would flow from each CCG's duty to arrange services for "*persons for whom it has responsibility*".

11. We say 'would appear to reflect' such a systemic objective – rather than 'do reflect' it - because of an insertion into the definition of "persons for whom [a CCG] has responsibility" during the passage of the Health and Social Care Bill through Parliament. When the Bill was first introduced in January 2011,¹⁰ the definition only included "persons who are provided with primary medical services by a member of the [CCG]". If this had been the enacted definition, then this would clearly have reflected a systemic objective of only covering individuals on lists. However, in the version of the Bill in July 2011 (Bill 221, as amended, on re-committal, in public bill committee), an additional category of persons was added to the definition, namely "persons who usually reside in the [CCG's] area and are not provided with primary medical services by a member of any [CCG]" because of the concern that otherwise everybody would not be covered.

12. This gives the impression that systemically everybody is covered. However, the change from the pre-Bill allocation formula, from area-based to list-based, was implemented regardless of this change in the definition. NHS England acknowledges that:

"using registered lists does not take into account people who are not registered with a GP practice. ACRA [Advisory Committee on Resource Allocation] in 2013 considered whether an adjustment should be made to the formula for unregistered populations, but due to the absence of reliable data being available on the size of the unregistered population by area and their healthcare needs, concluded it is not presently possible to do so."

13. In failing to cover the unregistered population therefore the current allocation formula does not match up with the duty of CCGs. Not only is this inconsistency highly unsatisfactory in itself, the shift from area-based capitation to list-based capitation erodes equity (equal access for equal need), universality (services for all) and social solidarity (risk pooling for everyone). We are very concerned that this problem does not appear to have been widely recognised.

14. Under the draft ACO contract, entitlement would appear to depend on whether an individual falls within the definition of "the Population", either by being registered on the ACO's list (or, for partially-integrated ACOs, on an Associate Practice's list), or by being permanently or temporarily resident in the "Contract Area". This appears to be intended to mirror the definition of persons for whom a CCG has responsibility in s.3(1A) of the 2006 Act (as amended in 2012). To this extent, the mismatch between statute and the allocation formula would continue.

15. But the introduction of these constructs in the contract – which are not in the NHS Standard Contract – also gives rise to several uncertainties.

⁹ A Brief History of Resource Allocation in the NHS 1948-98, RAWP 4:
http://webarchive.nationalarchives.gov.uk/20120503151425/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4109403.pdf

¹⁰ Bill 132 - <https://services.parliament.uk/bills/2010-12/healthandsocialcare/documents.html>

16. It is not clear how people living in the Contract Area would receive health services if they are not on the ACO's list, either because they are not registered on any list or because their GP practice is a member of a CCG which contracts with another ACO, an NHS body or a non-ACO private provider. Neither is it clear who would provide social services to people on the ACO list who live in an area where the local authority does not contract with the ACO, which seems to present an obstacle to integration.

17. The definition of the Contract Area is not clear. It will be shown on a map, and seems to be "the aggregate of the practice areas of the practices absorbed into" the ACO. Whether these practice areas constitute contiguous geographic areas is impossible to know.

18. A note to the proposed definition states that where the ACO "is to provide social care and/or public health services, the Contract Area should be consistent with the relevant local authority area". However, the note also states that "[w]e assume, in particular, that the population for which social care and/or public health services are to be provided under the contract will exclude individuals (whether or not they are Registered Service Users) who are not permanently or temporarily resident in the Contract Area. But this is subject to confirmation by local authority commissioners".

19. NHSE's assumption is worrying, as it suggests that an ACO would not be required to provide services to people who are present, rather than resident, in a local authority area - which is the basis for entitlement to open access sexual health services, for example.¹¹

Questions

- What is the evidence that giving list-based capitation budgets to non-statutory and possibly private bodies will promote a comprehensive health service that
 - delivers universal care on the basis of need and not ability to pay
 - ensures risk pooling rather than risk selection
 - more efficiently allocates resources on the basis of an area's needs
 - ensures public accountability for and scrutiny of transactions
 - ensures that vulnerable communities and people continue to receive local services
 - improves quality and outcomes, and
 - improves the monitoring of equity of access to services and treatments?
- How can services be planned for everyone when not everyone in a CCG's area would be included on the ACO list?
- How can services be provided equitably when not everyone has resources allocated to them because they are not on the ACO list?
- How can equity and access be monitored when people not on the list will not be counted in the denominator and people who are turned away from an ACO are not counted?
- What will be the impact of the estimates of incidence, prevalence and survival and outcomes of diseases and conditions in England?
- How will access and equity be monitored at the local level and under Joint Strategic Needs Assessments when the denominators are derived from GP lists and not an area's residents and where cases are not counted because they are not registered on the ACO list?
- How will socioeconomic, gender, racial and area-based inequalities in care be monitored when not all residents are counted in the denominator and if the ACO list of GP practices

¹¹ The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, Regulation 6, available at: <http://www.legislation.gov.uk/uksi/2013/351/regulation/6/made>

cover multiple CCG areas? In particular, what will be the safeguards against cherry-picking and risk-skimming?

- How will CCGs plan for changes to services if contracts are awarded for 10 to 15 years, and what are the mechanisms for doing so?

2. Public involvement and accountability

20. As well as the accountability issues arising from transferring billions of pounds to non-statutory providers, it appears that public involvement in and accountability for ACO decisions on services would be degraded, compared with the current position, in a number of ways.

21. Firstly, CCGs and NHSE are statutory bodies established by Parliament with statutory obligations to involve the public. ACOs will not be statutory bodies and will not have such statutory obligations. Even if an ACO is led by an NHS foundation trust – which is a statutory body – the involvement of the public is in relation to the trust, not in relation to the ACO.

22. Secondly, public involvement will have to depend on the terms of the ACO contract, which in turn will depend on what the commissioners and the ACO agree. And the terms of a contract are enforceable by the parties to a contract, not by members of the public. The statutory rights remain in place, but they will be distanced from the ACO which will, in the fully-integrated model, have “full responsibility” for services.

23. Thirdly, providers under the current NHS Standard Contract must involve “service users” and “the public” (amongst others) when developing and redesigning services. Under the ACO contract, ACOs will only be required to involve “the Population”, which is a much narrower term than “the public”. This reasoning is in line with the ACO concept, which is not based on providing services to everyone in a geographical area.

24. Fourthly, it is entirely unclear whether the ACO would be amenable to judicial review, or to a human rights or freedom of information challenge, which are remedies available against public bodies. Outsourcing of public services to private and voluntary bodies has led to several cases where the courts have had to wrestle with where and how to draw the line.¹² Private care homes funded through local authority contracts were held by the House of Lords in 2007 not to be exercising functions of a public nature under the Human Rights Act 1998,¹³ and this had to be reversed seven years later by primary legislation.¹⁴

Questions

- How can the public be involved in local decisions about their services if they are not on the list or they are on the list of an ACO which does not include their CCG?
- How will CCGs involve and consult with those people on their list but not resident in their areas, and how will these persons hold the CCG to account?

¹² R v Panel on Take-Over and Mergers, ex parte Datafin [1987] QB 815; R v The Insurance Ombudsman Bureau ex parte Aegon Life [1994] CLC 88; Hampshire County Council v Graham Beer (t/a Hammer Trout Farm) [2003] EWCA Civ 1056, available at: <http://www.bailii.org/ew/cases/EWCA/Civ/2003/1056.html>; Holmcroft Properties Ltd, R (on the application of) v KPMG LLP & Ors [2016] EWHC 323 (Admin), available at: <http://www.bailii.org/ew/cases/EWHC/Admin/2016/323.html>

¹³ YL (by her litigation friend the Official Solicitor) (FC) (Appellant) v. Birmingham City Council and others (Respondents) [2007] UKHL 27, available at: <http://www.bailii.org/uk/cases/UKHL/2007/27.html>

¹⁴ Care Act 2014, section 73, available at: <http://www.legislation.gov.uk/ukpga/2014/23/section/73>

- How effective can public involvement be when the public would have no statutory rights in relation to the ACO?

3. Ending the internal market and purchaser-provider split

25. It has been suggested that STPs, ACSs and ACOs will end the internal market.¹⁵ We agree – the internal market has now become an external market. Removing competition between NHS bodies is to be welcomed, but replacing it with an external market is not.

26. The internal market was introduced in 1990, with the creation of NHS trusts as bodies corporate, the purchaser-provider split, the use of non-legally binding contracts to link the two, competition between trusts, and a charge on capital employed (based on overinflated current valuation and replacement costs) which varied according to the size and state of a trust's estate, land values, equipment intensity and type of facility.¹⁶ (This charge created a revenue stream in the operating budget thereby paving the way for private finance and the switch for capital to be paid from revenue instead of capital budgets). The introduction after 2003 of NHS foundation trusts, which were allowed to retain surpluses and operate commercially with binding contracts, led to joint ventures with private health care providers, use of private finance, a growth in private income and activity, and more contracting.

27. Implementation of the purchaser-provider split was completed by the 2012 Act with abolition of the duty to provide and of primary care trusts.¹⁷ Replacing the Secretary of State's duty to provide with each CCG's duty to arrange provision (i.e., to make contracts), licensing private providers, allowing FTs to receive 49% of their income outside the NHS, and requiring virtually compulsory tendering under the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013, all combined to further the external market.

28. STPs, ACSs and ACOs are a part of and will implement that external market, and cannot be seen in isolation from what is happening to NHS property.

29. NHS Property and Estates has now been transferred to NHS Property Services, one of two Department of Health-owned property companies created in 2013, the other being Community Property Services, which covers LIFT. NHS Property Services now has 3,500 properties valued at over £3 billion pounds for which it is now demanding market rents and property services charges to CCGs, NHS trusts and to those GPs that occupied PCT owned health centres.

30. The introduction of the capital charging regime had been ostensibly to increase efficiency¹⁸. Market rents and property charges are adding to current NHS affordability problems which have been created by underfunding and PFI and a contributory factor in the accelerated closure of some GP practices, CCG mergers and NHS trust estate disposals and mergers.

¹⁵ For example: Is this the end of the NHS's internal market?

<https://www.economist.com/news/britain/21730887-three-decades-market-based-reforms-are-being-rethought-end-nhss-internal>

¹⁶ Shaoul J. Charging for capital in the NHS trusts: to improve efficiency? Management Accounting Research. 1998;9:95–112.

¹⁷ Explanatory Notes, Health and Social Care Act 2012, paragraph 71. Available here: <http://www.legislation.gov.uk/ukpga/2012/7/notes/division/5/1/1>

¹⁸ Heald D, Scott D. The valuation of NHS property under capital charges. Journal of Property Research Volume 1996; 13: issue 4

31. As for ending the purchaser-provider split, we note that NHSE Chief Executive told the Public Accounts Committee that “accountable care organisations or systems...will for the first time since 1990 effectively end the purchaser-provider split, bringing about integrated funding and delivery for a given geographical population”.¹⁹

32. We have already explained why ACOs would not be providing services to geographical populations – they will be providing or arranging for individuals on lists.

33. Neither will they end the purchaser-provider split, because that split was established by Parliament and the legislation remains unchanged – ‘working around it’ doesn’t make it go away.

34. The tendering of an ACO contract, and the significant sub-contracting that the ACO would undertake, demonstrate that the split continues. The Public Contracts Regulations 2015 will continue to apply, which are nothing to do with the 2012 Act. And the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 apply to the tendering of an ACO contract – regulations which the government chose to make, but was not required to make, under the 2012 Act, and which the government could simply revoke if concerns about the unworkability of the 2012 Act lie behind STPs, ACSs and ACOs.

35. Rather, commissioning for health and social care services are to be handed over for many years to bodies of unrestricted membership, with no basis for geographic planning. They would be in charge of allocating resources and designing care, using list-based not area-based capitation, allowed to make contracts for *all* of the services, and not be obliged to provide *any*. In other words, ACOs would become commissioners.

Questions

The same questions arise in relation to the external market as we have set out under section 1 above.

4. Integration

36. Commentators have emphasised that STPs, ACSs and ACOs allow NHS trusts, NHS foundation trusts and GPs to work more collaboratively rather than in competition. This is a desirable aim, however competition will continue because of the external market. Pursuing this aim within the external market will lead to takeovers and mergers since CCGs are obliged to contract and NHS providers obliged to compete. No amount of “emphasis on places, populations and systems rather than organisations”²⁰ will prevent market-driven mergers of NHS providers across CCG areas, let alone make up for the erosion of the geographic basis for planning, needs assessment and local accountability.

37. Integration of health and care services has long been a desirable aim. Parliament legislated for this in 1999, re-enacted in 2006, allowing NHS bodies and local authorities “to work together in new ways by enabling them to pool their resources, delegate functions and resources from one party to another and enable a single provider to provide both health and local authority services”²¹ – i.e., “s.75 partnership arrangements”.

¹⁹ House of Commons. Public Accounts Committee. Oral evidence: Integrated Health and Social Care, HC 959, 27 February 2017, Q93, available at:

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/integrated-health-and-social-care/oral/48009.html>

²⁰ <https://www.kingsfund.org.uk/publications/accountable-care-explained>

²¹ Explanatory Notes, Health Act 1999, paragraph 231. Available here:

38. According to NHSE “the current legislative framework for pooling budgets potentially poses some challenges for the ambitions of ACOs. NHS England has developed evidence to support discussions with the Department of Health about changes to the s.75 arrangements in order to enable the pooling of budgets for all services delivered by an ACO provider”.²²

39. According to the Department of Health, a “number of local areas looking to establish an ACO that includes social care and/or public health services have told us that they would like to see changes to the s75 partnership agreement regulations to help them achieve their ambitions. These regulations enable NHS bodies (CCGs and NHS trusts/FTs) and local authorities to collaborate in the exercise of their functions. The Department of Health continues to keep these regulations and related legislation under review, including considering how the legislative framework might help or hinder progress towards our goal to achieve better, joined up care for people using health and care services.”²³

40. Neither the government nor NHSE have been clear about what the problems are with the s.75 partnership arrangements, and whether they relate to s.75 itself or to regulations made under it. Nor has the evidence referred to by NHSE been made public.

41. But integration can only be achieved through legislation to resolve the different funding and population bases of local authorities, primary care, CCGs and NHS England. However, further fragmentation and loss of public control will result through contracting, and in the absence of the government’s duty to provide throughout England leave wide open the possibility of groups of people and services being excluded from NHS services as providers seek to find ways to reduce their financial risks and maximise their gains.

Question

- How can services be integrated when they have a different funding base, and a different population base?
- How do CCG mergers improve local accountability?
- What are the key drivers for CCG mergers?
- How do takeovers and mergers of NHS providers including general practices by trusts improve local accountability and access?
- How do joint ventures with property companies and health care corporations improve equity, access, efficiency, fairness in resource distribution and local accountability?
- How will private health care activity and income be monitored including use of NHS beds, staff, services and resources?
- How will the distribution of NHS and social services expenditure through an ACO and subcontracts be monitored?
- How will land and estate disposals and joint ventures public-private partnerships be monitored where trusts enter into joint ventures, private finance and sale-and-lease-back arrangements, to ensure local accountability?

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<http://www.legislation.gov.uk/ukpga/1999/8/notes/division/5/1/28>

²² https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-6_A.pdf

²³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643714/ACO-contract-reg-changes-consultation-1.pdf

